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The JM HHH Medicare Advisory contains coverage, billing and other information for Jurisdiction M HHH. This information is not intended to constitute legal advice. It is our official notice to those we serve concerning their responsibilities and obligations as mandated by Medicare regulations and guidelines. This information is readily available at no cost on the Palmetto GBA website. It is the responsibility of each facility to obtain this information and to follow the guidelines. The JM HHH Medicare Advisory includes information provided by the Centers for Medicare & Medicaid Services (CMS) and is current at the time of publication. The information is subject to change at any time. This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no-cost from our website at http://www.PalmettoGBA.com/Medicare.

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Upcoming Home Health and Hospice Educational Events

Hospice MACtoberfest Conference
Palmetto GBA, the JM Hospice MAC, is partnering with the Texas & New Mexico Hospice Organization to present an informative two-day Hospice MACtoberfest® on October 28 - 29, 2019.

Home Health Patient-Driven Groupings Model (PDGM) Webcast Part I: November 21, 2019
This webcast will be held on Thursday, November 21, 2019 at 2 p.m. ET. During this webcast, you will receive information to help your agency prepare to implement billing changes for the PDGM on January 1, 2020.

2019 Medical Review (MR) Hot Topic Targeted Probe and Educate (TPE) Teleconference
Palmetto GBA will host its last Medical Review Hot Topic Targeted Probe and Educate (TPE) Teleconference for the year at 2 p.m. ET on Monday, December 2, 2019 in 2019. These calls are open to all providers.

Home Health Patient-Driven Groupings Model (PDGM) Webcast Part Two: December 5, 2019
The second part of two collaborative webcasts will be held on Thursday, December 5, 2019 at 2 p.m. ET. During this webcast, you will receive information to help your agency prepare to implement billing changes for the PDGM on January 1, 2020.

For more information and registration instructions to attend these education sessions, please go to Page 33 of this issue.
MLN CONNECTS

MLN Connects will contain Medicare-related messages from the Centers of Medicare & Medicaid Services (CMS). These messages ensure planned, coordinated messages are delivered timely about Medicare-related topics. Please share with appropriate staff. To view the most recent issues, please copy and paste the following links into your Web browser:

Weekly Articles

October 24, 2019

October 17, 2019

October 10, 2019

October 3, 2019

September 26, 2019
**Special Edition Articles**

**Thursday, September 26, 2019**

**Provider Education Message:**
- Omnibus Burden Reduction (Conditions of Participation) Final Rule
- Discharge Planning Rule Supports Interoperability and Patient Preferences

**Omnibus Burden Reduction (Conditions of Participation) Final Rule**

On September 26, CMS took action at President Trump’s direction to “cut the red tape,” by reducing unnecessary burden for America’s health care providers allowing them to focus on their priority – patients. The Omnibus Burden Reduction (Conditions of Participation) Final Rule removes Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on hospitals and other health care providers to reduce inefficiencies and moves the nation closer to a health care system that delivers value, high quality care and better outcomes for patients at the lowest possible cost.

This rule advances the Patients over Paperwork initiative by saving providers an estimated 4.4 million hours of time previously spent on paperwork with an overall total projected savings to providers of $800 million annually.

This rule finalizes the provisions of three proposed rules
- Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction (“Omnibus Burden reduction”), published September 20, 2018
- Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, published June 16, 2016

For More Information:

Discharge Planning Rule Supports Interoperability and Patient Preferences

On September 26, CMS issued a final rule that empowers patients preparing to move from acute care into Post-Acute Care (PAC), a process called discharge planning. The rule puts patients in the driver’s seat of their care transitions and improves quality by requiring hospitals to provide patients access to information about PAC provider choices, including performance on important quality measures and resource-use measures, including:

• Number of pressure ulcers

• Proportion of falls that lead to injury

• Number of readmissions back to the hospital

The rule also:

• Advances CMS’s interoperability efforts by requiring the seamless exchange of patient information between health care settings, and ensuring that a patient’s health care information follows them after discharge from a hospital or PAC provider.

• Revises the discharge planning requirements that hospitals (including long-term care hospitals, Critical Access Hospitals (CAHs) psychiatric hospitals, children’s hospitals, and cancer hospitals), inpatient rehabilitation facilities, and home health agencies must meet to participate in Medicare and Medicaid programs. It requires the discharge planning process to focus on a patient’s goals and treatment preferences. Hospitals are mandated to ensure each patient’s right to access their medical records in an electronic format.


Hospitals and CAHs are already conducting most of the revised discharge planning requirements, with the exception of the discharge planning requirements of the IMPACT Act.

For More Information:


Monday, September 30, 2019

**New HCPCS Code J0642 for Levoleucovorin Injection**

For dates of service on or after October 1, use HCPCS code J0642 for levoleucovorin injection products marketed under the brand name of Khapzory.

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Wednesday, October 9, 2019

**Modernizing and Clarifying the Physician Self-Referral Regulations Proposed Rule**

On October 9, CMS issued a proposed rule to modernize and clarify the regulations that interpret the Medicare physician self-referral law (often called the “Stark Law”), which has not been significantly updated since it was enacted in 1989. The proposed rule supports the CMS “Patients over Paperwork” initiative by reducing unnecessary regulatory burden on physicians and other health care providers while reinforcing the Stark Law’s goal of protecting patients from unnecessary services and being steered to less convenient, lower quality, or more expensive services because of a physician’s financial self-interest. Through the Patients over Paperwork initiative, the proposed rule opens additional avenues for physicians and other health care providers to coordinate the care of the patients they serve - allowing providers across different health care settings to work together to ensure patients receive the highest quality of care.

For More information:


**HOME HEALTH AND HOSPICE INFORMATION**

**January 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files**

MLN Matters Number: MM11495  
Related CR Release Date: September 27, 2019  
Related CR Transmittal Number: R4404CP  
Related Change Request (CR) Number: 11495  
Effective Date: January 1, 2020  
Implementation Date: January 6, 2020

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

**Provider Action Needed**  
CR11495 informs MACs about new and revised Average Sales Price (ASP) and ASP Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs. The Centers for Medicare & Medicaid Services (CMS) will make files available for download on or after December 16, 2019. CMS gives MACs 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 found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf. Make sure that your billing staffs are aware of these changes.

**Background**  
The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CR11495 instructs MACs to download and implement the January 2020 and, if released, the revised October 2019, July 2019, April 2019, and January 2019 ASP drug pricing files for Medicare Part B drugs. CR11495 addresses the following pricing files:

- **File: January 2020 ASP and ASP NOC -- Effective Dates of Service: January 1, 2020, through March 31, 2020**

- **File: October 2019 ASP and ASP NOC -- Effective Dates of Service: October 1, 2019, through December 31, 2019**

- **File: July 2019 ASP and ASP NOC -- Effective Dates of Service: July 1, 2019, through September 30, 2019**

- **File: April 2019 ASP and ASP NOC -- Effective Dates of Service: April 1, 2019, through June 30, 2019**

- **File: January 2019 ASP and ASP NOC -- Effective Dates of Service: January 1, 2019, through March 31, 2019**
For any drug or biological not listed in the ASP or NOC drug pricing files, your MACs will determine the payment allowance limits in accordance with the policy in the Medicare Claims Processing Manual, Chapter 17, Section 20.1.3 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf.

For any drug or biological not listed in the ASP or NOC drug pricing files that you bill 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 (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act which is available at https://www.congress.gov/bill/114th-congress/house-bill/34.

Note: MACs will not search and adjust claims that have already been processed unless you bring such claims 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.

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>September 30, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

October 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)

MLN Matters Number: MM11451 Revised
Related CR Release Date: October 4, 2019
Related CR Transmittal Number: R4411CP
Related Change Request (CR) Number: 11451
Effective Date: October 1, 2019
Implementation Date: October 7, 2019

Note: We revised this article on October 7, 2019, to reflect the revised CR 11451, issued on October 4, 2019. CMS revised the CR to correct Table 7 to reinstate C9043 rather than delete it effective October 1, 2019. CR 11451 also added a new HCPCS code J0642, which is effective October 1, 2019, and revised the descriptor for J0641. The CR release date, transmittal number, and the web address of the CR are changed. All other information remains the same.
Provider Types Affected
This MLN Matters article is for hospital outpatient facilities, physicians, providers, including home health and hospice providers, and suppliers billing Medicare Administrative Contractors (MACs) for hospital outpatient services provided to Medicare beneficiaries.

