Medicare Bulletin
Jurisdiction 15

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Upcoming Educational Events

https://www.cgsmedicare.com/mycgs/index.html

myCGS is a secure Internet-based application where you can view beneficiary eligibility, claims status, online remittances, financial information, and much more!


#NewCardNewNumber
For Home Health Providers

**MM11104: Manual Updates Related to Home Health Certification and Recertification Policy Changes**

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

**MLN Matters Number:** MM11104  
**Related CR Release Date:** March 22, 2019  
**Related CR Transmittal Number:** R258BP and R870PI  
**Related Change Request (CR) Number:** CR 11104  
**Effective Date:** April 22, 2019  
**Implementation Date:** April 22, 2019

**Provider Type Affected**

This MLN Matters Article is for physicians and Home Health Agencies (HHAs) billing Medicare Administrative Contractors (MACs) for Home Health Services provided to Medicare beneficiaries.

**Provider Action Needed**

CR11104 updates the Medicare Benefit Policy Manual and Medicare Program Integrity Manual to reflect policy changes in recertification for home health services that the Centers for Medicare & Medicaid Services (CMS) finalized in the Calendar Year (CY) 2019 Home Health Prospective Payment System (HH PPS) final rule (83 FR 56406).

CR11104 also updates the Medicare Benefit Policy Manual to clarify the home health plan of care requirements for payment as a result of the recent changes to the home health plan of care requirements in the Medicare Conditions of Participation (CoPs) finalized in the January 13, 2017 Conditions of Participation for Home Health Agencies final rule (82 FR 4504).

**Background**

**Update to the Recertification Requirements**

The Code of Federal Regulations (CFR) at 42 CFR 424.22(b)(2) provides the requirements for home health services recertification. Currently, the regulations require the certifying physician to include a statement that:

1. Indicates the continuing need for services; and
2. Estimates how much longer the beneficiary will require home health services.
CMS finalized a change to these physician recertification requirements in the CY 2019 HH PPS final rule (83 FR 56524). Specifically, this rule eliminates the requirement that the certifying physician estimate how much longer the patient will require skilled care, when recertifying the patient for home health care. This change is effective for recertifications made on, and after January 1, 2019. Note that all other recertification requirements under Section 424.22(b)(2) remain unchanged.

**Clarification of Home Health Plan of Care Requirements for Payment**

The Home Health Conditions of Participation at 42 CFR 484.60(a) list the content requirements for the home health plan of care. Changes to these content requirements were finalized in the January 13, 2017 Home Health Conditions of Participation final rule (82 FR 4504) and became effective January 13, 2018.

CMS is clarifying that for HHA services to be covered, the individualized plan of care must specify the services necessary to meet the patient-specific needs identified in the comprehensive assessment. In addition, the plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in 42 CFR 484.60(a) that establish the need for such services. All care provided must be in accordance with the plan of care.

**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).

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

**Document History**

<table>
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<th>Date</th>
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<td>Initial article released.</td>
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</table>

**For Hospice Providers**

**MM11049 (Revised):** Ensuring Only the Active Billing Hospice Can Submit a Revocation

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

**MLN Matters Number:** MM11049 *Revised*  
**Related CR Release Date:** March 13, 2019  
**Related CR Transmittal Number:** R4254CP  
**Related Change Request (CR) Number:** 11049  
**Effective Date:** Claims received on or after July 1, 2019  
**Implementation Date:** July 1, 2019

**Note:** We revised this article on March 14, 2019, to reflect the revised CR11049 issued on March 13. CMS revised the CR to clarify one of the business requirements and we show that change in the article in a revision to the first bullet point on page 2. Also, 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 for hospices billing Medicare Administrative Contractors (MACs) for hospice services provided to Medicare beneficiaries.

Provider Action Needed
CR 11049 creates a new Common Working File (CWF) edit in Medicare systems to ensure that the provider identifier (the Centers for Medicare & Medicaid Services (CMS) Certification Number (CCN)) on Type of Bill (TOB) 8xB matches the most recent provider CCN on a hospice benefit period. CR 11049 contains no new policy. It revises Medicare systems to administer existing hospice benefit policy more efficiently. Make sure your billing staffs are aware of these edits.

Background
Original Medicare implemented the systems and operational changes needed to redesign how the CWF stores and updates hospice election and benefit period information. Generally, these changes ensure that election and revocation date information are separate from benefit period information, so the two types of information can be updated independently. Since the implementation of these changes, MACs have identified processing scenarios that call for additional changes, several of which are resolved in CR 10967, to be implemented April 1, 2019 (read the related article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10967.pdf). CR 11049 resolves another scenario.

CWF will allow Notices of Revocation/Termination (NOTR – TOB 8xB) if the provider CCN on the NOTR matches the CCN on the hospice election period. This occurs even if a transfer notice (8xC) or a change of ownership notice (8xE) has changed the billing provider on a benefit period within that election.

Hospice providers should be aware that MACs will reject an incoming TOB 8xB if:

- The provider CCN matches the CCN on the hospice election period or matches a previous transfer or change of ownership CCN that is not the latest; AND
- Transfer or change of ownership dates are present on a hospice benefit period; AND
- No claims have processed within the benefit period after the revocation date; AND
- The CCN does not match the CCN associated with the latest transfer or change of ownership date on the hospice benefit period.

MACs will return the rejected 8xB to the provider with a message stating that the active billing provider on the hospice benefit period must submit the revocation.

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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CGS Website Updates

CGS has recently made updates to their website, giving providers additional resources to assist with billing Medicare-covered services appropriately.

Please review the following updates:

- The **Claims Processing Issues Log** Web page at [https://www.cgsmedicare.com/hhh/claims/fiss_claims_processing_issues.html](https://www.cgsmedicare.com/hhh/claims/fiss_claims_processing_issues.html) was updated with the most recent updates.

