Medicare Bulletin
Jurisdiction 15

Reaching Out to the Medicare Community
Articles contained in this edition are current as of February 26, 2019.

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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.

<table>
<thead>
<tr>
<th>Date</th>
<th>PCC Training/Closures</th>
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<tbody>
<tr>
<td>Thursday, April 11</td>
<td>PCC Closed 9:00 – 11:00 a.m. Eastern Time</td>
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<tr>
<td>Thursday, April 25</td>
<td>PCC Closed 9:00 – 11:00 a.m. Eastern Time</td>
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</table>

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](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](https://www.cgsmedicare.com/partb/index.html) and click the "myCGS" button on the left side of the Web page.


Kentucky & Ohio
New Medicare Card Mailing Complete, 58% of Claims Submitted with MBI


Medicare patients are using their new cards in doctor’s offices and other health care facilities. For the week ending January 11, 2019, fee-for-service health care providers submitted 58% of claims with new Medicare Beneficiary Identifiers (MBIs), showing that many of you are already successfully submitting claims with MBIs. While you can continue using the former Social Security Number-based Health Insurance Claim Numbers during the transition period, we encourage you to use the new MBIs for all Medicare transactions.

To ensure that you have access to your patients’ new numbers, you can individually look up MBIs if you have access to your Medicare Administrative Contractor’s secure provider portal.
If your Medicare patients say they did not get a card, instruct them to:

- Look for unopened mail. We mailed new Medicare cards in a plain white envelope from the Department of Health and Human Services.
- Sign into MyMedicare.gov (https://www.mymedicare.gov/) to get their new numbers or print official cards. They need to create an account if they do not already have one.
- Call 1.800.MEDICARE (1.800.633.4227), so we can help them get their new cards.
- Continue to use their current cards to get health care services. They can use their old cards until December 31, 2019.

**Kentucky & Ohio**

**Coming Soon to Part B Reopenings**

Part B Reopenings will be updating form submissions to allow additional automation. Automation enables providers to submit required values which allow the claim to automate and adjust the claim without manual intervention. This will allow providers to be paid quicker.

Submitting Reopening requests utilizing the CGS Web Portal, myCGS, increases provider automation as some types of automation are not available through paper submissions.

Current automation allow providers to add/remove/replace modifiers, update diagnosis codes, procedure code changes, billed amount changes, correct dates of service, cancel a claim and cancel a line.

Future automation will allow providers to change units billed, correct the place of service, correct the rendering National Provider Identifier (NPI) number, reprocess a claim for an updated fee schedule, and reprocess a claim which initially denied for MSP and records are now updated.

Automation will also allow providers the ability to make multiple types of corrections in one adjustment. This will include current types of automation and new types of automation with some exceptions.

Providers are encouraged to utilize the myCGS Web Portal (https://www.cgsmedicare.com/partb/mycgs/index.html) for quick, easy, and accurate submission of your reopening requests.

Watch for notice of upcoming dates for the new Part B Reopenings automation.

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The MAC Satisfaction Indicator (MSI) is the best way to share your opinions directly with the Centers for Medicare & Medicaid Services (CMS) about your experience with us. These survey results will help us gain valuable insights and determine process improvements.

Thank you for your feedback.
Kentucky & Ohio

Local Coverage Article: Therapeutic Apheresis for Familial Hypercholesterolemia (A56289)

Change Request 10473 added CPT code 36516 to the editing criteria for National Coverage Determination (NCD) 20.5 because CPT code 36515 was deleted. With this addition, CPT code 36516 may be allowed if billed for apheresis. Claim editing has been updated and claims denied have been adjusted. You may refer to the local coverage article for Therapeutic Apheresis for Familial Hypercholesterolemia (A56289) for additional guidance. The article is located at https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=56289&ver=2&SearchType=Advanced&CoverageSelection=Local&ArticleType=Ed&s=22&DateTag=C&kq=true&bc=IAAAAACAAAAA&.

Kentucky & Ohio

Need a Duplicate Electronic Remittance or Claim Response Report? Online Ordering is Available and Easy with the EDI Report Request Tool!

Did you know that you can quickly order a duplicate 835 Electronic Remittance or a duplicate 999 and 277CA Claims Response Report without calling our EDI helpdesk? The CGS EDI Report Request Tool will allow you to order duplicate 835 remittances that are within 45 calendar days and duplicate Response Reports (999 and 277CA) that are within 1 year from the current date. This tool is available for J15 providers, clearinghouses and billing services and can be found on the Part B Self-Service Options Web page at https://www.cgsmedicare.com/partb/tools/index.html or you can access directly at https://www.cgsmedicare.com/medicare_dynamic/edi_reports/001.asp

Kentucky & Ohio

New to Filing An Appeal or Just Want to Know What’s New? CGS Has a Web Page Designed Just for You!

Visit us at: https://www.cgsmedicare.com/partb/appeals/index.html

Providers and beneficiaries may appeal an initial claim determination when Medicare’s decision is to deny or partially deny a claim. The appeals web-page contains helpful information at a click of a button.

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<th>Question</th>
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<tr>
<td>Need to know which level of appeal the claim should be submitted to?</td>
<td>Click on the “Level of Appeal” button.</td>
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<tr>
<td>Need to know when to or when not to file an appeal?</td>
<td>Click on the “When to File Appeal” or the “When Not to File Appeal” buttons.</td>
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<tr>
<td>Need help determining what documentation to submit with the appeal?</td>
<td>Click on the “What Should I Submit with My Appeal?” button.</td>
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<tr>
<td>Need help finding out the deadline for filing the appeal?</td>
<td>Click on the “Timeliness Calculator” button.</td>
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<tr>
<td>Need help determining what form to use?</td>
<td>Click on the “Which form do I use?” button and following the Appeals Decision Tree.</td>
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<tr>
<td>Already know what form you need?</td>
<td>Click on the “Forms” button for a quick and easy way to get to the forms.</td>
</tr>
<tr>
<td>Have questions on PQRS, EHR, VBMQ or Legislative CMS Reductions?</td>
<td>Click on the “CMS Reductions” button.</td>
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<tr>
<td>Need help decreasing the need to submit appeals?</td>
<td>Click on the “Appeals Data Analysis” button.</td>
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<td>Need to view CMS Resources?</td>
<td>Click on the “CMS Resources” button.</td>
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<tr>
<td>For Other Helpful Tools</td>
<td>Click on the “Job Aid” button.</td>
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**Current Buttons Available**

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<th>Current Buttons Available</th>
<th>Timeliness Calculator</th>
<th>Which Form Do I use?</th>
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<td>What should I submit with My Appeal?</td>
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**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](http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp) and complete the required information.