Provider Action Needed
CR 11451 describes changes to and billing instructions for various payment policies that Medicare is implementing in the October 2019 Outpatient Prospective Payment System (OPPS) update. Make sure your billing staffs are aware of these changes.

Background
The October 2019 Integrated Outpatient Code Editor (I/OCE) will reflect the HCPCS, Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 11451.

The October 2019 revisions to I/OCE data files, instructions, and specifications are provided in the October 2019 I/OCE CR, which will be available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4383CP.pdf.

1. CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective Oct 1, 2019
The American Medical Association (AMA) CPT Editorial Panel deleted one PLA code (0104U) and established 34 new PLA codes (CPT codes 0105U-0138U), effective October 1, 2019. Table 1 lists the long descriptors and status indicators for the codes.

For more information on OPPS status indicators “A,” “D,” “E1,” “N,” and “Q4,” refer to OPPS Addendum D1 of the Calendar Year (CY) 2019 OPPS/ASC final rule for the latest definitions. CPT codes 0105U-0138U are in the October 2019 I/OCE with an effective date of October 1, 2019.

Table 1: Newly Established PLA Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
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<tbody>
<tr>
<td>0104U</td>
<td>Hereditary pan cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MRNA analytics to resolve variants of unknown significance when indicated (32 genes [sequencing and deletion/duplication], EPCAM and GREM1 [deletion/duplication only])</td>
<td>D</td>
<td>N/A</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Quarterly Code</td>
<td>Reportable Container</td>
</tr>
<tr>
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</tr>
<tr>
<td>0105U</td>
<td>Nephrology (chronic kidney disease), multiplex electrochemiluminescent immunoassay (ECLIA) of tumor necrosis factor receptor 1A, receptor superfamily 2 (TNFR1, TNFR2), and kidney injury molecule-1 (KIM-1) combined with longitudinal clinical data, including APOL1 genotype if available, and plasma (isolated fresh or frozen), algorithm reported as probability score for rapid kidney function decline (RKFD)</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0106U</td>
<td>Gastric emptying, serial collection of 7 timed breath specimens, non-radioisotope carbon-13 (13C) spirulina substrate, analysis of each specimen by gas isotope ratio mass spectrometry, reported as rate of 13CO2 excretion</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0107U</td>
<td>Clostridium difficile toxin(s) antigen detection by immunoassay technique, stool, qualitative, multiple-step method</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0108U</td>
<td>Gastroenterology (Barrett’s esophagus), whole slide–digital imaging, including morphometric analysis, computer-assisted quantitative immunolabeling of 9 protein biomarkers (p16, AMACR, p53, CD68, COX-2, CD45RO, HIF1a, HER-2, K20) and morphology, formalin-fixed paraffin-embedded tissue, algorithm reported as risk of progression to high-grade dysplasia or cancer</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0109U</td>
<td>Infectious disease (Aspergillus species), real-time PCR for detection of DNA from 4 species (A. fumigatus, A. terreus, A. niger, and A. flavus), blood, lavage fluid, or tissue, qualitative reporting of presence or absence of each species</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0110U</td>
<td>Prescription drug monitoring, one or more oral oncology drug(s) and substances, definitive tandem mass spectrometry with chromatography, serum or plasma from capillary blood or venous blood, quantitative report with steady-state range for the prescribed drug(s) when detected</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0111U</td>
<td>Oncology (colon cancer), targeted KRAS (codons 12, 13, and 61) and NRAS (codons 12, 13, and 61) gene analysis, utilizing formalin-fixed paraffin-embedded tissue</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0112U</td>
<td>Infectious agent detection and identification, targeted sequence analysis (16S and 18S rRNA genes) with drug-resistance gene</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0113U</td>
<td>Oncology (prostate), measurement of PCA3 and TMPRSS2-ERG in urine and PSA in serum following prostatic massage, by RNA amplification and fluorescence-based detection, algorithm reported as risk score</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Frequency</td>
<td>Notes</td>
</tr>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>0114U</td>
<td>Gastroenterology (Barrett’s esophagus), VIM and CCNA1 methylation analysis, esophageal cells, algorithm reported as likelihood for Barrett’s esophagus</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0115U</td>
<td>Respiratory infectious agent detection by nucleic acid (DNA and RNA), 18 viral types and subtypes and 2 bacterial targets, amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0116U</td>
<td>Prescription drug monitoring, enzyme immunoassay of 35 or more drugs confirmed with LC-MS/MS, oral fluid, algorithm results reported as a patient-compliance measurement with risk of drug to drug interactions for prescribed medications</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>0117U</td>
<td>Pain management, analysis of 11 endogenous analytes (methylmalonic acid, xanthurenic acid, homocysteine, pyroglutamic acid, vanilmandelate, 5-hydroxyindoleacetic acid, hydroxymethylglutarate, ethylmalonate, 3-hydroxypropyl mercapturic acid (3-HPMA), quinolinic acid, kynurenic acid), LC-MS/MS, urine, algorithm reported as a pain-index score with likelihood of atypical biochemical function associated with pain</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0118U</td>
<td>Transplantation medicine, quantification of donor-derived cell-free DNA using whole genome next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA in the total cell-free DNA</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0119U</td>
<td>Cardiology, ceramides by liquid chromatography–tandem mass spectrometry, plasma, quantitative report with risk score for major cardiovascular events</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0120U</td>
<td>Oncology (B-cell lymphoma classification), mRNA, gene expression profiling by fluorescent probe hybridization of 58 genes (45 content and 13 housekeeping genes), formalin-fixed paraffin-embedded tissue, algorithm reported as likelihood for primary mediastinal B-cell lymphoma (PMBCL) and diffuse large B-cell lymphoma (DLBCL) with cell of origin subtyping in the latter</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0121U</td>
<td>Sickle cell disease, microfluidic flow adhesion (VCAM-1), whole blood</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0122U</td>
<td>Sickle cell disease, microfluidic flow adhesion (P-Selectin), whole blood</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0123U</td>
<td>Mechanical fragility, RBC, shear stress and spectral analysis profiling</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
<td>Modifier</td>
<td>Payment Indicator</td>
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</tr>
<tr>
<td>0124U</td>
<td>Fetal congenital abnormalities, biochemical assays of 3 analytes (free beta-hCG, PAPP-A, AFP), time-resolved fluorescence immunoassay, maternal dried-blood spot, algorithm reported as risk scores for fetal trisomies 13/18 and 21</td>
<td>E1</td>
<td>N/A</td>
</tr>
<tr>
<td>0125U</td>
<td>Fetal congenital abnormalities and perinatal complications, biochemical assays of 5 analytes (free beta-hCG, PAPP-A, AFP, placental growth factor, and inhibin-A), time-resolved fluorescence immunoassay, maternal serum, algorithm reported as risk scores for fetal trisomies 13/18, 21, and preeclampsia</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0126U</td>
<td>Fetal congenital abnormalities and perinatal complications, biochemical assays of 5 analytes (free beta-hCG, PAPP-A, AFP, placental growth factor, and inhibin-A), time-resolved fluorescence immunoassay, includes qualitative assessment of Y chromosome in cell-free fetal DNA, maternal serum and plasma, predictive algorithm reported as a risk scores for fetal trisomies 13/18, 21, and preeclampsia</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0127U</td>
<td>Obstetrics (preeclampsia), biochemical assays of 3 analytes (PAPP-A, AFP, and placental growth factor), time-resolved fluorescence immunoassay, maternal serum, predictive algorithm reported as a risk score for preeclampsia</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0128U</td>
<td>Obstetrics (preeclampsia), biochemical assays of 3 analytes (PAPP-A, AFP, and placental growth factor), time-resolved fluorescence immunoassay, includes qualitative assessment of Y chromosome in cell-free fetal DNA, maternal serum and plasma, predictive algorithm reported as a risk score for preeclampsia</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0129U</td>
<td>Hereditary breast cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis and deletion/duplication analysis panel (ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, and TP53)</td>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0130U</td>
<td>Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), targeted mRNA sequence analysis panel (APC, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, and TP53) (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>modifier</td>
<td>Payment</td>
</tr>
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<td>-------</td>
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</tr>
<tr>
<td>0131U</td>
<td>Hereditary breast cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (13 genes) (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0132U</td>
<td>Hereditary ovarian cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (17 genes) (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0133U</td>
<td>Hereditary prostate cancer–related disorders, targeted mRNA sequence analysis panel (11 genes) (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0134U</td>
<td>Hereditary pan cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (18 genes) (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0135U</td>
<td>Hereditary gynecological cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (12 genes) (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0136U</td>
<td>ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia) mRNA sequence analysis (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0137U</td>
<td>PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) mRNA sequence analysis (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0138U</td>
<td>BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) mRNA sequence analysis (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### 2. New CPT Category II Codes Effective October 1, 2019