- The **Top Claim Submission Errors (Reason Codes) and How to Resolve** Web page at [https://www.cgsmedicare.com/hhh/education/materials/cses.html](https://www.cgsmedicare.com/hhh/education/materials/cses.html) has been updated with the most recent data.

- The **HHH Recorded Webinars** Web page at [https://www.cgsmedicare.com/hhh/education/recorded_webinars.html](https://www.cgsmedicare.com/hhh/education/recorded_webinars.html) was updated with the most recent home health and hospice related educational events.

- The **HHH Provider Audit, Contact Us** Web page at [https://www.cgsmedicare.com/hhh/audit/contact.html](https://www.cgsmedicare.com/hhh/audit/contact.html) was updated to include the **Part A and HHH – Change of Contact** form. Use this form at [https://www.cgsmedicare.com/pdf/j15_change_of_contact_form.pdf](https://www.cgsmedicare.com/pdf/j15_change_of_contact_form.pdf) if your Audit and Reimbursement contact information needs to be updated.

- The **Home Health Medicare Billing Codes Sheet** quick resource tool at [https://www.cgsmedicare.com/hhh/education/materials/pdf/home_health_billing_codes.pdf](https://www.cgsmedicare.com/hhh/education/materials/pdf/home_health_billing_codes.pdf) was updated to include a note to HCPCS code G0162 indicating that it is not valid for visits made on or after 1/1/2017.

- A quarterly review of the **Frequently Asked Questions (FAQs)** [https://www.cgsmedicare.com/medicare_dynamic/faqs/J15hhh.asp](https://www.cgsmedicare.com/medicare_dynamic/faqs/J15hhh.asp) was completed. Updates were made as necessary. In addition, a link to the FAQs has been added to the left side navigation menu for quick and easy access.

- The HCPCS Code G0162 description on the **Claim Page 02 – Entering a RAP or Claim** Web page at [https://www.cgsmedicare.com/hhh/education/materials/hhe_claim_page_2.html](https://www.cgsmedicare.com/hhh/education/materials/hhe_claim_page_2.html) and the **Home Health Medicare Billing Codes Sheet** at [https://www.cgsmedicare.com/hhh/education/materials/pdf/home_health_billing_codes.pdf](https://www.cgsmedicare.com/hhh/education/materials/pdf/home_health_billing_codes.pdf) were updated to indicate that G0162 is not valid for services provided on or after January 1, 2017.

- The **Jurisdiction 15 Home Health & Hospice Provider Outreach and Education (POE) Advisory Group** Web page at [https://www.cgsmedicare.com/hhh/education/advisory_groups.html](https://www.cgsmedicare.com/hhh/education/advisory_groups.html) was updated to include the March 19, 2019 Advisory Group meeting minutes.

- **NEW:** The **Home Health Patient-Driven Groupings Model (PDGM)** Web page at [https://www.cgsmedicare.com/hhh/education/materials/pdgm.html](https://www.cgsmedicare.com/hhh/education/materials/pdgm.html) was developed to include resources provided by the Centers for Medicare & Medicaid Services (CMS). Watch for updates to this page as CGS educational materials are made available.
Fiscal Intermediary Standard System (FISS)
Direct Data Entry (DDE) Screen Changes

The April 2019 quarterly system release, which will be implemented on April 1, 2019, includes changes to the following FISS DDE screens. In addition, the Home Health and Hospice FISS DDE Guide (https://www.cgsmedicare.com/hhh/education/materials/fiss.html) has been updated to reflect these changes.

New Inquiry Screen Option 1D – PROV PRACTICE ADDR QUER and MAP 1AB1 and MAP 1AB2

The PROV PRACTICE ADDR QUER, Option 1D, allows you to view the practice location address for an off-campus, outpatient, provider-based department of a hospital. Effective April 1, 2019, system edits will be activated that require the service facility address reported on the claim to be an exact match to the provider practice file address provided in this screen. For additional information, refer to the CMS MLN Matters article SE18023 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18023.pdf).

Note: This inquiry screen is not applicable to home health and hospice providers.

When 1D is entered in the ENTER MENU SELECTION field, the new inquiry screen MAP1AB1 will display. MAP1AB1 will list all off-campus, outpatient, provider-based departments for your provider.

Enter an “S” in the SEL field and MAP1AB2 will display.
MAP 171E

The MAP171E screen was updated by adding the MOLDX field. MAP171E is accessed by pressing F11 once from Claim Page 02 (MAP1712). Refer to the CMS MLN Matters article MM10760 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm10760.pdf) at for additional information.

Providers will be able to manually enter or correct the Molecular Diagnostic Services (MolDx) test ID field. If the information entered in the MOLDX field is not valid, reason code 19956 will assign and the claim will be sent to the Return to Provide (RTP) status/location T B9997 for you to correct.

<table>
<thead>
<tr>
<th>MAP 171E</th>
<th>MAP171E PAE 02</th>
<th>OSS J15 MIE - XXX REGION</th>
<th>ACTPA052 MM/SS/YY</th>
<th>D000001</th>
<th>SC</th>
<th>INST CLAIM ENTRY</th>
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<th>B0001111</th>
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MAP 1712

MAP1712 was updated to add two new fields for future Prior Authorization (PA) programs. The **RRB EXCL IND** field identifies if a Railroad Medicare beneficiary is subject to Prior Authorization for services provided. The **PROV VAL TYPE** field identifies the designated provider on the claim.