**Kentucky & Ohio**

**Physicians and Non-Physician Practitioners:**

**New Medicare Enrollment Application**

CMS received approval for a new Medicare Enrollment Application for physicians and nonphysician practitioners (CMS-855I dated 12/2018). Many changes are minor; the major ones reduce provider burden:

- Eliminated reporting for advanced diagnostic imaging, Clinical Laboratory Improvement Amendments number, and the Food and Drug Administration radiology certification number
- Expanded instructions for individual and group affiliations to simplify reporting
- Made it optional to list a contact person
- Added electronic storage information for those who no longer keep paper records
- Created a more logical data flow

You may begin using the new application immediately. Through April 30, Medicare Administrative Contractors will accept applications dated 7/2011, but after that, you have to use the new version.
MM10901 Revised: Local Coverage Determinations (LCDs)

MLN Matters Number: MM10901 Revised
Related CR Transmittal Number: R863PI
Effective Date: October 3, 2018
Related CR Release Date: February 12, 2019
Related Change Request (CR) Number: 10901
Implementation Date: January 8, 2019

Note: We revised the article on February 14, 2019, to reflect the revised CR 10901 issued on February 12, 2019, that includes changes to the updates in Chapter 13 of the Medicare Program Integrity Manual. The CR changed the effective date to October 3, 2018; we made that change in the article. CMS also revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

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
CR 10901 notifies MACs that, in accordance with Section 4009 of H.R. 34-21st Century Cures Act (Public Law No: 114-255), the Centers for Medicare & Medicaid Services (CMS) is updating the “Medicare Program Integrity Manual” with detailed changes to the LCD process. You should ensure that your staffs are aware of these changes.

Background
Through feedback received in the proposed Calendar Year (CY) 2018 Physician Fee Schedule (PFS) Rule (82 FR 33950), and through meetings and correspondence; stakeholders, including providers and health care associations, have provided CMS with valuable insight regarding modernization of the LCD process.

Most stakeholders acknowledged that the local coverage process is an important means to provide decisions related to the items and services that benefit Medicare’s beneficiaries and to ensure beneficiary access to life saving and medically necessary products and procedures.

However, there is concern about the lack of local coverage process transparency, including notifying stakeholders of proposed revisions to, and drafting of, new LCDs.

Additional stakeholder concerns include: ineffective MAC processes for soliciting from, and providing to, stakeholders feedback on information provided during open public meetings, a lack of non-physician representation on Contractor Advisory Committees (CACs), and concerns that CAC meetings are not open to the public.

In CR10901, the revisions to the Medicare Program Integrity Manual, Chapter 13, CMS is revising instructions to MACs, reflecting policy process changes in response to the new statutory (21st century Cures Act) requirements and to the stakeholder comments. These changes will help to increase transparency, clarity, consistency, reduce provider burden and enhance public relations while retaining the ability to be responsive to local clinical and coverage policy concerns.

The 2016 21st Century Cures Act included changes to the LCD process, adding language to 1862(l)(5)(D) of the Social Security Act (the Act) to describe the LCD process. Section 1862(l)(5)(D) of the Act requires each MAC that develops an LCD to make available on their website, at least 45 days before the effective date of such determination, the following information:

• Such determination in its entirety
• Where and when the proposed determination was first made public
• Hyperlinks to the proposed determination and a response to comments submitted to the MAC with respect to such proposed determination
• A summary of evidence that was considered by the contractor during the development of such determination and a list of the sources of such evidence
• An explanation of the rationale that supports such determination
CMS revamped the format of the manual so that it could be used as a roadmap to understand the steps of the local coverage process, which enable stakeholders to effectively engage in the process. This transparency also carries through to the reconsideration process, which is a process by which stakeholders can request a MAC take a second look at an existing decision using evidence that has developed since its first review.

The manual also sets forth consistent requirements for communication to providers and other stakeholders to occur at predictable milestones so anyone with an interest in the local policy can stay informed as the policy moves through the process.

**New LCD Process**

The key parts of the New LCD Process are summarized as follows:

1. **The New LCD Process may begin with informal meetings in which interested parties within the MAC’s jurisdiction can discuss potential LCD requests. These educational meetings, which are not required, can be held either in person, using web-based technologies, or via teleconference, which allow discussions before requestors submit a formal request.**

2. **New LCD Requests**

   The New LCD Request Process is a mechanism through which interested parties within a MAC’s jurisdiction can request a new LCD. In this process, MACs will consider all new LCD requests from:

   - Beneficiaries residing or receiving care in the MAC’s jurisdiction
   - Health care professionals doing business in the MAC’s jurisdiction
   - Any interested party doing business in the MAC’s jurisdiction

   MACs will consider a New LCD Request to be a complete, formal request if the following requirements are met. The request:

   - Is in writing and is sent to the MAC via email, facsimile or written letter
   - Clearly identifies the statutorily-defined Medicare benefit category to which the requestor believes the item or service applies
   - Identifies the language that the requestor wants in an LCD
   - Includes a justification supported by peer-reviewed evidence (full copies of published evidence must be included or the request is not valid)
   - Addresses relevance, usefulness, clinical health outcomes, or the medical benefits of the item or service
   - Fully explains the design, purpose, and/or method, as appropriate, of using the item or service for which the request is made.

   Within 60 calendar days of the day they receive the request; MACs will review the materials and determine whether the request is complete or incomplete. If the request is complete, the MAC will follow the New LCD Process, as described in the revised manual. If, however, the process is incomplete, they will respond, in writing, to the requestor explaining why the request was incomplete.

3. **Clinical Guidelines, Consensus Documents and Consultation**

   During an LCD’s development, MACs should (when applicable and available) supplement their research with clinical guidelines, consensus documents, or consultation by experts (recognized authorities in the field), medical associations or other health care professionals for an advisory opinion. They will summarize the opinions they receive as a result of this consultation with health care professional expert(s), professional societies, and others prior to the drafting of a proposed or final LCD, and include this information in the proposed or final LCD. Note that acceptance by individual health care providers, or even a limited group of health care providers, does not indicate general acceptance of the item or service by the medical community.
4. Publication of the Proposed LCD

The public announcement of a MAC’s proposed determination begins with the date the proposed LCD is published on the Medicare Coverage Database (MCD) at https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Once the proposed LCD is published, MACs will provide a minimum of 45 calendar days for public comment, and will contact the CMS if they determine an extension to the comment period is needed.

These processes shall be used for all LCDs except in the following situations:

- Revised LCD Being Issued for Compelling Reasons.
- Revised LCD that Makes a Non-Substantive Correction - For example, typographical or grammatical errors that do not substantially change the LCD.
- Revised LCD that Makes a Non-discretionary Coverage Update - Contractors shall update LCDs to reflect changes in NCDs or when a conflict with national policy occurs, coverage provisions in interpretive manuals, and payment systems.
- Revise LCD to effectuate an Administrative Law Judge’s decision to nullify an existing LCD due to an LCD Challenge.

5. Contractor Advisory Committee (CAC)

The CAC is to be composed of health care professionals, beneficiary representatives, and representatives of medical organizations; and is used to supplement the MAC’s internal expertise, and to ensure an unbiased and contemporary consideration of “state of the art” technology and science. Additionally, all CAC meetings will be open to the public to attend and observe.

MACs will establish one CAC per state or have the option of establishing one CAC per jurisdiction or multi-jurisdictional CAC with representation from each state. If a MAC chooses to have one CAC per jurisdiction or multi-jurisdictional CAC, the MAC must endeavor to ensure that each state has a full committee and the opportunity to discuss the quality of the evidence used to make a determination.

The CAC’s purpose is to provide a formal mechanism for health care professionals to be informed of the evidence used in developing the LCD and promote communications between the MACs and the health care community. The CAC is advisory in nature, with the final decision on all issues resting with MACs.