For the October 2019 update, the Centers for Medicare & Medicaid Services (CMS) is implementing five new CPT Category II codes that the AMA released on July 8, 2019, for implementation on October 1, 2019. New CPT codes 2023F, 2025F, 2033F, 3051F, and 3052F are in the October 2019 I/OCE with an effective date of October 1, 2019.
Also, the AMA is revising the code descriptors for CPT codes 2022F, 2024F, 2026F, and deleting 3045F on September 30, 2019. The status indicators and APC assignments for the codes are shown in Table 2 These codes, along with their short descriptors, status indicators, and payment rates are listed in the October 2019 OPPS Addendum B that is posted at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html). For information on the OPPS status indicator “M”, refer to OPPS Addendum D1 of the CY 2019 OPPS/ASC final rule for the latest definition.

**Table 2: New, Revised, and Deleted CPT Category II Codes**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Status</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022F</td>
<td>REVISE</td>
<td>Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)^2</td>
<td>M</td>
<td>N/A</td>
</tr>
<tr>
<td>2023F</td>
<td>NEW</td>
<td>Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)^2</td>
<td>M</td>
<td>N/A</td>
</tr>
<tr>
<td>2024F</td>
<td>REVISE</td>
<td>7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)^2</td>
<td>M</td>
<td>N/A</td>
</tr>
<tr>
<td>2025F</td>
<td>NEW</td>
<td>7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)^2</td>
<td>M</td>
<td>N/A</td>
</tr>
<tr>
<td>2026F</td>
<td>REVISE</td>
<td>Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy (DM)^2</td>
<td>M</td>
<td>N/A</td>
</tr>
<tr>
<td>2033F</td>
<td>NEW</td>
<td>Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy (DM)^2</td>
<td>M</td>
<td>N/A</td>
</tr>
<tr>
<td>3045F</td>
<td>DELETE</td>
<td>Most recent hemoglobin A1c (HbA1c) level 7.0–9.0% (DM)</td>
<td>D</td>
<td>N/A</td>
</tr>
<tr>
<td>3051F</td>
<td>NEW</td>
<td>Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)</td>
<td>M</td>
<td>N/A</td>
</tr>
<tr>
<td>3052F</td>
<td>NEW</td>
<td>Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)^2</td>
<td>M</td>
<td>N/A</td>
</tr>
</tbody>
</table>
3. Advanced Diagnostic Laboratory Tests (ADLT) Under the Clinical Lab Fee Schedule (CLFS)

On May 17, 2019, CMS announced the approval of three laboratory tests as ADLTs under paragraph (1) of the definition of an ADLT in 42 CFR Section 414.502. CMS notes that under the OPPS, tests that receive ADLT status under Section 1834A(d)(5)(A) of the Social Security Act (the Act) are assigned to status indicator “A.” These laboratory tests are listed in Table 3.

Based on the ADLT designation, CMS revised the OPPS status indicator for HCPCS codes 0080U and 81599 to “A” (Not paid under OPPS. Paid by MACs under a fee schedule or payment system other than OPPS) effective July 1, 2019. However, because the ADLT designation was made in May 2019, it was too late to include this change in the July 2019 I/OCE Release and the July 2019 OPPS update; therefore, we are including this change in the October 2019 I/OCE Release with an effective date of July 1, 2019.

Note that the DecisionDx-UM test, as described by HCPCS code 0081U, was also approved for ADLT status on May 17, 2019, however it was already assigned OPPS SI “A” based on being a molecular pathology test.

The latest list of ADLTs under the CLFS is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/List-of-Approved-ADLTs.pdf. For more information on the OPPS status indicator “A”, refer to OPPS Addendum D1 of the CY 2019 OPPS/ASC final rule for the latest definitions.

<table>
<thead>
<tr>
<th>Lab Name</th>
<th>Test Name</th>
<th>CPT Code</th>
<th>CPT Code Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biodesix</td>
<td>BDX-XL2</td>
<td>0080U</td>
<td>Oncology (lung), mass spectrometric analysis of galectin-3-binding protein and scavenger receptor cysteine-rich type 1 protein M130, with five clinical risk factors (age, smoking status, nodule diameter, nodule-spiculation status and nodule location), utilizing plasma, algorithm reported as a categorical probability of malignancy</td>
</tr>
<tr>
<td>Castle BioSciences, Inc.</td>
<td>DecisionDX-Melanoma</td>
<td>81599*</td>
<td>Unlisted multianalyte assay with algorithmic analysis</td>
</tr>
<tr>
<td>Castle BioSciences Inc.</td>
<td>DecisionDx-UM</td>
<td>0081U</td>
<td>Oncology (uveal melanoma), mRNA, gene-expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping genes), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis</td>
</tr>
</tbody>
</table>
4. Drugs, Biologicals, and Radiopharmaceuticals

a. HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-through Status
For October 2019, two HCPCS codes have received pass-through status for reporting drugs and biologicals in the hospital outpatient setting. These new codes are in Table 4.

Table 4: Codes Receiving Pass-Through Status

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>J3111</td>
<td>Injection, romosozumab-aqqg, 1 mg</td>
<td>G</td>
<td>9327</td>
</tr>
<tr>
<td>J9356</td>
<td>Injection, trastuzumab, 10 mg and Hyaluronidase-oysk</td>
<td>G</td>
<td>9314</td>
</tr>
</tbody>
</table>

b. Separately Payable Drugs and Biologicals that Will Receive Pass-Through Status (Status Indicator = “G”) for the Period of April 1, 2019, Through June 30, 2019
The status indicator for HCPCS code C9042 (Injection, bendamustine hcl (belrapzo), 1 mg) for the period of April 1, 2019, through June 30, 2019, will be changed retroactively from status indicator = “E2” to status indicator = “G.” This drug is in Table 5.

Table 5: C9042 Updated Status Indicator

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Old SI</th>
<th>New SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9042</td>
<td>Injection, bendamustine hcl (belrapzo), 1 mg</td>
<td>E2</td>
<td>G</td>
<td>9313</td>
</tr>
</tbody>
</table>

c. Drugs and Biologicals that Will Change from Non-Payable Status (Status Indicator = “E2”) to Separately Payable Status (Status Indicator = “K”) for the Period of July 18, 2019, through September 30, 2019
The status indicator for HCPCS code Q5107 (Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg) for the period of July 18, 2019, through September 30, 2019, will be changed retroactively from status indicator = “E2” to status indicator = “K”. This drug is in Table 6.

Table 6: Q5107 Updated Status Indicator

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Old SI</th>
<th>New SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5107</td>
<td>Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg</td>
<td>E2</td>
<td>K</td>
<td>9329</td>
</tr>
</tbody>
</table>
d. New Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of October 1, 2019

There are 45 new drug, biological, and radiopharmaceutical HCPCS codes that will be established on October 1, 2019. The new codes are in Table 7.