- **RRB EXCL IND** - Railroad Board (RRB) Exclusion Indicator. Valid values are:
  - **Y** – Exclude RRB beneficiary services from the prior authorization program
  - **Blank** – Subject RRB beneficiary services to prior authorization

- **PROV VAL TYPE** - Provider validation type. Valid values are:
  - **RP** (Rendering Provider)
  - **OP** (Operating Physician)
  - **CP** (Ordering/Referring Physician)
  - **AP** (Attending Physician)
  - **FA** (Facility)

Home Health and Hospice

https://www.cgsmedicare.com/hhh/education/materials/fiss.html
For Home Health and Hospice Providers

MLN Connects® Weekly News

The MLN Connects® is the official news from the Medicare Learning Network and contains a weeks worth of Medicare-related messages. These messages ensure planned, coordinated messages are delivered timely about Medicare-related topics. The following provides access to the weekly messages. Please share with appropriate staff. If you wish to receive the listserv directly from CMS, refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html.


For Home Health and Hospice Providers

MM11137 (Revised): Evaluation and Management (E/M) When Performed with Superficial Radiation Treatment

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

MLN Matters Number: MM11137 Revised
Related CR Release Date: February 22, 2019
Related CR Transmittal Number: R4246CP
Related Change Request (CR) Number: 11137
Effective Date: January 1, 2019
Implementation Date: March 25, 2019

Note: We revised this article on March 1, 2019, to correct an E/M code on page 2 of this article, which should have been E/M codes 99211. All other information is unchanged.

Provider Types Affected
This MLN Matters Article is for physicians and other providers billing Medicare Administrative Contractors (MACs) for Evaluation and Management (E/M) related to radiation services provided to Medicare beneficiaries.

Provider Action Needed
CR11137 revises Chapter 13 of the Medicare Claims Processing Manual to allow providers to bill E/M codes 99211, 99212, and 99213 for Levels I through III, when performed with superficial radiation treatment delivery (up to 200 kV), when performed for the purpose of reporting physician work associated with:

- Radiation therapy planning
- Radiation treatment device construction
Radiation treatment management when performed on the same date of service as superficial radiation treatment delivery

Make sure your billing staffs are aware of these revisions.

Background

Radiation treatment delivery codes recognize technical-only services and contain no physician work, while providers should use treatment management codes to report the professional component. According to Current Procedural Terminology (CPT) guidance, providers should not report superficial radiation (up to 200 kV) with CPT codes for planning and management. Providers should report the professional component associated with this service with the appropriate E/M codes. According to Chapter 13 of the Medicare Claims Processing Manual, Medicare does not make separate payment for E/M services for established patients.

CR11137 revises Chapter 13 of the Manual to allow providers to bill E/M codes 99211, 99212, and 99213 for Levels I through III when performed for the purpose of reporting physician work associated with:

- Radiation therapy planning (including, but not limited to, clinical treatment planning, isodose planning, and physics consultation)
- Radiation treatment device construction
- Radiation treatment management when performed on the same date of service as superficial radiation treatment delivery

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

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

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<tr>
<td>February 25, 2019</td>
<td>Initial article released.</td>
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For Home Health and Hospice Providers

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

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

MLN Matters Number: MM11163 Revised
Related CR Release Date: March 18, 2019
Related CR Transmittal Number: R4258CP
Related Change Request (CR) Number: 11163
Effective Date: January 1, 2019
Implementation Date: April 1, 2019

Note: We revised this article on March 19, 2019, to reflect an updated Change Request (CR) that revised the attachment for codes G2014 and G2015 (see page 2 below). The CR release date, transmittal number and link to the transmittal was also changed. All other information remains the same.

Provider Types 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 MPFSDB 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 for these instructions and other information.

Table: April Updates to the 2019 MPFSD

<table>
<thead>
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<th>HCPCS</th>
<th>ACTION</th>
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<tbody>
<tr>
<td>G9987</td>
<td>Assistant Surgery, Co-Surgeon, &amp; Team Surgeon indicator = 9</td>
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<tr>
<td>G2001</td>
<td>All MPFS indicators and RVUs = 99341</td>
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<tr>
<td>G2002</td>
<td>All MPFS indicators and RVUs = 99342</td>
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<td>G2003</td>
<td>All MPFS indicators and RVUs = 99343</td>
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<td>G2005</td>
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<td>G2006</td>
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<td>G2007</td>
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<td>G2008</td>
<td>All MPFS indicators and RVUs = 99349</td>
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<td>G2009</td>
<td>All MPFS indicators and RVUs = 99350</td>
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<tr>
<td>G2013</td>
<td>All MPFS indicators and RVUs = 99345</td>
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</table>

G2014 - Procedure Status = A; RVUs = Work 1.25, Non-Facility .85, Facility .85, MP 0.07, Multiple Surgery = 0, Bilateral Surgery = 0, Assistant at Surgery = 0, Co-Surgeons = 0, Team Surgeons = 0, PC/TC = 0

G2015 - Procedure Status = A; RVUs = Work 1.80, Non-Facility 1.14, Facility 1.14, MP .11, Multiple Surgery = 0, Bilateral Surgery = 0, Assistant at Surgery = 0, Co-Surgeons = 0, Team Surgeons = 0, PC/TC = 0

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


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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For Home Health and Hospice Providers

MM11192: April 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.1

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

MLN Matters Number: MM11192 Related Change Request (CR) Number: 11192
Related CR Release Date: March 15, 2019 Effective Date: April 1, 2019
Related CR Transmittal Number: R4256CP Implementation Date: April 7, 2019

Provider Type Affected

This MLN Matters Article is providers and suppliers billing Medicare Administrative Contractors (MACs), including the Home Health and Hospice MACs, for services provided to Medicare beneficiaries.

Provider Action Needed

CR11192 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Integrated OCE that Medicare uses.
• Under the Outpatient Prospective Payment System (OPPS)
• For Non-OPPS hospital outpatient departments, community mental health centers and all non-OPPS providers
• For limited services when provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System
• For a hospice patient for the treatment of a non-terminal illness.

Make sure your billing staffs are aware of these changes.