6. Open Meeting

After the proposed LCD is made public, MACs will hold open meetings to discuss the review of the evidence and the rationale for the proposed LCD(s) with stakeholders in their jurisdiction. Interested parties (generally those that would be affected by the LCD, including providers, physicians, vendors, manufacturers, beneficiaries, caregivers, etc.) can make presentations of information related to the proposed LCDs. Members of the CAC may also attend these open meetings. MACs must notify the public about the dates and location for the open meeting. MACs have the option of setting up email electronic mailing lists to announce this information or may use other education methods to adequately inform the public. The electronic mailing list or other method should clearly identify the location, dates and telephone/video/on-line conference information for the open meeting to ensure that this information is clearly distinguished from the information for the CAC meetings.

7. Publication of the Final Determination

After the close of the comment period and the required meetings and consultation, the final LCD and the Response to Comment (RTC) Article will be published on the MCD.
8. Response to Public Comments

MACs will respond to all comments received during the comment period of the proposed LCD by using the RTC article associated with the LCD. The RTC Article is published on the start date of the notice period. The RTC Article will remain publicly available indefinitely on the MCD or the MCD Archive.

9. Notice Period

The date the final LCD is published on the MCD, marks the beginning of the required notice period of at least 45 calendar days before the LCD can take effect. If the notice period is not extended by the MAC, the effective date of the LCD is the 46th calendar day after the notice period began.

Full details of this new process are in the updated manual which is an attachment to CR10901.

**LCD Reconsideration Process**

The LCD reconsideration process is a mechanism by which a beneficiary or stakeholder (including a medical professional society or physician) in the MAC’s jurisdiction can request a revision to an LCD. The LCD reconsideration process differs from an initial request for an LCD in that it is available only for final effective LCDs. The whole LCD or any provision of the LCD may be reconsidered. In addition, MACs have the discretion to revise or retire their LCDs at any time on their own initiative. This process is summarized as follows:

1. MACs shall consider all LCD reconsideration requests from:
   - Beneficiaries residing or receiving care in a contractor’s jurisdiction
   - Providers doing business in a contractor’s jurisdiction
   - Any interested party doing business in a contractor’s jurisdiction

2. MACs should only accept reconsideration requests for LCDs published as an effective final. Requests shall not be accepted for other documents including:
   - National Coverage Determinations (NCDs);
   - Coverage provisions in interpretive manuals;
   - Proposed LCDs;
   - Template LCDs, unless or until they are adopted and in effect by the contractor;
   - Retired LCDs;
   - Individual claim determinations
   - Bulletins, articles, training materials; and
   - Any instance in which no LCD exists, that is, requests for development of an LCD.

3. Process Requirements - The requestor shall submit a valid LCD reconsideration request to the appropriate MAC, following instructions on the MAC’s website. Within 60 calendar days of the day the request is received, the MAC shall determine whether the request is valid or invalid. If the request is invalid, the MAC will respond, in writing, to the requestor explaining why the request was invalid. If the request is valid, the MAC will open the LCD and follow the LCD process as outlined in the above for new LCDs or include the LCD on the MAC’s waiting list. The MAC shall respond, in writing, to the requestor notifying the requestor of the acceptance, and if applicable, wait-listing, of the reconsideration request.

**Other Important Changes**

Other key changes to the manual include the following:

- MACs shall finalize or retire all proposed LCDs within one calendar year of publication date on the MCD.
- Upon further notice from CMS, it will no longer be appropriate to routinely include Current Procedure Terminology (CPT) codes or International Classification of Diseases- Tenth
Revision-Clinical Modification (ICD-10-CM) codes in the LCDs. All codes will be removed from LCDs and placed in billing & coding articles that are linked to the LCD.

Additional Information


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

As part of the CMS commitment to continuous improvement, CMS invites interested stakeholders to submit feedback on their experience with the revised LCD process. CMS will collect feedback via submissions to LCDmanual@cms.hhs.gov and consider additional revisions based on stakeholder feedback.

Document History

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<tr>
<td>February 14, 2019</td>
<td>CMS revised the article to reflect the revised CR 10901 issued on February 12, 2019, that includes changes to the updates in Chapter 13 of the Medicare Program Integrity Manual. The CR changed the effective date to October 3, 2018, and we made that change in the article. CMS also revised the CR release date, transmittal number, and the web address of the CR.</td>
</tr>
<tr>
<td>February 1, 2019</td>
<td>The article was revised to reflect the revised CR 10901 issued on January 30, 2019, to include the updates in Chapter 13 of the “Medicare Program Integrity Manual”, which were erroneously not updated in the most recent on-line manual change. The effective date in the article was also corrected. We also revised the CR release date, transmittal number, and the web address of the CR.</td>
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<tr>
<td>January 11, 2019</td>
<td>We revised the article to reflect the revised CR 10901 issued on January 11. In the article, we added language to show that MACs have the discretion to host multi-jurisdictional CACs. Also, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.</td>
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<td>October 3, 2018</td>
<td>Initial article released.</td>
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Kentucky & Ohio

**MM11003 Revised:** Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System

**MLN Matters Number:** MM11003 Revised  **Related CR Release Date:** February 21, 2019

**Related CR Transmittal Number:** R2264OTN  **Related Change Request (CR) Number:** 11003

**Effective Date:** July 1, 2019  **Implementation Date:** July 1, 2019

*Note:* We revised the article on February 22, 2019, to reflect the revised CR11003 issued on February 21. In the article, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

**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) 11003 makes the changes required to send Additional Documentation Request (ADR) letters to participating providers via the (esMD) system.

A CR to effectuate the exchange of ADR letters to registered providers via the esMD system will be released later.
Background

In response to a number of requests from Medicare providers, the Centers for Medicare & Medicaid Services (CMS) is adding the functionality to send ADR letters electronically. CMS conducted a pilot supporting the electronic version of the ADR letter known as Electronic Medical Documentation Request (eMDR) via the esMD system. Since the eMDRs may contain Protected Health Information (PHI) data being sent to the prospective provider, CMS will require a valid consent from the authorized individual representing the provider along with the destination details including any delegation to their associated or representing organizations such as Health Information Handlers (HIHs).

The sender (esMD) will have to complete the required identity proofing and always make sure to check for any registration updates before sending each eMDR. CR 11003 will effectuate the automation of eMDR registration and any corresponding updates will be done with esMD support.

CMS is requiring its review contractors to support sending ADR letters electronically as eMDRs. The Payment Error Rate Measurement contractors are exempted from this mandate. The Comprehensive Error Rate Testing (CERT) contractors and the Quality Improvement Organizations (QIO) can opt to participate in the eMDR process.

Registration Assumptions

- A provider (by billing National Provider Identifier (NPI)) registering for the first time to receive eMDR will receive both electronically and by postal mail for the first three ADRs.
- A provider enrollment for MAC portals and Direct Data Entry (DDE) (Part A) are separate from eMDR enrollment and registration.
- A provider (by billing NPI) registering for eMDR is applicable to receive eMDRs for all its Provider Transaction Access Numbers (PTANs).