Table 7: New Drug, Biological, and Radiopharmaceutical Codes to be Established on October 1, 2019

<table>
<thead>
<tr>
<th>New HCPCS Code</th>
<th>Old HCPCS Code</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1943</td>
<td>C9035</td>
<td>Injection, aripiprazole lauroxil (aristada initio), 1 mg</td>
<td>G</td>
<td>9179</td>
</tr>
<tr>
<td>J0222</td>
<td>C9036</td>
<td>Injection, Patisiran, 0.1 mg</td>
<td>G</td>
<td>9180</td>
</tr>
<tr>
<td>J2798</td>
<td>C9037</td>
<td>Injection, risperidone, (perseris), 0.5 mg</td>
<td>G</td>
<td>9181</td>
</tr>
<tr>
<td>J9204</td>
<td>C9038</td>
<td>Injection, mogamulizumab-kpkc, 1 mg</td>
<td>G</td>
<td>9182</td>
</tr>
<tr>
<td>J0291</td>
<td>C9039</td>
<td>Injection, plazomicin, 5 mg</td>
<td>G</td>
<td>9183</td>
</tr>
<tr>
<td>J3031</td>
<td>C9040</td>
<td>Injection, fremanezumab-vfrm, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)</td>
<td>G</td>
<td>9197</td>
</tr>
<tr>
<td>J0641(1)</td>
<td></td>
<td>Injection, levoleucovorin, not otherwise specified, 0.5 mg</td>
<td>K</td>
<td>1236</td>
</tr>
<tr>
<td>J0642</td>
<td></td>
<td>Injection, Levoleucovorin (khapzory), 0.5 mg</td>
<td>B</td>
<td>N/A</td>
</tr>
<tr>
<td>J9119</td>
<td>C9044</td>
<td>Injection, cemiplimab-rwlc, 1 mg</td>
<td>G</td>
<td>9304</td>
</tr>
<tr>
<td>J9313</td>
<td>C9045</td>
<td>Injection, moxetumomab pasudotox-tdfk, 0.01 mg</td>
<td>G</td>
<td>9305</td>
</tr>
<tr>
<td>J1096</td>
<td>C9048</td>
<td>Dexamethasone, lacrimal ophthalmic insert, 0.1 mg</td>
<td>G</td>
<td>9308</td>
</tr>
<tr>
<td>J1096</td>
<td>C9048</td>
<td>Dexamethasone, lacrimal ophthalmic insert, 0.1 mg</td>
<td>G</td>
<td>9308</td>
</tr>
<tr>
<td>J9269</td>
<td>C9049</td>
<td>Injection, tagraxofusp-erzs, 10 micrograms</td>
<td>G</td>
<td>9309</td>
</tr>
<tr>
<td>J9210</td>
<td>C9050</td>
<td>Injection, emapalumab-lzsg, 1 mg</td>
<td>G</td>
<td>9310</td>
</tr>
<tr>
<td>J0121</td>
<td>C9051</td>
<td>Injection, omadacycline, 1 mg</td>
<td>G</td>
<td>9311</td>
</tr>
<tr>
<td>J1303</td>
<td>C9052</td>
<td>Injection, ravulizumab-cwvz, 10 mg</td>
<td>G</td>
<td>9312</td>
</tr>
<tr>
<td>J1097</td>
<td>C9447</td>
<td>Phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml</td>
<td>G</td>
<td>9324</td>
</tr>
<tr>
<td>J0122</td>
<td></td>
<td>Injection, eravacycline, 1 mg</td>
<td>K</td>
<td>9325</td>
</tr>
<tr>
<td>J0593</td>
<td></td>
<td>Injection, lanadelumab-flyo, 1 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered)</td>
<td>K</td>
<td>9326</td>
</tr>
<tr>
<td>J1944</td>
<td>J1942</td>
<td>Injection, aripiprazole lauroxil, (aristada), 1 mg</td>
<td>K</td>
<td>9470</td>
</tr>
<tr>
<td>J7314</td>
<td></td>
<td>Injection, fluocinolone acetonide, intravitreal implant (Yutiq), 0.01 mg</td>
<td>K</td>
<td>9328</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>E2</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>----</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>J7331</td>
<td>Hyaluronan or derivative, synojoynt, for intra-articular injection, 1 mg</td>
<td>E2</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>J7332</td>
<td>Hyaluronan or derivative, triluron, for intra-articular injection, 1 mg</td>
<td>E2</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>J9118</td>
<td>Injection, calaspargase pegol-mknl, 10 units</td>
<td>E2</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4205</td>
<td>Membrane graft or membrane wrap, per square centimeter</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4206</td>
<td>Fluid flow or fluid GF, 1 cc</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4208</td>
<td>Novafix, per square centimeter</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4209</td>
<td>Surgraft, per square centimeter</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4210</td>
<td>Axolotl graft or axolotl dualgraft, per square centimeter</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4211</td>
<td>Amnion bio or Axobiomembrane, per square centimeter</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4212</td>
<td>Allogen, per cc</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4213</td>
<td>Ascent, 0.5 mg</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4214</td>
<td>Cellesta cord, per square centimeter</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4215</td>
<td>Axolotl ambient or axolotl cryo, 0.1 mg</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4216</td>
<td>Artacent cord, per square centimeter</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4217</td>
<td>Woundfix, BioWound, Woundfix Plus, BioWound Plus, Woundfix Xplus or BioWound Xplus, per square centimeter</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4218</td>
<td>Surgicord, per square centimeter</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4219</td>
<td>Surgigraft-dual, per square centimeter</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4220</td>
<td>BellaCell HD or Surederm, per square centimeter</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4221</td>
<td>Amniowrap2, per square centimeter</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4222</td>
<td>Progenamatrix, per square centimeter</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q4226</td>
<td>MyOwn skin, includes harvesting and preparation procedures, per square centimeter</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q5107</td>
<td>Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg</td>
<td>K</td>
<td>9329</td>
<td></td>
</tr>
<tr>
<td>Q5116</td>
<td>Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg</td>
<td>E2</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Q5117</td>
<td>Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg</td>
<td>K</td>
<td>9330</td>
<td></td>
</tr>
<tr>
<td>Q5118</td>
<td>Injection, bevacizumab-bver, biosimilar, (Zirabev), 10 mg</td>
<td>E2</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>J7401</td>
<td>S1090 Mometasone furoate sinus implant, 10 micrograms</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

(1) HCPCS J0641 is not new for October 1, 2019, but please note that the long descriptor has changed for J0641, effective October 1, 2019.
e. Ambulatory Payment Classification (APC) Assignment Change for HCPCS code J9030, BCG live intravesical instillation, 1 mg, Effective July 1, 2019, in the October 2019 I/OCE Release

See Table 8 for the APC assignment change for HCPCS code, J9030, effective July 1, 2019, in the October 2019 I/OCE Release.

Table 8: J9030 – APC Assignment Change

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Old APC Assignment</th>
<th>New APC Assignment</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9030</td>
<td>BCG live intravesical instillation, 1 mg</td>
<td>0809</td>
<td>9322</td>
<td>07/01/19</td>
</tr>
</tbody>
</table>

f. Drugs and Biologicals with Payments Based on Average Sales Price (ASP)

For CY 2019, payment for nonpass-through drugs, biologicals, and therapeutic radiopharmaceuticals that were not acquired through the 340B Program is made at a single rate of ASP + 6 percent (or ASP - 22.5 percent if acquired under the 340B Program), which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological, or therapeutic radiopharmaceutical. In CY 2019, a single payment of ASP + 6 percent for pass-through drugs, biologicals, and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items.

Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later-quarter ASP submissions become available. Effective October 1, 2019, payment rates for some drugs and biologicals have changed from the values published in the July 2019 update of the OPPS Addendum A and Addendum B. CMS is not publishing the updated payment rates in this CR implementing the October 2019 update of the OPPS. However, the updated payment rates effective October 1, 2019, can be found in the October 2019 update of the OPPS Addendum A and Addendum B on the CMS website at http://www.cms.gov/HospitalOutpatientPPS/.

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

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the CMS website on the first date of the quarter at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html. Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

5. Clarification on the Guidance for Intraocular or Periocular Injections of Combinations of Anti-Inflammatory Drugs and Antibiotics

On September 15, 2015, CMS issued CR 9298 (Transmittal R3352CP), which provided guidance for “dropless cataract surgery.” (See related MLN Matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9298.pdf. CR 11451 is a clarification to CR 9298 on “dropless cataract surgery.” Intraocular or periocular injections...
of combinations of anti-inflammatory drugs and antibiotics are being used with increased frequency in ocular surgery (primarily cataract surgery). One example of combined or compounded drugs includes, triamcinolone and moxifloxacin with or without vancomycin. Such combinations may be administered as separate injections or as a single combined injection. Because such injections may obviate the need for post-operative anti-inflammatory and antibiotic eye drops, some have referred to cataract surgery with such injections as “dropless cataract surgery.” However, nothing in this CR is intended to preclude physicians or other professionals from discussing the potential benefits and drawbacks of dropless therapy with their patients and prescribing it if the patient so elects.