Background
CR11192 informs the MACs and the Fiscal Intermediary Shared System (FISS) maintainer that the Centers for Medicare & Medicaid Services is updating the I/OCE for April 1, 2019. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. CMS will post the I/OCE specifications at http://www.cms.gov/OutpatientCodeEdit/.

The table below summarizes the modifications of the I/OCE for the April 2019 V20.1 release. Readers should review the entire document and note the highlighted sections, which also indicate changes from the prior release of the software. CMS has added some I/OCE modifications in the update retroactively to prior releases. If so, the retroactive date appears in the ‘Effective Date’ column.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/1/2019</td>
<td>Updates to the following tables (additional details included in the tables):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1.1 Line Item Input Information Table</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Add new field “Contractor bypass edit”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Add new field “CB payment APC”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Add new field “CB Status Indicator”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Add new field “CB Payment Indicator”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Add new field “CB Discounting Formula number”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Add new field “CB Line Item Denial or Rejection Flag”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Add new field “CB Packaging Flag”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Add new field “Payment Adjustment Flag”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Add new field “Payment Method Flag”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1.2 IOCE Control Block Table</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increase size (bytes) of Pointer Field “Sgptr” to 76</td>
<td></td>
</tr>
<tr>
<td>4/1/2019</td>
<td>Add new Claim Processed Flag of 4 to be returned if a fatal error has occurred for any contractor bypass condition. <strong>Claim Return Buffer.</strong></td>
<td></td>
</tr>
<tr>
<td>4/1/2019</td>
<td>Add new <strong>Payment Method Flag Z</strong> “Contractor bypass determines payment for services,” to be returned if a Contractor has applied a bypass condition for any line item submitted on a claim. <strong>NOTE:</strong> Only a contractor can apply bypass conditions.</td>
<td></td>
</tr>
<tr>
<td>4/1/2018</td>
<td>106, 107, 108 Update add-on code logic to return an add-on code edit if the primary procedure is not provided on the same day or day before. This change is being made retroactive to the inception of add-on code editing.</td>
<td></td>
</tr>
<tr>
<td>1/1/2017</td>
<td>Update current logic for conditional processing of laboratory procedures when a line item action flag of 2 or 3 is present on certain payable OPPS services (Status Indicator (SI) = Q1, Q3, S, T, V).</td>
<td></td>
</tr>
<tr>
<td>4/1/2019</td>
<td>Add new <strong>Value Code (QW)</strong> and value code amount to be returned on a Partial Hospitalization Program (PHP) interim claim when the total hours of services provided on the partial week do not add up to at least 20-hours. See Partial Hospitalization and Community Mental Health Processing Logic Section.</td>
<td></td>
</tr>
<tr>
<td>1/1/2017</td>
<td>Updated the program logic for payment adjustment flag assignment to return values 9, 21, 22, 23, and 24 when appropriate. There is no change to documentation as this is a program logic update only.</td>
<td></td>
</tr>
</tbody>
</table>
Table of Edits

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/2012</td>
<td>6</td>
<td>Implement new logic to not return edit 6 when a procedure is effective on a HHA (32x) claim with dates of service that span between the annual (January) release and prior quarter. This change is retroactively effective to the earliest date of the component. See Hospice and Home Health Processing logic section.</td>
</tr>
<tr>
<td>4/1/2019</td>
<td></td>
<td>Add the following Revenue Codes to the Valid Revenue Code List: - 870, 871, 872, 873, 874, 875, and 891</td>
</tr>
<tr>
<td>4/1/2019</td>
<td></td>
<td>Add new logic section in documentation for Contractor Defined Functions contained within the IOCE.</td>
</tr>
<tr>
<td>4/1/2019</td>
<td>20, 40</td>
<td>Implement version 25.1 of the NCCI (as modified for applicable outpatient institutional providers).</td>
</tr>
</tbody>
</table>

Additional Information


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

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 15, 2018</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>

For Home Health and Hospice Providers

**MM11204:** Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

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

<table>
<thead>
<tr>
<th>MLN Matters Number: MM11204</th>
<th>Related Change Request (CR) Number: 11204</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related CR Release Date:</td>
<td>Effective Date: July 1, 2019</td>
</tr>
<tr>
<td>Related CR Transmittal Number: R4253CP</td>
<td>Implementation Date: July 1, 2019</td>
</tr>
</tbody>
</table>

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters are available at no cost from our website at https://www.cgsmedicare.com. © 2019 Copyright, CGS Administrators, LLC.
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
CR11204 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs the ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy Print (MREP) and PC Print software. Be sure your billing staffs are aware of these changes and obtain the updated MREP and PC Print if they use that software.

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

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

CMS provides CR11204 as a code update notification indicating when the Washington Publishing Company (WPC) makes updated CARC and RARC lists available on its website. Medicare systems make required code deactivations, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date later than the implementation date specified in CR11204, MACs must implement on the date specified on the WPC website (http://wpc-edi.com/Reference/).

A discrepancy between the dates may arise, as the WPC only updates its website three times per year and may not match the CMS release schedule. The MACs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update CR (CR10620).

Additional Information

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

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

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<tbody>
<tr>
<td>March 15, 2019</td>
<td>Initial article released.</td>
</tr>
</tbody>
</table>
MM11216: April 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)

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

MLN Matters Number: MM11216
Related CR Release Date: March 15, 2019
Related CR Transmittal Number: R4255CP
Related Change Request (CR) Number: 11216
Effective Date: April 1, 2019
Implementation Date: April 1, 2019

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

Provider Action Needed
CR 11216 describes changes to, and billing instructions for, various payment policies implemented in the April 2019 OPPS update. The April 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 CR11216. Make sure your billing staffs are aware of these changes.

Background

The following summarizes the OPPS changes for April 2019.