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**

**MM11022:** Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)—Clarification of Payment Rules and Expansion of International Classification of Diseases Tenth Edition (ICD-10) Diagnosis Codes

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<td>Related CR Release Date: February 1, 2019</td>
<td>Related CR Transmittal Number: R4229CP</td>
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<td>Effective Date: May 25, 2017</td>
<td>Implementation Date: July 1, 2019, shared system edits, March 19, 2019, local MAC edits</td>
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**Provider Type Affected**

This MLN Matters® Article is intended for physicians and providers billing Medicare Administrative Contractors (MACs) for Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) provided for Medicare beneficiaries.

**Provider Action Needed**

CR 11022 informs providers that on May 25, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD) to cover SET for Medicare beneficiaries with Intermittent Claudication (IC) for the treatment of symptomatic PAD. See the Key Points section of this article and make sure your billing staff is aware of this update.

**Background**

SET involves the use of intermittent walking exercise, which alternates periods of walking to moderate-to-maximum claudication, with rest. SET has been recommended as the initial treatment for patients suffering from IC, the most common symptom experienced by people with PAD.

**Key Points**

On May 25, 2017, CMS issued an NCD to cover SET for beneficiaries with IC for the treatment of symptomatic PAD. Medicare will cover up to 36 sessions over a 12-week period if all of the following components of a SET program are met:

- Consist of sessions lasting 30-60 minutes comprising a therapeutic exercise-training program for PAD in patients with claudication
- Conducted in a hospital outpatient setting, or a physician’s office
- Delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD
- Under the direct supervision of a physician (as defined in Section 1861(r)(1)) of the Social Security Act (the Act), physician assistant, or nurse practitioner/clinical nurse specialist (as identified in Section 1861(aa)(5) of the Act) who must be trained in both basic and advanced life support techniques

Beneficiaries must have a face-to-face visit with the physician responsible for PAD treatment to obtain the referral for SET. At this visit, the beneficiary must receive information regarding cardiovascular disease and PAD risk factor reduction, which could include education, counseling, behavioral interventions, and outcome assessments.

MACs have the discretion to cover SET beyond 36 sessions over 12 weeks and may cover an additional 36 sessions (up to 72 sessions) over an extended period of time.

MACs will accept the inclusion of the -KX modifier on the claim line(s) as an attestation by the provider of the services that documentation is on file verifying that further treatment beyond the 36 sessions of SET over a 12-week period meets the requirements of the medical policy.
SET is non-covered for beneficiaries with absolute contraindications to exercise as determined by their primary attending physician.

**Coding Requirements for SET**

Providers should use Current Procedural Terminology (CPT) 93668 (Under PAD Rehabilitation) to bill for these services with appropriate ICD-10 Code as follows:

<table>
<thead>
<tr>
<th>I70.211 – right leg</th>
<th>I70.511 – right leg</th>
</tr>
</thead>
<tbody>
<tr>
<td>I70.212 – left leg</td>
<td>I70.512 – left leg</td>
</tr>
<tr>
<td>I70.213 – bilateral legs</td>
<td>I70.513 – bilateral legs</td>
</tr>
<tr>
<td>I70.218 – other extremity</td>
<td>I70.518 – other extremity</td>
</tr>
<tr>
<td>I70.311 – right leg</td>
<td>I70.611 – right leg</td>
</tr>
<tr>
<td>I70.312 – left leg</td>
<td>I70.612 – left leg</td>
</tr>
<tr>
<td>I70.313 – bilateral legs</td>
<td>I70.613 – bilateral legs</td>
</tr>
<tr>
<td>I70.318 – other extremity</td>
<td>I70.618 – other extremity</td>
</tr>
<tr>
<td>I70.411 – right leg</td>
<td>I70.711 – right leg</td>
</tr>
<tr>
<td>I70.412 – left leg</td>
<td>I70.712 – left leg</td>
</tr>
<tr>
<td>I70.413 – bilateral legs</td>
<td>I70.713 – bilateral legs</td>
</tr>
<tr>
<td>I70.418 – other extremity</td>
<td>I70.718 – other extremity</td>
</tr>
</tbody>
</table>

MACs will deny claim line items for SET (CPT 93668) unless accompanied by ICD-10 codes in the table above, which also includes the codes identified in CR 10295 (see MM10295, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10295.pdf):

When denying a line-item on those claims, MACS will use the following codes:

- Claim Adjustment Reason Code (CARC) 167: This (these) diagnosis (es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386: “This decision was based on a NCD 20.35. 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 liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group 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.

**Special Billing Requirements for Professional Claims**

Medicare allows professional claim services for SET only in place of service (POS) 11 (office). MACs will deny claims with any other POS for SET on or after May 25, 2017, using the following messages:

- Claim Adjustment Reason Code (CARC) 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.
- Remittance Advice Remark Code (RARC) N386: “This decision was based on a NCD 20.35. 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.”
Special Billing Requirements for Institutional Claims

Medicare requires institutional claims for SET be submitted on Type of Bills (TOB) 13X or 85X. MACs will deny line items on institutional claims for SET that are not submitted on TOB 13X or 85X using the following messages:

- **CARC 58:** “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. 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 NCD 20.35. 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 CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed Advance Beneficiary Notice (ABN) is on file.

**Note:** Effective May 25, 2017, Medicare will not pay claims for SET services containing CPT 93668 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II.

MACs will not search and adjust any SET claims (CPT 93668) prior to the implementation of CR 11022. However, they may adjust such claims that you bring 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](http://go.cms.gov/MAC-website-list).

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**Kentucky & Ohio**

**MM11061: Independent Laboratory Billing of Laboratory Tests for End-Stage Renal Disease (ESRD) Beneficiaries and the Sunset of the CB Modifier**

- **MLN Matters Number:** MM11061
- **Related CR Release Date:** February 1, 2019
- **Related CR Transmittal Number:** R4227CP
- **Effective Date:** July 1, 2019
- **Related Change Request (CR) Number:** 11061
- **Implementation Date:** July 1, 2019

**Provider Type Affected**

This MLN Matters Article is intended for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for ESRD services provided to Medicare beneficiaries.
Provider Action Needed
Change Request (CR) 11061 sunsets the requirement for Independent Laboratories to use the CB modifier to bill separately for renal dialysis laboratory tests. Make sure your billing staff is aware of these changes.

Background
The Skilled Nursing Facility (SNF) Consolidated Billing (CB) provision requires a SNF to include on its Part A bill almost all of the services that its residents receive during the course of a Part A covered stay. There are several categories of services that the Social Security Act ((Section 1888(e)(2)(A)(ii) (https://www.ssa.gov/OP_Home/ssact/title18/1888.htm) specifically excludes from this provision. These excluded services remain separately billable under Part B by the outside provider or supplier that furnishes them.

One of the excluded categories encompasses those items and services that fall within the scope of the Part B benefit that covers chronic dialysis for beneficiaries with ESRD (see the Social Security Act (Section 1861(s)(2)(F)) at https://www.ssa.gov/OP_Home/ssact/title18/1861.htm).

Prior to January 1, 2011
Prior to January 1, 2011, Medicare paid independent laboratories directly for furnishing diagnostic tests that were ESRD dialysis-related. For purposes of the SNF CB, ESRD dialysis-related was defined as:

1. The beneficiary must be an ESRD beneficiary.
2. The test must have been ordered by an ESRD facility.
3. The test must relate directly to the dialysis treatment of the beneficiary’s ESRD.