6. OPPS Pricer logic and data changes for October
There are no OPPS PRICER logic or data changes for October; therefore, there is no OPPS PRICER release for October.

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

Additional Information

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

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 7, 2019</td>
<td>We revised this article to reflect the revised CR 11451, issued on October 4, 2019. CMS revised the CR to correct Table 7 to reinstate C9043 rather than delete it effective October 1, 2019. CR11451 also added a new HCPCS code J0642, which is effective October 1, 2019, and revised the descriptor for J0641. The CR release date, transmittal number, and the web address of the CR are changed. All other information remains the same.</td>
</tr>
<tr>
<td>September 3, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
ePass is Now Available to Ease the Burden of Repeated Authentication When Calling Palmetto GBA’s Provider Contact Center

Authentication is required before Palmetto GBA is authorized to discuss Medicare information with a provider. The ePass is an eight-digit code providers can elect to receive, per each NPI and PTAN combination, following their first-time authentication when they call the Provider Contact Center (PCC). This ePass can then be used for the remainder of the day in order to authenticate. This code will be delivered in one of two ways:

- Through the IVR, follow the first-time authentication steps by selecting Option 5 for ePass and then Option 2 to receive ePass; or

- Request your ePass verbally while speaking with a Customer Service Agent (CSA) following first-time authentication

The goal of the ePass is to ease provider burden by eliminating the need to repeatedly authenticate each time you contact the PCC in a given day. The ePass can then be used for the remainder of that business day in order to authenticate. Simply select Option 5 for ePass and Option 1 to enter your 8-digit ePass number.

This enhancement is in direct response to provider feedback with the goal of improving your provider experience with Palmetto GBA.
Get Your Medicare News Electronically

The Palmetto GBA Medicare listserv is a wonderful communication tool that offers its members the opportunity to stay informed about:

- Medicare incentive programs
- Fee Schedule changes
- New legislation concerning Medicare
- And so much more!

How to register to receive the Palmetto GBA Medicare Listserv:

Go to http://tinyurl.com/PalmettoGBAListserv and select “Register Now.” Complete and submit the online form. Be sure to select the specialties that interest you so information can be sent.

Note: Once the registration information is entered, you will receive a confirmation/welcome message informing you that you’ve been successfully added to our listserv. You must acknowledge this confirmation within three days of your registration.

Medicare Learning Network® (MLN)

Want to stay informed about the latest changes to the Medicare Program? Get connected with the Medicare Learning Network® (MLN) – the home for education, information, and resources for health care professionals.

The Medicare Learning Network® is a registered trademark of the Centers for Medicare & Medicaid Services (CMS) and the brand name for official CMS education and information for health care professionals. It provides educational products on Medicare-related topics, such as provider enrollment, preventive services, claims processing, provider compliance, and Medicare payment policies. MLN products are offered in a variety of formats, including training guides, articles, educational tools, booklets, fact sheets, web-based training courses (many of which offer continuing education credits) – all available to you free of charge!

The following items may be found on the CMS web page at:

- MLN Catalog: is a free interactive downloadable document that lists all MLN products by media format. To access the catalog, scroll to the “Downloads” section and select “MLN Catalog.” Once you have opened the catalog, you may either click on the title of a product or you can click on the type of “Formats Available.” This will link you to an online version of the product or the Product Ordering Page.
• MLN Product Ordering Page: allows you to order hard copy versions of various products. These products are available to you for free. To access the MLN Product Ordering Page, scroll to the “Related Links” and select “MLN Product Ordering Page.”

• MLN Product of the Month: highlights a Medicare provider education product or set of products each month along with some teaching aids, such as crossword puzzles, to help you learn more while having fun!

Other resources:
• MLN Publications List: contains the electronic versions of the downloadable publications. These products are available to you for free. To access the MLN Publications go to: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html. You will then be able to use the “Filter On” feature to search by topic or key word or you can sort by date, topic, title, or format.

MLN Educational Products Electronic Mailing List
To stay up-to-date on the latest news about new and revised MLN products and services, subscribe to the MLN Educational Products electronic mailing list! This service is free of charge. Once you subscribe, you will receive an e-mail when new and revised MLN products are released.

To subscribe to the service:
1. Go to https://list.nih.gov/cgi-bin/wa.exe?A0=mln_education_products-l and select the ‘Subscribe or Unsubscribe’ link under the ‘Options’ tab on the right side of the page.
2. Follow the instructions to set up an account and start receiving updates immediately – it’s that easy!

If you would like to contact the MLN, please email CMS at MLN@cms.hhs.gov.

MEDICARE BENEFICIARY IDENTIFIER (MBI) INFORMATION

New Medicare Card: Transition Period Ends in Less Than Three Months

Starting January 1, 2020, you must use the Medicare Beneficiary Identifier (MBI). We will reject claims you submit with the Health Insurance Claim Number (HICN), with a few exceptions (https://www.cms.gov/Medicare/New-Medicare-Card/index.html) and reject all eligibility transactions.
Many providers are using the MBI for Medicare transactions. For the week ending August 2, providers submitted 77% of fee-for-service claims with the MBI. Protect your patients’ identities by using MBIs now for all Medicare transactions. Don’t have an MBI?


- Use your Medicare Administrative Contractor’s look up tool. Sign up (https://www.cms.gov/Medicare/New-Medicare-Card/Providers/MACs-Provider-Portals-by-State.pdf) for the Portal to use the tool.

- Check the remittance advice. We return the MBI on the remittance advice for every claim with a valid and active HICN.


**Medicare Beneficiary Identifier (MBI) Look-up Tool**

The Medicare Beneficiary Identifier (MBI) Lookup tool allows providers to use our secure eServices online portal to obtain the new MBI number when patients do not present their Medicare card. If you do not already have access, sign up (https://www.onlineproviderservices.com/ecx_improvev2/initLogin.do) now for access to eServices to use the tool.

As background, the New Medicare Card Project was established in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 which mandates the removal of the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) from Medicare cards by April, 2019. CMS began mailing new Medicare cards with the MBI on April 2, 2018.

From April 1, 2018, to December 31, 2019, CMS will offer a transition period during which the system will accept both HICNs and MBIs on Medicare transactions (including eligibility requests and claims) for beneficiaries in the Medicare program prior to April 1, 2018 (i.e., those who received an HICN on their Medicare card). The transition period ensures your Medicare patients continue to get care by allowing you to use either the HICN or the MBI for all Medicare transactions. **Note: Providers should not submit both numbers on the same transaction.**

Beginning in January, 2020, providers may only use MBIs, with limited exceptions,

To submit an inquiry you must do the following:

- Once logged into eServices, click on the **MBI LOOKUP** tab located in the header of the portal
- Complete the **required** fields:
  - Beneficiary’s Last Name
  - First Name
  - Date of Birth
  - Social Security Number (Note: the social security number must be in the XXX-XX-XXXX format)
- To meet our CAPTCHA requirements, you must select the **I’M NOT A ROBOT** checkbox
- Click **SUBMIT INQUIRY**

**Figure 1: MBI Lookup Tab**

**Lookup Tool Status Results**
If the inquiry successfully returns an MBI, the screen will refresh with the data at the bottom.
Figure 2: MBI Lookup Successful Response Screenshot

In the event that your MBI Lookup request does not result in a successful response, eServices will display an error message to assist you. If any required fields are left blank or are not in a proper format, a message will appear advising you which fields to correct.

Figure 3: MBI Lookup Unsuccessful Response Screenshot


APPEALS INFORMATION

Notification of the 2020 Dollar Amount in Controversy Required to Sustain Appeal Rights for an Administrative Law Judge (ALJ) Hearing or Federal District Court Review

Section 1869(b)(1)(E) of the Social Security Act (the Act), as amended by Section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires an annual reevaluation of the dollar amount in controversy required for an Administrative Law Judge (ALJ) hearing or Federal District Court review.

The amount in controversy is adjusted by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

• ALJ Hearing Requests - The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2019 is $160. This amount will increase to $170 for ALJ hearing requests filed on or after January 1, 2020.
Federal District Court - The amount that must remain in controversy for reviews in Federal District Court requested on or before December 31, 2019 is $1,630. This amount will increase to $1,670 for appeals to Federal District Court filed on or after January 1, 2020.