The American Medical Association (AMA) CPT Editorial Panel established four new PLA CPT codes, specifically, CPT codes 0080U through 0083U effective January 1, 2019. Because the codes were released on November 30, 2018, they were too late to include in the January 2019 OPPS update and are instead included in the April 2019 update with an effective date of January 1, 2019.

Table 1 lists the long descriptors and status indicators for CPT codes 0080U through 0083U. For more information on OPPS status indicators “A” and “Q4”, refer to OPPS Addendum D1 of the Calendar Year (CY) 2019 OPPS/ASC (Ambulatory Surgery Center) final rule for the latest definitions. CPT codes 0080U through 0083U have been added to the April 2019 I/OCE with an effective date of January 1, 2019. These codes, along with their short descriptors and status indicators, will also be in the April 2019 OPPS Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

Table 1 ─ Proprietary Laboratory Analyses (PLA) CPT Coding Changes Effective January 1, 2019

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<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>
<td>Q4</td>
<td>N/A</td>
</tr>
</tbody>
</table>
### Table 1 — Proprietary Laboratory Analyses (PLA) CPT Coding Changes Effective January 1, 2019

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<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>
<td>A</td>
<td>N/A</td>
</tr>
<tr>
<td>0082U</td>
<td>Drug test(s), definitive, 90 or more drugs or substances, definitive chromatography with mass spectrometry, and presumptive, any number of drug classes, by instrument chemistry analyzer (utilizing immunoassay), urine, report of presence or absence of each drug, drug metabolite or substance with description and severity of significant interactions per date of service</td>
<td>Q4</td>
<td>N/A</td>
</tr>
<tr>
<td>0083U</td>
<td>Oncology, response to chemotherapy drugs using motility contrast tomography, fresh or frozen tissue, reported as likelihood of sensitivity or resistance to drugs or drug combinations</td>
<td>Q4</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### 2. New Advanced Diagnostic Laboratory Test (ADLT) Under the Clinical Lab Fee Schedule (CLFS)

On December 21, 2018, effective January 1, 2019, the laboratory test described by CPT code 81538 (Oncology (lung), mass spectrometric 8-protein signature, including amyloid α, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival), was approved as an ADLT. Based on the ADLT designation, the Centers for Medicare & Medicaid Services (CMS) revised the OPPS status indicator for CPT code 81538 from “Q4” to “A” effective January 1, 2019. However, because the code’s ADLT designation was made in December 2018, it was too late to include this change in the January 2019 OPPS update, therefore, CMS is including this change in the April 2019 update with an effective date January 1, 2019. The latest list of ADLT codes is available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/List-of-Approved-ADLTs.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/List-of-Approved-ADLTs.pdf). For more information on the OPPS status indicators “A” and “Q4”, refer to OPPS Addendum D1 of the CY 2019 OPPS/ASC final rule for the latest definitions. CMS has added CPT code 81538 to the April 2019 I/OCE with an effective date of January 1, 2019. CPT code 81538, along with its short descriptor and status indicator, is also listed in the April 2019 OPPS Addendum B.

### 3. The Comprehensive APC (C-APC) Exclusion List

CR 11216 updates the Comprehensive APC (C-APC) exclusion list in section 10.2.3, chapter 4 of the Medicare Claims Processing Manual to match the list provided in Addendum J of the CY 2019 OPPS/ASC Final Rule. The additions to the list included brachytherapy sources, self-administered drugs, services assigned to status indicators F and L, certain part B inpatient services, and therapy services.

### 4. Drugs, Biologicals, and Radiopharmaceuticals

#### a. New HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals

For CY 2019, seven new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed below in Table 2.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9040</td>
<td>Injection, fremanezumab-vfrm, 1mg</td>
<td>G</td>
<td>9197</td>
</tr>
</tbody>
</table>
b. Separately Payable Drugs and Biologicals that Will Receive Pass-Through Status (Status Indicator “G”) Effective April 1, 2019

Some separately payable drugs and biologicals will change from status indicator “K” to status indicator “G” effective April 1, 2019 as these drugs and biologicals have been given pass-through status. These drugs and biologicals are reported below in Table 3.

Table 3 ─ Other CY 2019 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective April 1, 2019

<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>Q5108</td>
<td>Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg</td>
<td>K</td>
<td>G</td>
<td>9173</td>
</tr>
<tr>
<td>J3245</td>
<td>Injection, tildrakizumab, 1 mg</td>
<td>E2</td>
<td>G</td>
<td>9306</td>
</tr>
<tr>
<td>Q5110</td>
<td>Injection, filgrastim-aafi, biosimilar, (nivestym), 1 microgram</td>
<td>K</td>
<td>G</td>
<td>9193</td>
</tr>
<tr>
<td>Q5111</td>
<td>Injection, Pegfilgrastim-cbqv, biosimilar, (udenyca), 0.5 mg</td>
<td>K</td>
<td>G</td>
<td>9195</td>
</tr>
</tbody>
</table>

c. 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 April 1, 2019, payment rates for some drugs and biologicals have changed from the values published in the January 2019 update of the OPPS Addendum A and Addendum B available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html. CMS is not publishing the updated payment rates in this CR implementing the April 2019 update of the OPPS. However, the updated payment rates effective April 1, 2019 are in the April 2019 update of the OPPS Addendum A and Addendum B available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

d. 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.
5. Reassignment of Skin Substitute Products from the Low Cost Group to the High Cost Group

Four skin substitute products, HCPCS codes Q4183, Q4184, Q4194, and Q4203 have been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. The products are listed in Table 4.