Therefore, an independent laboratory could be paid separately (outside of the SNF CB) for an ESRD dialysis-related diagnostic test furnished to a SNF Part A resident, provided the test was outside the ESRD facility’s composite rate when the diagnostic test was billed with the CB modifier – services ordered by a dialysis facility physician as part of the ESRD beneficiary’s dialysis benefit, is not part of the composite rate, and is separately reimbursable.


January 1, 2011, ESRD Prospective Payment System (PPS)
The Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b), https://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf) required the implementation of the ESRD PPS effective January 1, 2011.

The ESRD PPS replaced the basic case-mix adjusted composite payment system and the methods for the reimbursement of separately billable outpatient ESRD related items and services. The ESRD PPS provides a single payment to ESRD facilities (that is, hospital-based providers of services and renal dialysis facilities) that pays for all the resources used in providing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis in the ESRD facility or at a patient’s home, drugs, biologicals, laboratory tests, training, and support services.

The ESRD PPS includes CB requirements for limited Part B services included in the ESRD facility’s bundled payment. The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of items and services that are subject to Part B CB and are, therefore, no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities.

Since the implementation of the ESRD PPS, independent laboratories are no longer able to bill Medicare directly for any diagnostic test that is related to the treatment of ESRD as payment for the test is already included in the ESRD PPS base rate paid to the ESRD facility. CMS inadvertently did not eliminate the use of the CB modifier in the ESRD PPS.

**CR 11061 July 1, 2019, Sunset of CB Modifier**

Therefore, CR 11061 sunsets the requirement for independent laboratories to use the “CB” HCPCS modifier to bill separately for renal dialysis laboratory tests.

Effective January 1, 2011, independent laboratories are no longer allowed to report the CB modifier. All laboratory tests determined to be furnished for the treatment of ESRD are paid in the ESRD facility bundled payment and therefore, may only be reported by the ESRD facility.

Therefore, effective with dates of service on or after July 1, 2019, the CB modifier, which is a payment mechanism for independent laboratories to report when requesting separate payment outside the SNF CB for ESRD dialysis-related services, will not be available.

Effective with dates of service on or after July 1, 2019, claims with the CB modifier will be returned to the provider (RTP) with the following codes:

- Reason code 31164 - Invalid line item modifier or line item date of service is not within or equal to modifier effective and termination date
- CARC Code 182 - “Procedure modifier was invalid on the date of service.”
- Group Code CO - Contractual Obligation.

With the January 1, 2011, implementation of the ESRD PPS and effective for date of service on or after July 1, 2019, Exhibit 1 (see “Medicare Claims Processing Manual” Chapter 16, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf) is no longer recognized as the list of separately billable ESRD dialysis-related services. Instead, a list of the recognized renal dialysis laboratory tests that are subject to Part B ESRD PPS CB requirements, are considered routinely performed for the treatment of ESRD, and are not separately paid when provided to ESRD beneficiaries by providers or suppliers other than the ESRD facility, is located on the CMS website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html.

The list of renal dialysis laboratory tests provided in the Part B ESRD PPS CB requirements is not an all-inclusive list. For laboratory tests not included in this list, the distinction of what is considered to be a renal dialysis laboratory test is a clinical decision determined by the ESRD beneficiary’s ordering practitioner. If the practitioner orders such a laboratory test for the treatment of ESRD, then the laboratory test is considered to be included in the ESRD PPS, is the responsibility of the ESRD facility and is excluded from the SNF PPS. More information regarding renal dialysis services payable under the ESRD PPS is available in the “Medicare Benefit Policy Manual”, Chapter 11 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c11.pdf).

Beneficiaries in a SNF Part A stay are eligible for a broad range of diagnostic services as part of the SNF Part A benefit. Physicians ordering medically necessary diagnostic tests that are not directly related to the beneficiary’s ESRD are subject to the SNF CB requirements. Physicians may bill the A/B MAC (B) for the professional component of these diagnostic tests. In most cases, however, the technical component of diagnostic tests is included in the SNF PPS rate and is not separately billable to the A/B MAC (B). Physicians should coordinate with
the SNF in ordering such tests since the SNF will be responsible for bearing the cost of the technical component.

**Note:** A patient’s physician or practitioner may order a laboratory test that is included on the list of items and services subject to CB edits for reasons other than for the treatment of ESRD. When this occurs, the SNF CB applies.

**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**

**MM11112: Processing Instructions to Update the Standard Paper Remit (SPR)**

**MLN Matters Number:** MM11112

**Related CR Transmittal Number:** R2245OTN

**Related Change Request (CR) Number:** 11112

**Effective Date:** July 1, 2019

**Implementation Date:** July 1, 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) 11112 instructs MACs to update their systems to ensure that SPRs mailed after July 1, 2019, mask the Health Insurance Claim Number (HICN), so the Social Security Number (SSN) does not show. Make sure your billing staff is aware of these instructions.

**Background**

With the passage and signing of the Social Security Number Fraud Prevention Act of 2017, which became Public Law No. 115-59, the law, restricts the inclusion of SSNs on documents sent by mail by the Federal Government effective not later than 5 years after the date of its enactment.

CR 11112 instructs MACs to update their systems, effective July 1, 2019, to mask the HICNs (for example, xxxxx7777A, xxxxx7777C1) and the Railroad Retirement Board HICNs (for example, Axxxxx1370, WCAxxxxx2388, and CAxxxxx1) on any print file used to create an SPR for mailing. **The Medicare Beneficiary Identifier (MBI) will not be masked.**

**Note:** This masking requirement does not apply to RRB numbers issued before March 1964, which include an alpha prefix and 6 digits (for example, A000000).

**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).
The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, Pub. L. No. 110-275, Section 144 (2008) established coverage for cardiac rehabilitation programs and ICR programs under Part B. These provisions are primarily codified in section 1861(eee) of the Act. The Centers for Medicare & Medicaid Services (CMS) implemented the statutory provisions through rulemaking codified at 42 CFR 410.49 that were effective January 1, 2010.

Effective January 1, 2010, Medicare Part B covered ICR program services for beneficiaries who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months;
- A coronary artery bypass surgery;
- Current stable angina pectoris;
- Heart valve repair or replacement;
- Percutaneous transluminal coronary angioplasty or coronary stenting;
- A heart or heart-lung transplant.

Effective February 9, 2018, Section 51004 of the BBA of 2018, Pub. L. No. 115-123 (2018), amended Section 1861(eee)(4)(B) of the Act to expand coverage in an ICR to the following additional conditions:

- Stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35 percent or less and New York Heart Association (NYHA) Class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks; or
- Any additional condition for which the Secretary has determined that a cardiac rehabilitation program will be covered, unless the Secretary determines, using the same process used to determine that the condition is covered for a cardiac rehabilitation program, that such coverage is not supported by the clinical evidence.
Expanded Coverage

CMS plans to amend the ICR regulations specified at 42 CFR 410.49 (https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5%3Bnode%3D42%3A0.1.2.10&se=42.2.410_149) to reflect this expanded coverage. CMS anticipates that the changes will be included in the 2020 Medicare Physician Fee Schedule notice of proposed rulemaking. However, because the expanded coverage under the statutory change was effective upon enactment, expanded ICR coverage for these conditions will be made effective for services furnished on or after February 9, 2018. See Pub. 100-02, "Medicare Benefit Policy Manual", Chapter 15 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf), Section 232 and Pub 100-04, Chapter 32, Section 140.3.

Note: For claims with dates of service on or after February 9, 2018, but received before the implementation date of CR 11117, MACs will not search their files, but they 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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<tr>
<td>February 6, 2019</td>
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</table>

Kentucky & Ohio

**MM11121: Healthcare Provider Taxonomy Codes (HPTCs) April 2019 Code Set Update**

**MLN Matters Number:** MM11121  
**Related CR Transmittal Number:** R4239CP  
**Effective Date:** July 1, 2019  
**Related CR Release Date:** February 15, 2019  
**Related Change Request (CR) Number:** 11121  
**Implementation Date:** July 1, 2019

**Provider Type Affected**

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

**What You Need to Know**

CR 11121 directs MACs to obtain the most recent Healthcare Provider Taxonomy Codes (HPTCs) code set and use it to update their internal HPTC tables and/or reference files. Make sure your billing staffs are aware of these changes.

**Background**

The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available for view or for download from the NUCC website at http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40.

The changes to the code set include the addition of a new code and addition of definitions to existing codes. When reviewing the HPTC code set online, revisions made since the last release are identifiable by the following color code:

- New items are green
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

You should note that:

- Valid HPTCs are those codes approved by the NUCC for current use
- Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears
- Specialty and/or provider type codes issued by any entity other than the NUCC are not valid
- Medicare would be guilty of non-compliance with HIPAA if MACs accepted claims that contain invalid HPTCs

Although the NUCC generally posts their updates on the Washington Publishing Company (WPC) web page 3 months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update.

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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<tr>
<td>February 19, 2019</td>
<td>Initial article released.</td>
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</table>

**Kentucky & Ohio**

**MM11134: International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)**

**MLN Matters Number:** MM11134

**Related CR Transmittal Number:** R2243OTN

**Implementation Date:** July 1, 2019, – shared system edits, MAC local edits, April 2, 2019

**Effective Date:** July 1, 2019 - Unless otherwise indicated

**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) 11134 constitutes a maintenance update of International Classification of Diseases, 10th 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.

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 on the
Centers for Medicare & Medicaid Services (CMS) website at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs.

Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent
quarterly releases and individual CRs as appropriate. No policy-related changes are included
with the ICD-10 quarterly updates. Any policy related changes to NCDs continue to be
implemented via the current, long-standing NCD process.

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.

Please follow the link below for the NCD spreadsheets included with CR 11134:

Relevant NCD coding changes in CR 11134 include:

- NCD20.29 Hyperbaric Oxygen Therapy (HBO)
- NCD110.18 Aprepitant for Chemotherapy-Induced Emesis
- NCD110.23 Stem Cell Transplantation (formerly NCD110.8.1)
- NCD160.18 Vagus Nerve Stimulation (VNS)
- NCD160.24 Deep Brain Stimulation (DBS) for Essential Tremor and Parkinson's Disease
- NCD110.21 Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related
  Neoplastic Conditions
- NCD150.3 Bone Mineral Density Studies

When denying claims associated with the above NCDs, except where otherwise indicated,
MACs will use:

- Remittance Advice Remark Codes (RARC) N386 with Claim Adjustment Reason
  Code (CARC) 50, 96, and/or 119. See latest CAQH CORE update.
- 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 that 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.

Note: MACs will adjust any claims processed in error associated with CR 11134 that are brought to their attention.

Additional Information

The official instruction, CR11134, issued to your MAC regarding this change is available at
R2243OTN.pdf.
Kentucky & Ohio

**MM11163: Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSD) - April 2019 Update**

**MLN Matters Number:** MM11163
**Related CR Transmittal Number:** R4234CP
**Effective Date:** January 1, 2019

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

**Provider Action Needed**
This article informs you that the Centers for Medicare & Medicaid Services (CMS) has issued payment files to the MACs based upon the 2019 Medicare Physician Fee Schedule (MPFS) Final Rule. CR 11163 amends those payment files. Please be sure your billing staffs are aware of these changes.

**Background**

Below is a summary of the changes for the April update to the 2019 Medicare Physician Fee Schedule Database (MPFSD). These changes are effective for dates of service on and after January 1, 2019. CMS has added new HCPCS codes (G2001-G2009 and G2013-G2015) to the 2019 MPFSD and updated another code (G9987) as shown in the table below. CMS communicated instructions for these new codes (G2001-G2009 and G2013-G2015) through a separate CR (CR 10907). Please consult MLN Matters article MM10907 at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10907.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10907.pdf) for these instructions and other information.

**Table: April Updates to the 2019 MPFSD**

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<tr>
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<tr>
<td>G9987</td>
<td>Assistant Surgery, Co-Surgeon, &amp; Team Surgeon indicator = 9</td>
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<td>All MPFS indicators and RVUs = 99339</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G2015</td>
<td>All MPFS indicators and RVUs = 99340</td>
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</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 that you bring to their attention.
Additional Information
The official instruction, CR11163, issued to your MAC regarding this change, is available at

If you have questions, your MACs may have more information. Find their website

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Kentucky & Ohio

MM11168: Modification of the MCS Claims Processing System Logic for Modifier 59, XE, XS, XP, and XU Involving the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Column One and Column Two Codes

MLN Matters Number: MM11168  Related CR Transmittal Number: R2259OTN
Related CR Release Date: February 15, 2019  Related Change Request (CR) Number: 11168
Effective Date: July 1, 2019  Implementation Date: July 1, 2019

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

Provider Action Needed
CR11168 informs MACs about changes to National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edits which consist of column one and column two codes. Make sure that your billing staffs are aware of these changes.

Background
Modifiers 59, XE, XS, XP, and XU are among the NCCI-associated modifiers. The Multi-Carrier System (MCS) currently requires that modifiers 59, XE, XS, XP, or XU be appended to the column two code of a PTP edit to bypass the edit. With the implementation of CR 11168, Medicare will allow modifiers 59, XE, XS, XP, or XU on column one and column two codes to bypass the edit.

Additional Information
The official instruction, CR11168, issued to your MAC regarding this change is available at

If you have questions, your MACs may have more information. Find their website

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<td>February 19, 2019</td>
<td>Initial article released.</td>
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Kentucky & Ohio

MM11179: April Quarterly Update for 2019 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

MLN Matters Number: MM11179
Related CR Transmittal Number: R4242CP
Effective Date: April 1, 2019
Related CR Release Date: February 15, 2019
Related Change Request (CR) Number: 11179
Implementation Date: April 1, 2019

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

Provider Action Needed
CR11179 informs DME MACs about the changes to the DMEPOS fee schedule which Medicare updates 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
Section 1834(a), (h), and (i) of the Social Security Act (the Act) requires payment on a fee schedule basis for DMEPOS items. Also, payment on a fee schedule basis is a regulatory requirement in 42 Code of Federal Regulations (CFR) Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts and Intraocular Lenses (IOLs) inserted in a physician’s office. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjusted fee schedule amounts under Section 1834(a)(1)(F) of the Act, as well as codes that are not subject to the fee schedule Competitive Bidding Program (CBP) adjustments.

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 (CBAs), based on information from CBPs for DME. Section 1842(s)(3)(B) of the Act provides authority for adjusting the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs.

42 CFR Section 414.210(g) establishes the methods for adjusting DMEPOS fee schedule amounts. Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in:


Due to a delay in announcement of the next round of the CBP, contracts will not be in effect in Round 1, Round 2, or the National Mail Order CBAs beginning January 1, 2019, resulting in a temporary gap period in the CBP. Beginning January 1, 2019, CMS bases the fee schedule amounts for items furnished in former CBAs on the lower of the supplier’s charge for the item or fee schedule amounts adjusted in accordance with Sections 1834(a)(1)(F) and 1842(s)(3)(B) of the Act.
Pursuant to 42 CFR Section 414.210(g), Medicare bases the fee schedules for items and services furnished in former CBAs on the Single-Payment Amounts (SPAs), in effect in the CBA on the last day before the CBP contract periods of performance ended, increased by the projected percentage change in the Consumer Price Index for all Urban Consumers (CPI-U) for the 12-month period on the date after the contract periods ended. If the gap in the CBP lasts more than 12 months, Medicare increases fee schedule amounts once every 12 months on the anniversary date of the first day after the contract period ended with the CPI-U.

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. The DMEPOS Rural ZIP code file contains the ZIP codes designated as rural areas.

ZIP codes for non-continental Metropolitan Statistical Areas (MSAs) are not included in the DMEPOS Rural ZIP code file. CMS updates the DMEPOS Rural ZIP code file on a quarterly basis as necessary. Regulations at 42 CFR Section 414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any MSA. A rural area also includes any ZIP Code within an MSA that is excluded from a competitive bidding area established for that MSA.

The ZIP code associated with the permanent address of the beneficiary determines applicability of the adjusted fee schedule amounts in former CBAs. During a gap in the CBP, a former CBA ZIP code file will contain the ZIP codes for Round 1 2017 and Round 2 Recompete CBAs and CMS will update the files on a quarterly basis as necessary.

CR11179 adds fee schedule amounts for the following HCPCS codes to the DMEPOS fee schedule file effective April 1, 2019:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
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<tbody>
<tr>
<td>L0623</td>
<td>Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, off-the-shelf</td>
</tr>
<tr>
<td>E2216</td>
<td>Manual wheelchair accessory, foam filled propulsion tire, any size, each</td>
</tr>
<tr>
<td>E2217</td>
<td>Manual wheelchair accessory, foam filled caster tire, any size, each</td>
</tr>
<tr>
<td>E2218</td>
<td>Manual wheelchair accessory, foam propulsion tire, any size, each</td>
</tr>
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Also, CR11179 provides instructions for the April 2019 DMEPOS Rural ZIP code file containing the Quarter 1 2019 Rural ZIP code changes.

The following DMEPOS fee schedule and ZIP code Public Use Files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html):

1. DMEPOS Fee schedule file PUF
2. DME PEN Fee schedule PUF
3. DME Rural ZIP code PUF
4. Former CBA Fee Schedule PUF
5. Former CBA National Mail Order Diabetic Testing Supply fee schedule PUF
6. Former CBA ZIP code PUF


**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

SE17023 Revised: Guidance on Coding and Billing Date of Service on Professional Claims

MLN Matters Number: SE17023 Revised  
Related CR Transmittal Number: N/A  
Effective Date: N/A

Article Release Date: February 1, 2019  
Related Change Request (CR) Number: N/A  
Implementation Date: N/A

Note: This article was revised on February 1, 2019, to correct a statement in the Home Health Certification and Recertification Section to read, “the physician completes and signs the plan of care.” All other information is unchanged.

Provider Type Affected

This MLN Matters Article is intended for physicians, non-physician practitioners, and others submitting claims on a CMS-1500 form or the X12 837 Professional Claim to Medicare Administrative Contractors (MACs) for reimbursement for Medicare Part B services.

Provider Action Needed

STOP – Impact to you:
Physicians and non-physician practitioners need to identify the correct date of service for the services they provide to a Medicare patient.

CAUTION – What you need to know:
This MLN Matters Article is intended for physicians, providers, and suppliers billing MACs for services provided to Medicare beneficiaries.

GO – What you need to do:
Providers need to determine the Medicare rules and regulations concerning the date of service and submit claims appropriately. Be sure your billing and coding staffs are aware of this information.

Background

The information below will not provide all the billing instructions for the individual services. The article does not present any new or revised Medicare policy. Instead, the article reiterates current Medicare policy. This information concentrates on the date(s) of service to submit when billing for these services. If you are providing these services, please take advantage of the information available on the CMS website in addition to your MACs. The Medicare Benefit Policy Manual, Chapter 15, Section 20 shows that expenses are considered to have been incurred on the date the beneficiary received the item or service, regardless of when it was paid for or ordered. You may review this manual section at https://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/bp102c15.pdf.

Radiology Services

Typically, radiology services have two separate components: a professional and technical component. These services will have a PC/TC indicator of “1” on the Medicare Physician Fee Schedule (MPFS) Relative Value File. The technical component is billed on the date the patient had the test performed. When billing a global service, the provider can submit the professional
component with a date of service reflecting when the review and interpretation is completed or can submit the date of service as the date the technical component was performed. This will allow ease of processing for both Medicare and the supplemental payers. If the provider did not perform a global service and instead performed only one component, the date of service for the technical component would be the date the patient received the service and the date of service for the professional component would be the date the review and interpretation is completed.

The Medicare Physician Fee Schedule Relative Value File is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html.

**Surgical and Anatomical Pathology**

Surgical and anatomical pathology services may have two components: a professional and a technical component. These services will have a PC/TC indicator of “1” on the MPFS Relative Value File. The technical component is billed on the date the specimen was collected. This would be the surgery date. When billing a global service, the provider can submit the professional component with a date of service reflecting when the review and interpretation is completed or can submit the date of service as the date the technical component was performed. This will allow ease of processing for both Medicare and the supplemental payers. If the provider did not perform a global service and instead performed only one component, the date of service for the technical component would be the date the patient received the service and the date of service for the professional component would be the date the review and interpretation is completed.

When the collection spans two calendar dates, use the date the specimen collection ended. There are exceptions for stored specimens as follows:

**Stored Specimens**

In the case of a test/service performed on a stored specimen, if a specimen was stored for less than or equal to 30 calendar days from the date it was collected, the DOS of the test/service must be the date the test/service was performed only if:

- The test/service is ordered by the patient’s physician at least 14 days following the date of the patient’s discharge from the hospital
- The specimen was collected while the patient was undergoing a hospital surgical procedure
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted
- The results of the test/service do not guide treatment provided during the hospital stay; and
- The test/service was reasonable and medically necessary for treatment of an illness.

If the specimen was stored for more than 30 calendar days before testing, the specimen is considered to have been archived and the DOS of the test/service must be the date the specimen was obtained from storage.

For more information, see the Medicare Claims Processing Manual, Chapter 16, Section 40.8, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf.

**Care Plan Oversight (CPO)**

CPO is physician supervision of a patient receiving complex and/or multidisciplinary care as part of Medicare covered services provided by a participating home health agency or Medicare approved hospice. Providers must provide physician supervision of a patient involving 30 or more minutes of the physician’s time per month to report CPO services. The claim for CPO must not include any other services and is only billed after the end of the month in which CPO was provided. The date of service submitted on the claim can be the last date of the month or the date in which at least 30 minutes of time is completed.

Home Health Certification and Recertification

The date of service for the Certification is the date the physician completes and signs the plan of care. The date of the Recertification is the date the physician completes the review.


Physician End-Stage Renal Disease (ESRD) Services

A physician may provide monthly or daily oversight of a patient on dialysis with ESRD. The date of service for a patient beginning dialysis is the date of their first dialysis through the last date of the calendar month. For continuing patients, the date of service is the first through the last date of the calendar month. For transient patients or less than a full month service, these can be billed on a per diem basis. The date of service is the date of responsibility for the patient by the billing physician. This would also include when a patient’s dies during the calendar month.

When submitting a date of service span for the monthly capitation procedure codes, the day/units should be coded as “1”.


Transitional Care Management (TCM)

TCM services are 30-day services provided when a patient is discharged from an appropriate facility and requires moderate or high-complexity medical decision making. The date of service is the date the practitioner completes the required face-to-face visit. Keep in mind, there are additional services to be provided during the 30-day period.

TCM Guidance including Questions and Answers and Fact Sheets are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html.

Clinical Laboratory Services

Generally, the date of service for clinical laboratory services is the date the specimen was collected. If the specimen is collected over a period that spans two calendar dates, the date of service is the date the collection ended. There are three exceptions to the general date of service rule for clinical laboratory tests:

1. Date of service for tests/services performed on stored specimens

   In the case of a test/service performed on a stored specimen, if the specimen was stored less than or equal to 30 calendar days from the date it was collected, the date of service of the test/service must be the date the test/service was performed only if:

   - The test/service was ordered by the patient’s physician at least 14 days following the date of the patient’s discharge from the hospital;
   - The specimen was collected while the patient was undergoing a hospital surgical procedure;
   - It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;
   - The results of the test/service do not guide treatment provided during the hospital stay; and
The test/service was reasonable and necessary for the treatment of an illness.

If the specimen was stored for more than 30 calendar days before testing, the specimen is considered to have been archived and the date of service of the test/service must be the date the specimen was obtained from storage.

2. Date of service for chemotherapy sensitivity tests/services performed on live tissue

In the case of a chemotherapy sensitivity test/service performed on live tissue, the date of service of the test/service must be the date the test/service was performed only if:

- The decision as to the specific chemotherapy agent to test is made at least 14 days after discharge;
- The specimen was collected while the patient was undergoing a hospital surgical procedure;
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;
- The results of the test/service do not guide treatment provided during the hospital stay; and
- The test/service was reasonable and medically necessary for treatment of an illness.

3. Date of service for advanced diagnostic laboratory tests (ADLTs) and molecular pathology tests

In the case of a molecular pathology test or a test designated by CMS as an ADLT under paragraph (1) of the definition of advanced diagnostic laboratory test in 42 CFR 414.502, the date of service must be the date the test was performed only if:

- The test was performed following a hospital outpatient's discharge from the hospital outpatient department;
- The specimen was collected from a hospital outpatient during an encounter;
- It was medically appropriate to collect the sample from the hospital outpatient during the hospital outpatient encounter;
- The results of the test do not guide treatment provided during the hospital outpatient encounter; and
- The test was reasonable and necessary for the treatment of an illness.

ADLTs and molecular pathology tests subject to the third exception to the general laboratory date of service rule are available on the Medicare Clinical Laboratory Fee Schedule Web page under the Laboratory Date of Service Policy tab at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html.


Home Prothrombin Time (PT/INR) Monitoring

There are several procedure codes applicable to this service. The G0248 describes the initial demonstration use of home INR monitoring and instructions for reporting. The date of service is the date the demonstration and instructions for reporting are given in a face-to-face setting with the patient. G0249 describes the provision of test materials and equipment for home INR monitoring. The date of service is the date the test materials and equipment are given to the patient. G0250 describes the physician review, interpretation, and patient management of home INR testing. This service is payable only once every 4 weeks. The date of service is the date of the fourth test interpretation. For 2018, there is also code 93793 describing the physician interpretation and instructions. The appropriate date of service is the date of the review.
Cardiovascular Monitoring Services

There are many different procedure codes that represent the cardiovascular monitoring services. These can be identified as professional components, technical components, or a combination of the two. Some of these monitoring services may take place at a single point in time, others may take place over 24 or 48 hours, or over a 30-day period. The determination of the date of service is based on the description of the procedure code and the time listed. When the service includes a physician review and/or interpretation and report, the date of service is the date the physician completes that activity. If the service is a technical service, the date of service is the date the monitoring concludes based on the description of the service. For example, if the description of the procedure code includes 30 days of monitoring and a physician interpretation and report, then the date of service will be no earlier than the 30th day of monitoring and will be the date the physician completed the professional component of the service.


Psychiatric Testing and Evaluations

In some cases, for various reasons, psychiatric evaluations (90791/90792) and/or psychological and neuropsychological tests (96101/96146) are completed in multiple sessions that occur on different days. In these situations, the date of service that should be reported on the claim is the date of service on which the service (based on CPT code description) concluded.

Documentation should reflect that the service began on one day and concluded on another day (the date of service reported on the claim). If documentation is requested, medical records for both days should be submitted.

Psychiatric Testing when provided over multiple days based on the patient being able to provide information, is billed based on the time involved as described by CPT and the last date of the test. For more information, see the Medicare Benefit Policy Manual, Chapter 15, Section 80.2, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

Surgical Services

Medicare’s payment for most surgical services is made using the global surgery rules. All services considered to be part of the global package including follow-up visits, are considered to have occurred on the same day as the surgical service and are not submitted separately.

Surgeons who perform the surgery and then transfer post-operative care to another practitioner will submit their claims using the date of the surgery as the date of service along with Modifier 54. If the surgeon keeps responsibility for the patient for some of the post-operative care, he/she would submit the date of the surgery, the surgery procedure code with Modifier 55, and the last date of responsibility indicated in Item 19 or the electronic equivalent. The practitioner receiving the transfer of care will submit his/her post-operative services using the surgical procedure code with Modifier 55 with the date of the surgery as his/her date of service. If the practitioner receives the patient on a date other than the discharge date from an inpatient stay, Item 19 or the electronic equivalent will include the date care began. For more information, see the Medicare Claims Processing Manual, Chapter 12, Section 40 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.
Maternity Benefits

All expenses incurred for surgical and obstetrical care including preoperative/prenatal examinations, testing, and post-operative/postnatal services are part of the maternity package and may be billed under the appropriate surgical code on the date of delivery or termination. Charges the practitioner may impose that are not related to the delivery are incurred on the date furnished.


Services Which Transpire Over to Another Calendar Date

This category could include multiple types of services. The service would be started on one day and concluded the following day. The service cannot be submitted to Medicare until completed. Unless otherwise notated, the billing entity can use either the date the service began or the following day when the service concluded.

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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<tr>
<td>January 24, 2019</td>
<td>CMS reissued the article to clarify information.</td>
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<tr>
<td>October 2, 2017</td>
<td>CMS rescinded the article.</td>
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