**ESERVICES INFORMATION**

**Do You Have a Question Regarding eServices? We Can Help!**

Palmetto GBA has dedicated representatives available to provide technical assistance and answer questions about our secure online portal — eServices. Our Provider Contact Center (PCC) representatives can be reached at 855–696–0705 (Monday – Friday, 8 a.m. to 4:30 p.m. ET).

To connect with an eServices representative:

- Press/say 1 or EDI
- Press/say 2 for all other calls
- Press/say 1 or eServices


**How Can We Be of “eService” to You?**

You may have noticed that over the past year we have been busy upgrading our secure web portal, eServices. Designed specifically with you, the provider, in mind, we have added many new features to help you manage patient accounts and practice information in a more efficient manner.

**How Does eServices Help You?**

Palmetto GBA’s eServices is a free internet-based, provider self-service secure application. Palmetto GBA’s goal is to give the provider secure and fast access to their Medicare information seamlessly via our website through the eServices application. Our innovative tool allows you to access a wide range of information — from looking up patient eligibility to retrieving a variety of detailed provider reports. The best part is… we are not finished yet! Keep an eye out for more improvements in the near future. Let’s revisit the many features the eServices application provides. Over the next few months we will delve deeper into several key features.

- Eligibility
- Claims Status
- eClaim Submissions — available for Part B and Railroad Medicare providers
- Clerical Error Claim Reopening Requests — available for Part B
• Remittances Online
• Financial Information — payment floor and last three checks paid
• Financial Forms — eOffset requests, eCheck payments and CMS-838 Credit Balance form (Part A and HHH only)
• Secure Forms — Appeals, Medical Review ADR Response Form, Prior Authorization Form (JM Part B and HHH), Wage Index Form (Part A only) and General Inquiry Form
• eDelivery
• eReview — eCBR, eUtilization and eAudit (JM, JJ Part A and RRB only)
• Additional Documentation Form — available for JJ Part B and JM Part B
• MBI (Medicare Beneficiary Identifier) Lookup

You can participate in eServices if you have a signed Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA and have payment amounts on file. This agreement with instructions to complete can be found at, www.PalmettoGBA.com under the EDI section for your line of business.

The eServices home page is: www.palmettogba.com/eServices. If you are not taking advantage of the many benefits of eServices, what are you waiting for? Get started today!

**HOME HEALTH REVIEW CHOICE DEMONSTRATION (RCD) INFORMATION**

**Review Choice Demonstration (RCD) for the Texas Home Health Services Has Been Rescheduled**


The ability for home health agencies to make a selection will end today, October 21, 2019, and reopen again on January 15, 2020. Selections that have already been made will be maintained. If you have already made your selection, you will not need to make a new selection when the selection period opens back up on January 15, 2020, but you will be able to make changes as desired through February 13, 2020.

**Need to stay abreast of the newest information regarding the Home Health Review Choice Demonstration (RCD)?**

Palmetto GBA has created a special listserv category just for you! This will allow you to receive the most up to date information available.

**Already receive Palmetto GBA Listservs?**

- Sign into your listserv profile by selecting the Log In external link button on the Email updates page
- Scroll down to Step 3 – Select your Specialties
- Select the JM Home Health and Hospice link on the left side of the screen
- Select the “Home Health Review Choice Demonstration” category
- This new category will show up at the top of your chosen list
- Scroll down and select “Update Profile”

**Not registered to receive listservs from Palmetto GBA?**

Registering is quick, easy and free! Sign up now to receive email updates. If you would like to receive these updates by email, you must register (https://www.palmettogba.com/registration.nsf/newie?OpenForm) and create a customized profile of the documents you would like to receive. Be sure to include the new Home Health Review Choice Demonstration category in your selection.

**Monthly Review Choice Demonstration (RCD) Provider Teleconference Schedule (November - December 2019)**

If you are a home health provider in Illinois, North Carolina, Ohio, Florida or Texas, please join us for the monthly Review Choice Demonstration (RCD) teleconferences. These teleconferences will provide up-to-date RCD information and give you a chance to ask any questions you may have about RCD. Each teleconference session will be held from 11 a.m. to 12 p.m. ET.
Please review the schedule to select the date and dial-in information for the teleconference session you want to attend. Please share this information with your staff.

**November 6, 2019**
Participant Number: 877–789–3907
Conference ID: 4497141

**December 4, 2019**
Participant Number: 877–789–3907
Conference ID: 9199956

**INFLUENZA VACCINE INFORMATION**

It’s Flu season again - Use Medicare Beneficiary Identifiers to Bill Medicare


Use MBIs to check eligibility and bill for influenza vaccinations to protect Medicare beneficiaries’ personal identities. Get the MBI:


- You can look up MBIs for your Medicare patients when they don’t or can’t give them. Sign up ([https://www.cms.gov/Medicare/New-Medicare-Card/Providers/MACs-Provider-Portals-by-State.pdf](https://www.cms.gov/Medicare/New-Medicare-Card/Providers/MACs-Provider-Portals-by-State.pdf)) for the Portal to use the tool. You can use this tool even after the end of the transition period — the tool doesn’t end on December 31, 2019. Even if your patients are in a Medicare Advantage Plan, you can look up their MBIs to bill for things like indirect medical education.

You must have your patient’s SSN for the search and it may differ from the HICN, which uses the SSN of the primary wage earner. If your Medicare patient doesn’t want to give the SSN, tell your patient to log into [https://www.mymedicare.gov/](https://www.mymedicare.gov/) to get the MBI.

If the lookup tool returns a last name matching error and the beneficiary’s last name includes a suffix, such as Jr. Sr. or III, try searching without and with the suffix as part of the last name.
• Check the remittance advice. CMS included the new MBI on the remittance advice for each claim you submitted with a valid and active HICN since October, 2018, and will continue to return MBIs through December 31, 2019. Get the MBI from the remittance advice, save it in your systems, and use it to bill for this year’s flu vaccinations.

Tips for using MBIs:
• Don’t use hyphens or spaces to avoid rejection of your claim
• MBIs use numbers 0—9 and all uppercase letters except for S, L, O, I, B and Z. We exclude these letters to avoid confusion when differentiating some letters and numbers (for example, between “0” and “O”).

Starting January 1, 2020, you must use the MBI:
• We will reject claims you submit with HICNs with a few exceptions (https://www.cms.gov/Medicare/New-Medicare-Card/index.html)
• We will reject all eligibility transactions you submit with HICNs

For more information, please review CMS’ New Medicare Beneficiary Identifier (MBI), Get It, Use It article (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18006.pdf).

Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS

MLN Matters Number: MM11335
Related CR Release Date: October 11, 2019
Related CR Transmittal Number: R2372OTN
Related Change Request (CR) Number: 11335
Effective Date: April 1, 2020
Implementation Date: April 6, 2020

Provider Types Affected
This MLN Matters Article is for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for Pneumococcal Pneumonia Vaccination (PPV) services provided to Medicare beneficiaries.

What You Need To Know
CR 11335 instructs Medicare’s Common Working File (CWF) to send the Date of Service (DOS) for both PPV HCPCS codes (90670 and 90732) to the Medicare Beneficiary Database (MBD). This will allow other systems to know whether the DOS was for the initial vaccine or the second vaccine. Once the CR is implemented, providers will receive more detail in reply to eligibility transactions on whether their beneficiaries have received one or both PPV vaccines.

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Background
Currently, the CWF groups these two HCPCS codes under the PPV HCPCS group code and sends a single next eligible date from the CWF to the MBD. There is no logic included on the MBD to differentiate between the initial vaccine (code 90670) and the second vaccine (code 90732).

For eligibility transactions, CWF processes the two codes as if they were the same code and stores the next eligible date in the one field that exists in the CWF Beneficiary Master File for PPV. This means that the date stored in this field may represent the date of the Initial dose or the second dose.

Eligibility transactions have a need to return the PPV DOS as well as the related National Provider Identifier (NPI) for both of these PPV HCPCS codes (90670 and 90732) for a beneficiary, so that a provider may determine if a beneficiary is eligible for either service, or if the beneficiary has already received both vaccines.

With CR 11335, eligibility transactions will be able to send providers more PPV details for a beneficiary. This includes up to 10 occurrences of historical PPV HCPCS codes, NPI, and DOS for each beneficiary.