<table>
<thead>
<tr>
<th>CY 2019 HCPCS Code</th>
<th>CY 2019 Short Descriptor</th>
<th>CY 2019 SI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4183</td>
<td>Surgigraft, 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4184</td>
<td>Cellesta, 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4194</td>
<td>Novachor 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4203</td>
<td>Derma-gide, 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
</tbody>
</table>

6. Chimeric Antigen Receptor (CAR) T-Cell Therapy

(CAR) T-cell therapy is a cell-based gene therapy in which T-cells are collected and genetically engineered to express a chimeric antigen receptor that will bind to a certain protein on a patient’s cancerous cells. The CAR T-cells are then administered to the patient to attack certain cancerous cells and the individual is observed for potential serious side effects that would require medical intervention.

As stated in the CY 2019 OPPS/ASC final rule, CMS is continuing OPPS pass-through payment status for CAR T HCPCS codes Q2041 (Yescarta) and Q2042 (Kymriah) (see long descriptors in Table 5). The OPPS pass-through payment rate is determined following the standard ASP methodology, updated on a quarterly basis if applicable information indicates that adjustments to the payment rates are necessary.

As shown in Table 5, the HCPCS Q-code for each currently approved CAR T-cell therapy includes leukapheresis and dose preparation procedures. The procedures described by CPT codes 0537T, 0538T, and 0539T describe various steps required to collect and prepare the genetically modified T-cells, and Medicare does not generally pay separately for each step used to manufacture a drug or biological. Therefore, in the CY 2019 OPPS/ASC final rule, CPT codes 0537T, 0538T, and 0539T were assigned to status indicator “B” (Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x). However, as noted in the OPPS final rule, it will be possible for Medicare to track utilization and cost data from hospitals reporting these services, even for HCPCS codes reported for services in which no separate payment is made under the OPPS. The CAR T-cell related revenue codes and value code established by the National Uniform Billing Committee (NUBC) will be reportable on Hospital Outpatient Department (HOPD) claims, and will be available for tracking utilization and cost data, effective for claims received on or after April 1, 2019.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptors</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2041</td>
<td>Axicabtagene ciloleucel, up to 200 million autologous antiCD19 car positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic dose</td>
<td>G</td>
<td>9035</td>
</tr>
<tr>
<td>Q2042</td>
<td>Tisagenlecleucel, up to 600 million car-positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic dose</td>
<td>G</td>
<td>9194</td>
</tr>
<tr>
<td>0537T</td>
<td>Chimeric antigen receptor T-cell (car-t) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous car-t cells, per day</td>
<td>B</td>
<td>N/A</td>
</tr>
<tr>
<td>0538T</td>
<td>Chimeric antigen receptor T-cell (car-t) therapy; preparation of blood-derived T lymphocytes for transportation (eg, cryopreservation, storage)</td>
<td>B</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Table 5 – CAR T-cell Therapy Codes

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptors</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0539T</td>
<td>Chimeric antigen receptor t-cell (car-t) therapy; receipt and preparation of car-t cells for administration</td>
<td>B</td>
<td>N/A</td>
</tr>
<tr>
<td>0540T</td>
<td>Chimeric antigen receptor t-cell (car-t) therapy; car-t cell administration, autologous</td>
<td>S</td>
<td>5694</td>
</tr>
</tbody>
</table>

Effective April 1, 2019, hospitals may report CPT codes 0537T, 0538T, and 0539T, as non-covered items/services to allow for Medicare to track these services when furnished in the outpatient setting. Also, hospitals may report the CAR T-cell related revenue codes 087X (Cell/Gene Therapy) and 089X (Pharmacy) as well as new value code 86 (Invoice Cost) established by the NUBC on HOPD claims.

CMS reminds hospitals that the administration of CAR T-cells in the hospital outpatient setting is paid separately under CPT code 0540T, which is assigned status indicator “S”.

Below is further clarification on billing of CAR-T related items and services in various clinical scenarios.

- **Scenario 1: CAR-T Dosing and Preparation Services and Viable T-cells Administered in Hospital Outpatient Setting:** In those instances when the CAR-T drug is administered in the hospital outpatient setting, report CPT code 0540T for the administration and HCPCS Q-code Q2041 or Q2042 for the drug/biological. As stated in the CY 2019 OPPS/ASC final rule, the procedures described by CPT codes 0537T (collection/handling), 0538T (preparation for transport), and 0539T (receipt and preparation) represent the various steps required to collect the cells and prepare the genetically modified T-cells are not separately payable. However, these services may be reported as non-covered charges on the outpatient claim.

- **Scenario 2: CAR-T Dosing and Preparation Services Administered in Hospital Outpatient Setting, but Viable T-cells not Administered:** In those instances when the CAR-T drug is not ultimately administered to the patient, but the CAR-T preparation services are initiated or performed in the HOPD facility, hospital outpatient departments may report CPT codes 0537T, 0538T, and 0539T (as appropriate) and the charges associated with each code under the appropriate revenue code on the HOPD claim as non-covered charges.

- **Scenario 3: CAR-T Dosing and Preparation Services Administered in Hospital Outpatient Setting, but Viable T-cells Administered in the Hospital Inpatient Setting:** When CAR T-cell preparation services are initiated and furnished in the hospital outpatient setting, but the CAR T-cells are administered in the inpatient setting following inpatient admission to the hospital more than 3 days after the related outpatient services are furnished, the hospital may not report the drug Q-code (which only applies when the T-cells are administered in the HOPD setting). However, the charges associated with the CAR T-cell dosing and preparation services as described by CPT codes 0537T, 0538T, and 0539T may be reported on the inpatient claim (bill type 11x) using revenue code 0891 – Special Processed Drugs – FDA (Food and Drug Administration) Approved Cell Therapy - Charges for Modified cell therapy.

Providers who have additional questions not covered by CR 11216 should consult their MAC for additional guidance on billing for these services.

7. **Modifier “ER”**

Effective January 1, 2019, hospitals were required to report new HCPCS modifier “ER” (Items and services furnished by a provider-based off-campus emergency department) on every claim line that contains a CPT/HCPCS code for an outpatient hospital service furnished in an off-campus provider-based emergency department. Modifier ER would be reported on the UB-04 form (CMS Form 1450) for hospital outpatient services.
Critical Access Hospitals (CAHs) would not be required to report this modifier.

Modifier ER is required to be reported in provider-based off-campus emergency departments that meet the definition of a “dedicated emergency department” as defined in 42 Code of Federal Regulations (CFR) 489.24 under the Emergency Medical Treatment and Labor Act (EMTALA) regulations. Per 42 CFR 489.24, a “dedicated emergency department” means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

1. It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;
2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
3. During the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

This policy change is in the revised section 20.6.18 of Chapter 4 of the Medicare Claims Processing Manual, which is attached to CR 11216.

8. 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. 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.

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.

Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>March 19, 2019</td>
<td>Initial article released</td>
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</table>
For Home Health and Hospice Providers

MM11225: July 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

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

MLN Matters Number: MM11225
Related CR Release Date: March 22, 2019
Related CR Transmittal Number: R4264CP
Related Change Request (CR) Number: 11225
Effective Date: July 1, 2019
Implementation Date: July 1, 2019

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
CR 11225 provides the quarterly update for Average Sales Price (ASP) and ASP Not Otherwise Classified (NOC) Medicare Part B Drug Pricing Files and Revisions to the prior quarterly pricing files. CR11225 instructs MACs to download and implement the July 2019 and, if released, the revised April 2019, January 2019, October 2018, and July 2018 files. Make sure your billing staffs are aware of these updates.

Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in chapter 4, section 50 of the Medicare Claims Processing Manual 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. CMS will supply the MACs with the ASP and ASP NOC drug pricing files for Medicare Part B drugs on a quarterly basis. CR 11225 addresses the following pricing files:

- 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
- File: October 2018 ASP and ASP NOC — Effective Dates of Service: October 1, 2018, through December 31, 2018
- File: July 2018 ASP and ASP NOC — Effective Dates of Service: July 1, 2018, through September 30, 2018

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 is billed with the KD modifier, MACs will determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item

For any drug or biological not listed in the ASP or NOC drug pricing files that is billed with the KD modifier, MACs will determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item
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 home health and hospice PCC at 1.877.299.4500 (option 1) will be closed for training.

<table>
<thead>
<tr>
<th>Date</th>
<th>PCC Training/Closures</th>
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<tbody>
<tr>
<td>Thursday, May 9, 2019</td>
<td>8:00 a.m.– 10:00 a.m. Central Time</td>
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<tr>
<td>Thursday, May 23, 2019</td>
<td>8:00 a.m.– 10:00 a.m. Central Time</td>
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<tr>
<td>Monday, May 27, 2019</td>
<td>Office Closed, Memorial Day</td>
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The Interactive Voice Response (IVR) (1.877.220.6289) 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/hhh/help/pdf/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/hhh/index.html and click the “myCGS” button on the left side of the webpage.

For Home Health and Hospice Providers

SE18006 (Revised): New Medicare Beneficiary Identifier (MBI) Get It, Use It

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

MLN Matters Number: SE18006 Revised
Article Release Date: March 6, 2019
Related Change Request (CR) Number: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

Note: We revised this article on March 6, 2019, to add language that the MBI look-up tool can be used to obtain an MBI even for patients in a Medicare Advantage Plan. All other information remains the same.

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

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) is mailing the new Medicare cards with the MBI in phases by geographic location (https://www.cms.gov/Medicare/New-Medicare-Card/NMC-Mailing-Strategy.pdf). There are 3 ways you and your office staff can get MBIs:

1. Ask your Medicare patients
   Ask your Medicare patients for their new Medicare card when they come for care. If they haven't received a new card at the completion of their geographic mailing wave, give them the “Still Waiting for Your New Card?” handout (in English (https://www.cms.gov/Medicare/New-Medicare-Card/Outreach-and-Education/Tear-Off-for-After-Card-Mailing-Ends.pdf) or Spanish (https://www.cms.gov/Medicare/New-Medicare-Card/Outreach-and-Education/Tear-Off-for-After-Card-Mailing-Ends-Spanish.pdf)) or refer them to 1.800.Medicare (1.800.633.4227).

2. Use the MAC’s secure MBI look-up tool
   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) for the Portal to use the tool. You can use this tool even after the end of the transition period – it doesn’t end on December 31, 2019. Even if your patient is in a Medicare Advantage Plan, you can look up the MBI to bill for things like indirect medical education.
   Your patient’s Social Security Number (SSN) is required for the search and may differ from their Health Insurance Claim Number (HICN), which uses the SSN of the primary wage earner. If your Medicare patients do not want to give their SSN, they can log into https://mymedicare.gov to get their MBI.
   If the look-up tool returns a last name matching error and the beneficiary last name includes a suffix, such as Jr. Sr. or III, try searching without and with the suffix as part of the last name.

3. Check the remittance advice
   Starting in October 2018 through the end of the transition period, we’ll also return the MBI on every remittance advice when you submit claims with valid and active HICNs.
You can start using the MBIs even if the other health care providers and hospitals who also treat your patients haven’t. When the transition period ends on December 31, 2019, you must use the MBI for most transactions.

**Background**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. A new, randomly generated Medicare Beneficiary Identifier, or MBI, is replacing the SSN-based HICN. The new MBI is noticeably different than the HICN. **Just like with the HICN, the MBI hyphens on the card are for illustration purposes: don’t include the hyphens or spaces on transactions.** The MBI uses 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 (e.g., between “0” and “O”).