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

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tbody>
<tr>
<td>October 11, 2019</td>
<td>Initial article released.</td>
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LEARNING AND EDUCATION INFORMATION

Home Health Patient-Driven Groupings Model (PDGM) Webcast Part I: November 21, 2019

Date: Thursday, November 21, 2019

Time: 2 p.m. ET

Register now: https://tinyurl.com/y4g4kyhn

This is the first of two collaborative webcasts about the Home Health Patient-Driven Groupings Model (PDGM), hosted by your Home Health Medicare Administrative Contractors (MACs), CGS, National Government Services and Palmetto GBA. During this webcast, you will receive information to help your agency prepare to implement billing changes for the PDGM on January 1, 2020. CMS will use the PDGM to reimburse home health agencies.

- Overview of the PDGM
- PDGM vs. Current PPS
- 30-Day Periods
- Billing and claims processing overview
- Requests for Anticipated Payment (RAPs)
- Reporting new occurrence codes

Part two will be presented on December 5, 2019. You may register (https://tinyurl.com/y4qdtela) for part two.

Audio
The audio for this presentation is broadcast through your computer speakers or headphones. Please test your audio device(s) prior to the start of the presentation. A telephone conference line is not used for the webcast.

Handouts
A copy of this presentation and addition resources will be available in the webcast once it begins.
**Hospice MACtoberfest Conference**

Palmetto GBA, the JM Hospice MAC, is partnering with the Texas & New Mexico Hospice Organization to present an informative two-day Hospice MACtoberfest® on October 28 - 29, 2019.

This conference is intended to keep providers apprised of Medicare guidelines, to include but not limited to: Appeals, Medical Review, Finance, Medical Affairs, Provider Enrollment, Electronic Data Interchange (EDI) and Provider Outreach and Education (POE). The recommended participants are hospice administrators, billers, nurses and other healthcare professionals that submit claims to Medicare.

Registration ([https://www.txnmhospice.org/product/2019pgba/](https://www.txnmhospice.org/product/2019pgba/)) for this event will be handled by the Texas and New Mexico Hospice Association.

**Target Audience:** Administrators, Billers, Managers, Nurses, Compliance Officers, Clinical and Support Staff.


**Continuing Education Information:**
Credit Designation for Nursing: AXIS Medical Education designates this continuing nursing education activity for a maximum of 10.25 contact hours.

Hospice Administrators, Social Workers and LPCs Continuing Education: 10.25 hours of continuing education.

Texas & New Mexico Hospice Organization is an approved provider of continuing education for Hospice Administrators by the Texas Health and Human Services Commission, the Texas State Board of Social Work Examiners and the Texas State Board of Examiners of Professional Counselors.
2019 Medical Review (MR) Hot Topic Targeted Probe and Educate (TPE) Teleconference Schedule

Palmetto GBA will host a series of Medical Review Hot Topic Targeted Probe and Educate (TPE) Teleconferences in 2019. These calls are open to all providers. Please mark your calendars to join our Medical Review Subject Matter Experts as they discuss and answer your questions concerning current TPE process.

<table>
<thead>
<tr>
<th>Medical Review Hot Topic Targeted Probe and Educate Teleconference</th>
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<tbody>
<tr>
<td><strong>Date</strong></td>
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<td><strong>Time</strong></td>
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<td><strong>Participation Number</strong></td>
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This schedule is also available on the Palmetto GBA Event Registration Portal at https://www.palmettogba.com/event/pgbaevent.nsf/SeriesDetails.xsp?EventID=B74TM73304

Home Health Patient-Driven Groupings Model (PDGM) Webcast Part Two: December 5, 2019

**Date:** Thursday, December 5, 2019

**Time:** 2 p.m. ET

Register now (https://tinyurl.com/y4qdtela).

This is second part of two collaborative webcasts about the Home Health Patient-Driven Groupings Model (PDGM), hosted by your Home Health Medicare Administrative Contractors (MACs), CGS, National Government Services and Palmetto GBA. During this webcast, you will receive information to help your agency prepare to implement clinical changes for the PDGM on January 1, 2020. CMS will use the PDGM to reimburse home health agencies.

- Admission Source and Timing
- Clinical Groups
- Functional Impairment Levels
- Comorbidity Group
- Case-Mix Weights
• Other Adjustments
• Diagnosis Information
• How OASIS data will be used

Part one will be presented on November 21, 2019. You may register for Part one here (https://tinyurl.com/y5ztot84)

After November 21, 2019, it will be available for encore viewing at the same link.

Audio
The audio for this presentation is broadcast through your computer speakers or headphones. Please test your audio device(s) prior to the start of the presentation. A telephone conference line is not used for the webcast.

Handouts
A copy of this presentation and addition resources will be available in the webcast once it begins.

Educational Events Where You Can Ask Questions and Get Answers from Palmetto GBA

Don’t Miss this Wonderful Opportunity!
If you are in search of an opportunity to interact with and get answers to your Medicare billing, coverage and documentation questions from Palmetto GBA’s Provider Outreach and Education (POE) department, please see these educational offerings which have a question and answer session.

To access the following information, go to: https://www.palmettogba.com/palmetto/providers.nsf/DocsCat/JM-Home-Health-and-Hospice~AH2JQU8321

<table>
<thead>
<tr>
<th>Quarterly Ask the Contractor Teleconferences (ACTs)</th>
<th>ACTs are intended to open the communication channels between providers and Palmetto GBA, which allows for timely identification of problems and information-sharing in an informal and interactive atmosphere. These teleconferences will be held at least quarterly via teleconference.</th>
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<tbody>
<tr>
<td></td>
<td>Preceding the presentation, providers are given an opportunity to ask questions both on the topics discussed as well as any other question they may have. While we encourage providers to submit questions prior to the call, this is not required. Just fill out the Ask the Contractor Teleconference (ACT): Submit A Question form. Once the form is completed, please fax it to (803) 935-0140, Attention: Ask-the-Contractor Teleconference</td>
</tr>
<tr>
<td>Quarterly Updates Webcasts</td>
<td>The Quarterly Update Webcasts are intended to provide ongoing, scheduled opportunities for providers to stay up to date on Medicare requirements. Providers are able to type a question and have it responded to by the POE department throughout the webcast. At the end of the presentation the moderator will also read and respond to questions submitted by attendees in order to share the responses with the group at large.</td>
</tr>
<tr>
<td>Event Registration Portal</td>
<td>Visit our Event Registration Portal to find information on upcoming educational events and seminars. This is a complete listing of both our face-to-face outreach opportunities as well as our teleconference and webcast listings. Providers are able to dialogue with POE and get answers to their questions at all of these educational events.</td>
</tr>
</tbody>
</table>

If you have a question that you need an answer to today or a claims specific question which requires the disclosure of PII or PHI for response, please contact the Provider Contact Center (PCC) at 1-855-696-0705.
MEDICAL DIRECTOR’S DESK

Medical Affairs publishes Medicare Local Coverage Determination (LCDs) and medically related articles in this special section of the Medicare Advisory. We encourage you to help us maintain accurate LCDs. Please review LCDs and address your comments and concerns to your Carrier Advisory Committee specialty representative or contact the Medical Affairs Department.

Medical articles are published in the Medicare Advisory to provide education and alert Medicare providers of billing/coding issues. Remember, physicians and non-physician practitioners (NPPs) who bill Medicare are responsible for accurate service coding. Errors may result in overpayment requests or Recovery Auditor (RA) referrals. If you purchase a new device or need to submit claims for a new procedure, please review applicable service codes and descriptions in the current CPT and HCPCS manuals. If you question the recommended service procedures received from other sources such as manufacturers, send your inquiry and the device description to the Medical Affairs Department.

To view these revised and retired Local Coverage Determinations (LCDs) and Medicare Coverage Database (MCD) Articles go to www.PalmettoGBA.com/hhh/lcd. Select “Active LCDs under the LCDs, NCDs, Coverage Articles page of the Medical Policies” section. Make sure “Active LCDs” is selected under the “Select LCD Types(s)” section. Then select the Submit button. The LCDs are listed in alphabetical order.