The Railroad Retirement Board (RRB) is also mailing new Medicare cards with the MBI. The RRB logo will be in the upper left corner and “Railroad Retirement Board” at the bottom, but you can’t tell from looking at the MBI if your patients are eligible for Medicare because they’re railroad retirees. You’ll be able to identify them by the RRB logo on their card, and we’ll return a “Railroad Retirement Medicare Beneficiary” message on the Fee-For-Service (FFS) MBI eligibility transaction response.

**RRB Issued Medicare Card**

Use the MBI the same way you use the HICN today. Put the MBI in the same field where you’ve always put the HICN. This also applies to reporting informational only and no-pay claims. **Don’t use hyphens or spaces with the MBI to avoid rejection of your claim.** The MBI will replace the HICN on Medicare transactions including Billing, Eligibility Status, and Claim Status. The effective date of the MBI, like the old HICN, is the date each beneficiary was or is eligible for Medicare. Until December 31, 2019, you can use either the HICN or the MBI in the same field where you’ve always put the HICN. After that the remittance advice will tell you if we rejected claims because the MBI wasn’t used. It will include Claim Adjustment Reason Code (CARC) 16, “Claim/service lacks information or has submission/billing error(s),” along with Remittance Advice Remark Code (RARC) N382 “Missing/incomplete/invalid patient identifier”.

The beneficiary or their authorized representative can request an MBI change. CMS can also initiate a change to an MBI. There are different scenarios for using the old or new MBIs:

**FFS claims submissions with:**

- Dates of service before the MBI change date – use the old or new MBI.
• Span-date claims with a “From Date” before the MBI change date – use the old or new MBI.

• Dates of service that are entirely on or after the effective date of the MBI change – use the new MBI.

FFS eligibility transactions when the:

• Inquiry uses new MBI – we’ll return all eligibility data.

• Inquiry uses the old MBI and request date or date range overlap the active period for the old MBI – we’ll return all eligibility data. We’ll also return the old MBI termination date.

• Inquiry uses the old MBI and request date or date range are entirely on or after the effective date of the new MBI – we’ll return an error code (AAA 72) of “invalid member ID.”

When the MBI changes, we ask the beneficiary to share the new MBI with you. You can also get the MBI from your MACs secure MBI lookup tool.

Protect the MBI as Personally Identifiable Information (PII); it is confidential like the HICN.

Submit all HICN-based claims by the end of the transition period, December 31, 2019. On January 1, 2020, even for dates of services before this date, you must use MBIs for all transactions; there are a few exceptions when you can use either the HICN or MBI:

• Appeals – You can use either the HICN or MBI for claim appeals and related forms.

• Claim status query – You can use HICNs or MBIs to check the status of a claim (276 transactions) if the earliest date of service on the claim is before January 1, 2020. If you are checking the status of a claim with a date of service on or after January 1, 2020, you must use the MBI.

• Span-date claims – You can use the HICN or the MBI for 11X-Inpatient Hospital, 32X-Home Health (home health claims and Request for Anticipated Payments [RAPs]) and 41X-Religious Non-Medical Health Care Institution claims if the “From Date” is before the end of the transition period (December 31, 2019). If a patient starts getting services in an inpatient hospital, home health, or religious non-medical health care institution before December 31, 2019, but stops getting those services after December 31, 2019, you may submit a claim using either the HICN or the MBI, even if you submit it after December 31, 2019. Since you submit home health claims for a 60-day payment episode, you can send in the episode’s RAP with either the HICN or the MBI, but after the transition period ends on December 31, 2019, you have to use the MBI when you send in the final claim that goes with it.

The MBI does not change Medicare benefits. Medicare beneficiaries may start using their new Medicare cards and MBIs as soon as they get them. Use MBIs as soon as your patients share them. The new cards are effective the date beneficiaries are eligible for Medicare.

Medicare Advantage and Prescription Drug plans continue to assign and use their own identifiers on their health insurance cards. For patients in these plans, continue to ask for and use the plans’ health insurance cards.

Additional Information

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

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at 1.877.299.4500 and choose Option 1.
To sign up for your MAC’s secure portal MBI look-up tool, visit https://www.cms.gov/Medicare/New-Medicare-Card/Providers/MACs-Provider-Portals-by-State.pdf.

The MBI format specifications, which provide more details on the construct of the MBI, are available at https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI.pdf.


### Document History

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<tr>
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<tr>
<td>March 6, 2019</td>
<td>We revised this article to add language that the MBI look-up tool can be used to obtain an MBI even for patients in a Medicare Advantage Plan. All other information remains the same.</td>
</tr>
<tr>
<td>December 10, 2018</td>
<td>The article was revised to update the language regarding when MACs can return an MBI through the MBI look up tool (page 1). All other information remains the same.</td>
</tr>
<tr>
<td>July 11, 2018</td>
<td>This article was revised to provide additional information regarding the format of the MBI not using letters S, L, O, I, B, and Z (page 2).</td>
</tr>
<tr>
<td>June 25, 2018</td>
<td>This article was revised to provide additional information regarding the ways your staff can get MBIs (page 1).</td>
</tr>
<tr>
<td>June 21, 2018</td>
<td>The article was revised to emphasize the need to submit the MBI without hyphens or spaces to avoid rejection of your claim.</td>
</tr>
<tr>
<td>May 25, 2018</td>
<td>Initial article released.</td>
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### For Home Health and Hospice Providers

#### Upcoming Educational Events

The CGS Provider Outreach and Education (POE) department offers educational events through webinars and teleconferences throughout the year. Registration for these events is required. For upcoming events, please refer to the Calendar of Events Home Health & Hospice Education Web page at https://www.cgsmedicare.com/medicare_dynamic/wrkshp/pr/HHH_Report.asp. CGS suggests that you bookmark this page and visit it often for the latest educational opportunities.

If you have a topic that you would like the CGS POE department to present, send us your suggestion to J15_HHH_Education@cgsadmin.com.