To contact the Medical Affairs Department:

email: A.Policy@palmettogba.com

Mail:
HHH Medical Affairs
Mail Code: AG-300
P.O. Box 100238
Columbia, SC 29202-3238
## HHH Local Coverage Determinations (LCDs) Updates

<table>
<thead>
<tr>
<th>Title</th>
<th>Changes/Additions/Deletions</th>
<th>Effective Date</th>
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<tr>
<td>Home Health Occupational Therapy</td>
<td>This LCD is being revised in order to adhere to CMS requirements per Chapter 13, Section 13.5.1 of the Program Integrity Manual, to remove all coding from LCDs. There has been no change in coverage with this LCD revision. Regulations regarding billing and coding were removed from the CMS National Coverage Policy section of this LCD and placed in the related Billing and Coding: Home Health Occupational Therapy A53057 article.</td>
<td>10/10/19</td>
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<td>LCD Number: L34560</td>
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<td>Revision Number: 20</td>
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<tr>
<td>Home Health Physical Therapy</td>
<td>This LCD is being revised in order to adhere to CMS requirements per Chapter 13, Section 13.5.1 of the Program Integrity Manual, to remove all coding from LCDs. There has been no change in coverage with this LCD revision. Regulations regarding billing and coding were removed from the CMS National Coverage Policy section of this LCD and placed in the related Billing and Coding: Home Health Physical Therapy A53058 article.</td>
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<td>LCD Number: L34564</td>
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<td>Revision Number: 21</td>
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<tr>
<td>Home Health - Psychiatric Care</td>
<td>This LCD is being revised in order to adhere to CMS requirements per Chapter 13, Section 13.5.1 of the Program Integrity Manual, to remove all coding from LCDs. There has been no change in coverage with this LCD revision. CMS Internet-Only Manual, Pub. 100-04, Medicare Claims Processing Manual, Chapter 10, §40.2 was removed from the CMS National Coverage Policy section of this LCD and placed in the related Billing and Coding: Home Health - Psychiatric Care A56756 article.</td>
<td>10/10/19</td>
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<td>LCD Number: L34561</td>
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<td>Revision Number: 17</td>
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<td>Hospice Cardiopulmonary Conditions</td>
<td>This LCD is being revised in order to adhere to CMS requirements per chapter 13, section 13.5.1 of the Program Integrity Manual, to remove all coding from LCDs. There has been no change in coverage with this LCD revision. Regulations regarding billing and coding were removed from the CMS National Coverage Policy section of this LCD and placed in the related Billing and Coding: Hospice Cardiopulmonary Conditions A56610 article.</td>
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<td>Revision Number: 9</td>
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<tr>
<td>Hospice - HIV Disease</td>
<td>This LCD is being revised in order to adhere to CMS requirements per Chapter 13, Section 13.5.1 of the Program Integrity Manual, to remove all coding from LCDs. There has been no change in coverage with this LCD revision. Regulations regarding billing and coding were removed from the CMS National Coverage Policy section of this LCD and placed in the related Billing and Coding: Hospice – HIV Disease A56677 article.</td>
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## HHH Article Updates

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<tr>
<th>Title</th>
<th>Changes/Additions/Deletions</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>Billing and Coding: Home Health Occupational Therapy</td>
<td>This article is being revised in order to adhere to CMS requirements per Chapter 13, Section 13.5.1 of the Program Integrity Manual, to remove all coding from LCDs and incorporate into related Billing and Coding Articles. Regulations regarding billing and coding were removed from the <strong>CMS National Coverage Policy</strong> section of the related Home Health Occupational Therapy L34560 LCD and placed in this article.</td>
<td>10/10/19</td>
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<tr>
<td>Article Number: A53057</td>
<td>Revision Number: 10</td>
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<td>Billing and Coding: Home Health Physical Therapy</td>
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<td>10/17/19</td>
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<td>Article Number: A53058</td>
<td>Revision Number: 11</td>
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<td>Billing and Coding: Home Health - Psychiatric Care</td>
<td>This article is being revised in order to adhere to CMS requirements per Chapter 13, Section 13.5.1 of the Program Integrity Manual, to remove all coding from LCDs and incorporate into related Billing and Coding Articles. <strong>CMS Internet-Only Manual</strong>, Pub. 100-04, Medicare Claims Processing Manual, Chapter 10, §40.2 was removed from the <strong>CMS National Coverage Policy</strong> section of the related Home Health - Psychiatric Care L34561 LCD and placed in this article.</td>
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<td>Article Number: A56756</td>
<td>Revision Number: 3</td>
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<td>Billing and Coding: Hospice – HIV Disease</td>
<td>This article is being revised in order to adhere to CMS requirements per Chapter 13, Section 13.5.1 of the Program Integrity Manual, to remove all coding from LCDs and incorporate into related Billing and Coding Articles. Regulations regarding billing and coding were removed from the <strong>CMS National Coverage Policy</strong> section of the related Hospice - HIV Disease L34566 LCD and placed in this article.</td>
<td>10/10/19</td>
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<td>Article Number: A56677</td>
<td>Revision Number: 2</td>
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<tr>
<td>Billing and Coding: Hospice Cardiopulmonary Conditions</td>
<td>This article is being revised in order to adhere to CMS requirements per chapter 13, section 13.5.1 of the Program Integrity Manual, to remove all coding from LCDs and incorporate into related Billing and Coding Articles. Regulations regarding billing and coding were removed from the <strong>CMS National Coverage Policy</strong> section of the related Hospice Cardiopulmonary Conditions L34548 LCD and placed in this article.</td>
<td>10/10/19</td>
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<tr>
<td>Article Number: A56610</td>
<td>Revision Number: 2</td>
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**PROVIDER ENROLLMENT INFORMATION**

**You Can Track Your Enrollment Application**

Palmetto GBA makes it easy for you to track your enrollment application with our Application Status Lookup Tool. This tool provides tracking data for application types 855A, 855B, 855I, 855R and 855O, and Medicare Diabetes Prevention Program. Additionally, the tool will provide updates on submitted CMS 588 (EFT), CMS 460 (Participating Agreement), reconsideration requests, opt-out affidavits, license updates and voluntary terminations requests.

Enrollment Application Status Lookup links:
Provider Enrollment Rebuttal Process

MLN Matters Number: MM10978
Related CR Release Date: September 27, 2019
Related CR Transmittal Number: R904PI
Related Change Request (CR) Number: 10978
Effective Date: December 31, 2019
Implementation Date: December 31, 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) 10978 puts into operation the provision under 42 C.F.R. Section 424.545(b), which permits providers-suppliers whose Medicare billing privileges are deactivated to file a rebuttal. CR 10978 provides instructions for MACs to advise providers-suppliers of their rebuttal rights, as well as for receiving and processing rebuttals.

A copy of the rebuttal submission form can be viewed in Attachment 2 of CR 10978. Make sure your billing staffs are aware of these instructions.

Background
This CR will align provider enrollment policy with the Code of Federal Regulations at 42 C.F.R. Section 424.545(b), which allows a provider or supplier whose billing privileges have been deactivated to file a rebuttal. The MACs will be responsible for advising providers and suppliers of their right to file a rebuttal in response to any enrollment deactivation. The MACs will also be responsible for receiving, reviewing, and issuing determinations regarding all rebuttals.

There is no legislative or regulatory impact associated with CR 10978.

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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<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>September 30, 2019</td>
<td>Initial article released.</td>
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This advisory should be shared with all health care practitioners and managerial members of the provider/supplier staff. Medicare Advisories are available at no cost from the Palmetto GBA website at www.PalmettoGBA.com/hhh.

Address Changes

Have you changed your address or other significant information recently? To update this information, please complete and submit a CMS 855A form. The most efficient way to submit your information is by Internet-based Provider Enrollment, Chain and Ownership System (PECOS). To make a change in your Medicare enrollment information via the Internet-based PECOS, go to https://pecos.cms.hhs.gov on the CMS website. To obtain the hard copy form plus information on how to complete and submit it, visit the Palmetto GBA website (www.PalmettoGBA.com/hhh).
TOOLS THAT YOU CAN USE

We’re using Medicare Beneficiary Identifiers (MBIs)

For more information about the new Medicare card, please go to the New Medicare card Web Page on the CMS Website.

To access this page, copy and paste the following link in your browser:

HELPFUL INFORMATION

Contact Information for Palmetto GBA Home Health and Hospice

Provider Contact Center: 855-696-0705

Email Part A: https://www.palmettogba.com/palmetto/Feedback.nsf/Feedback?OpenForm&SendTo=08

To contact a specific JM HHH department, please select the link below:
