RAILROAD MEDICARE ADVISORY

Latest Part B News for Railroad Medicare

February 2023
Volume 2023, Issue 02

What's Inside...

Continued >>

palmettogba.com/rr

The *Medicare Advisory* contains coverage, billing and other information for Railroad Medicare. 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 *Railroad 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 **https://www.PalmettoGBA.com/rr**.

RAILROAD RETIREMENT BOARD U.S.A.
A RRB-Contracted Specialty Medicare Administrative Contractor

PALMETTO GBA®
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Self-Service Information

Help Us Improve Your Experience

How can Palmetto GBA serve you better? Let us know how we're doing by completing our MAC Customer Experience survey. This video shares the importance of your feedback and how to access the surveys available. View at

https://bit.ly/3WegZzy

Need to speak with Railroad Medicare?

Call our Provider Contact Center toll-free 888-355-9165 at for Customer Service inquiries, technical support for EDI and the eServices portal, Provider Enrollment inquiries, and to request a Telephone Reopening.

Railroad Medicare representatives are available to handle provider inquiries Monday through Friday, from 8:30 a.m. to 4:30 p.m. for all time zones with the exception of Pacific Time (PT) which receives service from 8 a.m. to 4 p.m. PT. The PCC will be unavailable during weekly training and holidays.

When you call the toll-free 888-355-9165 line, the system provides the following selections:

Press 1 for Claim Status, Eligibility or a Duplicate Remittance Advice
Please note: Claim status, beneficiary eligibility and duplicate remittance advice should be requested through our Interactive Voice Response (IVR) unit at 1-877-288-7600 or through our secure internet portal, eServices, at https://www.onlineproviderservices.com/ecx_improvev2/.

Press 2 for Technical Support Regarding EDI or eServices, then
- Press 1 for eServices inquiries
- Press 2 for EFT
- Press 0 for technical assistance with electronic billing, Electronic Remittance Advice (ERA) or other EDI issues

Press 3 for Provider Enrollment

Press 4 for Telephone Reopening, then
- Press 1 for the explanation of a denied claim
- Press 0 to request a Telephone Reopening to correct minor errors or omissions

Press 5 for Customer Service
- Press 0 to speak to a Customer Service Advocate

Press 6 for Our Mailing Address and Hours of Operation

Press 9 to repeat this menu

Help Us to Help You: Have Your Provider and Patient Information Ready When You Call Customer Service

Having the required provider and beneficiary authentication elements available when you call Customer Service will save you time and help us handle your inquiry more efficiently.

You will be asked for the following information about the provider:

- The provider's National Provider Identifier (NPI)
- The provider's Railroad Medicare Provider Transaction Access Number (PTAN)
- The provider's Tax Identification Number (TIN): last five digits

The Centers for Medicare & Medicaid Services (CMS) requires authentication of these provider elements whenever a request would involve the disclosure of personally-identifiable information (PII) or protected health information (PHI). If you are not able to provide the required elements, our Customer Service Advocates may ask you to obtain the information and call back.

Don't have your Railroad Medicare PTAN? Providers can use our PTAN Lookup and Request Tool to lookup their Railroad Medicare PTAN. If you are employed by a clearinghouse or third-party biller, you must contact the provider to obtain the Railroad Medicare PTAN. See our Using Railroad Medicare's Online PTAN Lookup and Request Tool article for details https://www.palmettogba.com/palmetto/rr.nsf/DID/AK7K447304.

You will be asked to provide the following information about the beneficiary:

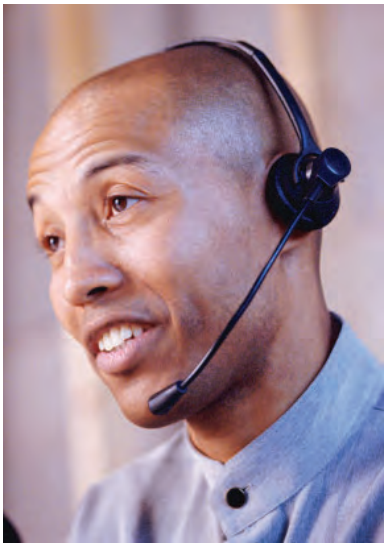
- The beneficiary's Medicare Beneficiary Identifier (MBI)
- The beneficiary's last name
- The beneficiary's first name or initial, and either
- The claim date(s) of service (for post-claim inquiries, such as reason for denial or rejection) or
- The beneficiary's date or birth (for pre-claim inquiries, such as entitlement requests/issues)

The CMS requires authentication of these beneficiary elements prior to disclosing PII or PHI about a Medicare beneficiary to an authenticated provider. All information must match. If you are not able to provide the required elements, our Customer Service Advocates may ask you to obtain the information and call back.

Don't have the patient's MBI? There are three ways you and your office staff can get MBIs:

1. Ask your patient
2. Use the MBI Look-up tool on the Palmetto GBA eServices portal or your local Medicare Administrative Contractor's portal
    - You can look up MBIs for your Medicare patients when they don't or can't give them. You must have your patient's first name, last name, date of birth and Social Security Number (SSN) to search. If a patient doesn't want to release their SSN to you, the patient will need to provide you with their MBI.
3. Check a remittance advice
    - If you previously saw a patient and got a claim payment decision based on a claim submission with a HICN before January 1, 2020, look at that remittance advice. We returned the MBI on every remittance advice when a provider submitted a claim with a valid and active HICN from October 1, 2018 through December 31, 2019.

Resource: MLN SE18006 — New Medicare Beneficiary Identifier (MBI) Get It, Use It at https://tinyurl.com/SE18006



Provider Customer Service Center Training and Closure Dates

The Centers for Medicare & Medicaid Services (CMS) and the Railroad Retirement Board (RRB) have approved the RRB Specialty Medicare Administrative Contractor (RRB SMAC) to close up to eight hours per month for provider Customer Service Advocates (CSAs) training and/or staff development. The goal is to help CSAs improve the consistency and accuracy of their responses to provider questions; enhance their awareness and understanding of Medicare policies and issues; and facilitate CSAs' retention of the facts of their training by increasing its frequency.

When our CSAs participate in training and developmental sessions on Thursdays of each month, you may use our online provider portal called eServices. eServices provides claim status, duplicate remittances, patient eligibility and much more. Register now at https://www.PalmettoGBA.com/eServices. Please refer to the training schedule below for specific closure dates and times.

Date	Phones Closed
January 26, 2023	PCC closed for training / 2:30 to 4:30 PM ET
February 2, 2023	PCC closed for training / 2:30 to 4:30 PM ET
February 9, 2023	PCC closed for training / 2:30 to 4:30 PM ET
February 16, 2023	PCC closed for training / 2:30 to 4:30 PM ET
February 23, 2023	PCC closed for training / 2:30 to 4:30 PM ET
May 29, 2023	Office closed / Memorial Day
July 4, 2023	Office closed / Independence Day
September 4, 2023	Office closed / Labor Day
November 23, 2023	Office closed / Thanksgiving Day
November 24, 2023	Office closed / Day After Thanksgiving
December 25, 2023	Office closed / Christmas Eve
December 26, 2023	Office closed / Christmas Day

Please note that we will attempt to provide advance notice of any changes to the above training schedule via the website, IVR features and automatic email notices.

If you have not already done so, we encourage you to sign up for automatic email notices of updates to our website. Subscribing to the email update is the fastest way to find out about Medicare changes that may affect you. There is no charge for the service, and we will not share your email address with others. To register, go to Email Updates at https://www.palmettogba.com/palmetto/rr.nsf/M/Registration.

How Can I Tell if a Patient Has Railroad Medicare?

Railroad Medicare beneficiaries historically have had unique Medicare numbers, which made them easily distinguishable from Social Security Medicare patients. With today's Medicare Beneficiary Identifiers (MBIs), the you can't tell the difference by the MBI. Instead, the difference lies in the design of the Medicare card.

The Medicare card of a person with Railroad Medicare is unique. The Railroad Retirement Board (RRB) issues Railroad Medicare cards with the RRB logo in the upper left corner, and 'Railroad Retirement Board' at the bottom, as shown here. Railroad Medicare cards also have a QR code on the front lower right-hand corner of the cards, while Medicare cards will have a QR code on the back of the card. Make sure to ask your patients for their new cards and program your system to identify Railroad Medicare patients based on their cards, if possible.

If you verify your patient's eligibility electronically, CMS will return a message on the eligibility transaction response for a Fee-For-Service (FFS) Railroad Medicare MBI inquiry that will read "Railroad Retirement Medicare Beneficiary" in 271 Loop 2110C, Segment MSG.

If you verify a patient's eligibility using an MBI in the Palmetto GBA eServices online provider portal, the portal will return the "Railroad Retirement Medicare Beneficiary" message in the Additional Information field of the Eligibility sub-tab, as shown below.

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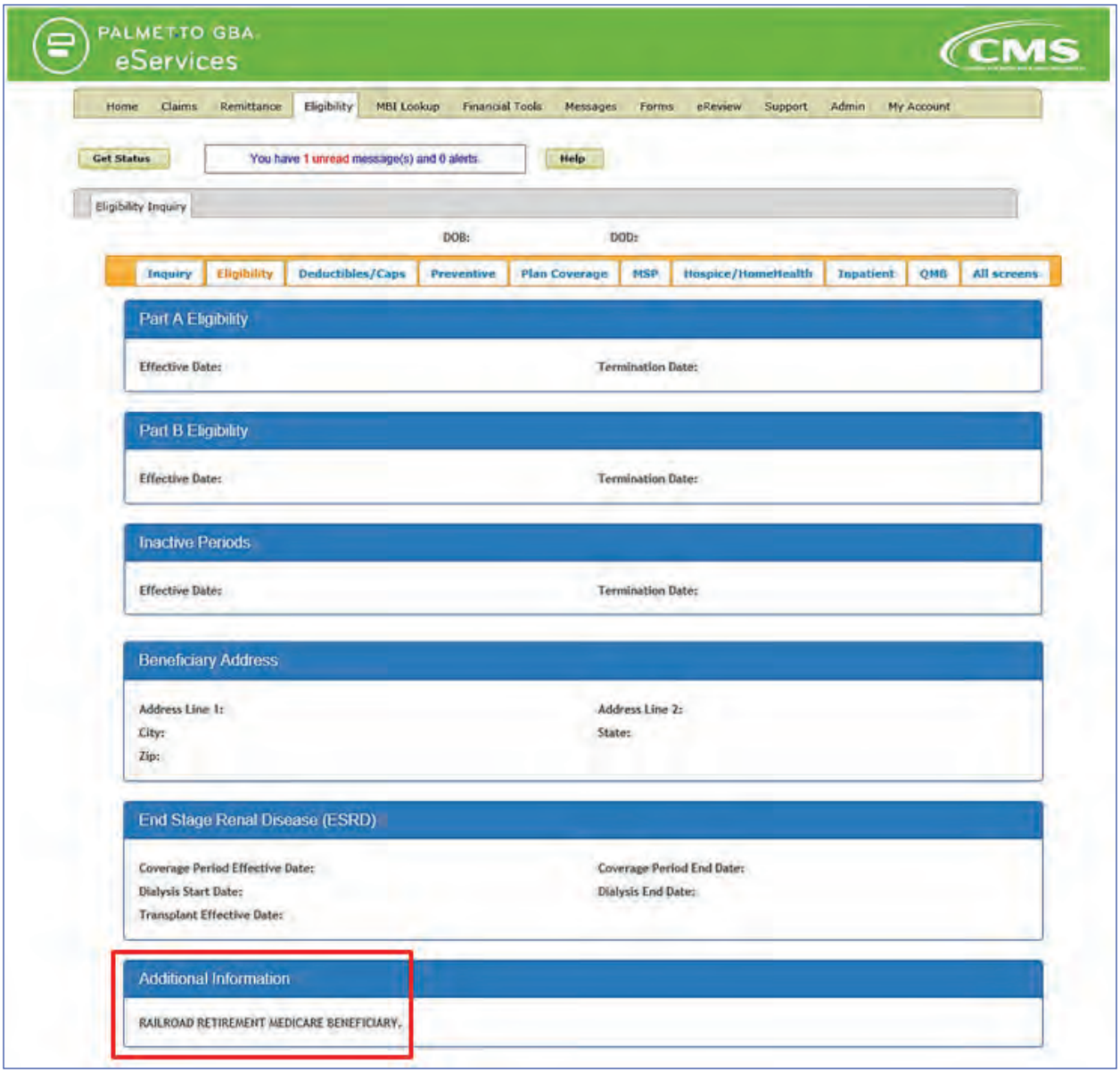

For more information on the new Medicare cards and using the MBIs, see the following Medicare Learning Network (MLN) resources:

- MBI website: https://www.cms.gov/Medicare/New-Medicare-Card/index
- MLN SE18006 - New Medicare Beneficiary Identifier (MBI) Get It, Use It: https://tinyurl.com/SE18006

New Medicare Part B Immunosuppressant Drug Benefit

MLN Matters Number: MM12804 Revised
Related CR Release Date: December 22, 2022
Related CR Transmittal Number: R11764GI, R11764CP, and R11764BP
Related Change Request (CR) Number: 12804
Effective Date: January 1, 2023
Implementation Date: January 3, 2023
Related CR Title: New Medicare Part B Immunosuppressant Drug Benefit (PBID) - Implementation

Note: We revised this Article due to a revised CR 12804. The CR revision didn't change the substance of the Article. We did revise the CR release date, transmittal numbers, and web addresses of the transmittals. All other information is the same.

Provider Types Affected
This MLN Matters Article is for physicians, providers, and suppliers billing claims to Medicare Administrative Contractors (MACs) for immunosuppressant drugs they provide to Medicare ESRD patients.

Provider Action Needed
Make sure your billing staff knows about the new benefit effective January 1, 2023:
- Extension of Medicare coverage for immunosuppressant drugs beyond 36 months for certain patients with kidney transplants
- Coverage of premiums and cost sharing for some of these patients

Background
Most individuals with ESRD are eligible for Medicare, regardless of age. CMS considers a kidney transplant as the best treatment for ESRD. When a patient gets a kidney transplant, Medicare coverage extends for 36 months after the month in which the patient gets a transplant.

Medicare Part B patients who had Medicare coverage when they had their transplant have coverage for immunosuppressive drug therapy for as long as they remain eligible and enrolled in Part B. After the 36 months, Medicare coverage ends unless the patient is otherwise entitled to Medicare (for example, if they're now eligible based on age or disability). Once ESRD-only patients exhaust their 36 months of Medicare eligibility, they lose Part B coverage for immunosuppressive drugs and must pay for the medications out of pocket, through other insurance, or with third-party assistance. The cost of paying for this drug therapy could be impossible for those who lose Medicare coverage after 36 months and who don't have another source of healthcare coverage.

If an individual doesn't take these immunosuppressive drugs, it's possible that the transplant rejects and the individual will be at risk of developing ESRD again. This would lead to further Medicare coverage, dialysis, and potentially another transplant.

Section 402 of the Consolidated Appropriations Act (CAA)
https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf#page=1819 makes an exception for eligibility for enrollment under Part B solely for the purposes of coverage of immunosuppressive drugs described in Section 1861(s)(2)(J) of the Social Security Act (the Act)

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https://www.ssa.gov/OP_Home/ssact/title18/1861.htm. Effective January 1, 2023, this provision allows individuals whose Medicare coverage based on ESRD ends 36 months after the month of a successful kidney transplant to keep enrollment under Part B only for the immunosuppressive drugs described in section 1861(s)(2)(J) of the Act with no time limit.

We refer to this benefit as the Part B immunosuppressive drug benefit or Part B-ID or PBID. The PBID benefit is unique because it's classified as a Part B benefit, but it provides coverage limited to immunosuppressive drugs. Only a small number of Medicare patients are eligible. Most rules and requirements applicable to Part B also apply to the PBID benefit. Patients entitled to the PBID benefit wouldn't get Medicare coverage for any other items or services. They're only eligible for the immunosuppressive drug coverage if they aren't enrolled in certain other types of coverage (for example, a group health plan, TRICARE, or a Medicaid state plan that covers immunosuppressive drugs).

Section 402 of the CAA doesn't make changes to payment limits for applicable billing and payment codes associated with immunosuppressive drugs, supplying fees to pharmacies (as described in Section 1842(o)(6) of the Act) https://www.ssa.gov/OP_Home/ssact/title18/1842.htm, or applicable patient deductible and coinsurance amounts. Section 402 of the CAA also amends the Medicare Savings Programs (MSP) under Sections 1905(a)(1)(A) https://www.ssa.gov/OP_Home/ssact/title19/1905.htm and 1902(a)(10)(E) https://www.ssa.gov/OP_Home/ssact/title19/1902.htm of the Act to pay some of the Part B premiums and, in some cases, all the cost sharing for certain low-income individuals under the MSP.

A small number of individuals will enroll in the PBID benefit each year. We anticipate that most will also qualify for the Qualified Medicare Beneficiary group, the MSP group that covers PBID premiums, deductibles, and coinsurance.

PBID enrollees will get a new Medicare card that will identify them as only eligible for immunosuppressant drugs under the PBID benefit. Coverage is limited to those drugs medically necessary and appropriate for the specific purpose of preventing or treating the rejection of a transplanted organ or tissue.

Drugs used for the treatment of conditions that may result from an immunosuppressive drug regimen (for example, antibiotics, antihypertensives, analgesics, vitamins, and other drugs that aren't directly related to organ rejection) aren't covered under this benefit.

The drugs must be FDA-approved, be available only through a prescription, and belong to 1 of the following 3 categories:

- A drug approved for marketing and labeled as an immunosuppressive drug
- A drug, such as a corticosteroid, approved and labeled for use in conjunction with immunosuppressive drugs to treat or prevent the rejection of a patient's transplanted organ or tissue
- A drug that a Part B MAC decides is reasonable and necessary or for use in conjunction with those immunosuppressive drugs for the purpose of preventing or treating the rejection of a patient's transplanted organ or tissue.

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Chapter 15, Section 50.5.1, of the Medicare Benefit Policy Manual https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf#page=73 states the covered immunosuppressive drugs labeled as such and FDA-approved for marketing include (The list below isn't all inclusive):

- Sandimmune (cyclosporine), Sandoz Pharmaceutical
- Imuran (azathioprine), Burroughs Wellcome
- Atgam (antithymocyte globulin), Upjohn
- Orthoclone OKT3 (Muromonab-CD3), Ortho Pharmaceutical
- Prograf (tacrolimus), Fujisawa USA, Inc
- Celicept (mycophenolate mefetil, Roche Laboratories
- Daclizumab (Zenapax)
- Cyclophosphamide (Cytoxan)
- Prednisone
- Prednisolone

Note: This is an exception to the standing drug policy which allows coverage of FDA-approved drugs for nonlabelled uses, where the uses are reasonable and necessary in an individual case.

More Information

We issued CR 12804 to your MAC as the official instruction for this change. The CR consists of 3 transmittals:

- R11764BP updates the Medicare Benefit Policy manual https://www.cms.gov/files/document/r11764bp.pdf
- R11764CP updates the Medicare Claims Processing manual https://www.cms.gov/files/document/r11764cp.pdf
- R11764GI updates the Medicare General Information, Eligibility, and Entitlement manual https://www.cms.gov/files/document/r11764gi.pdf

For more information, find your MAC's website. https://www.cms.gov/MAC-info

Document History

Date of Change	Description
December 23, 2022	We revised this Article due to a revised CR 12804. The CR revision didn't change the substance of the Article. We did revise the CR release date, transmittal numbers, and web addresses of the transmittals. All other information is the same.
December 16, 2022	Initial article released.

2023 Jurisdiction List for DMEPOS HCPCS Codes- January

NOTE: Deleted codes are valid for dates of service on or before the date of deletion.

NOTE: Updated codes are in bold.

NOTE: The jurisdiction list includes codes that are not payable by Medicare. Please consult the Medicare contractor in whose jurisdiction a claim would be filed in order to determine coverage under Medicare.

NOTE: All HCPCs code listed have DME or joint MAC Jurisdiction. Any other codes not listed as DME MAC only or dual DME MAC/Part B MAC jurisdiction shall be considered to be A/B MAC (Part B) only jurisdiction.

HCPCS	DESCRIPTION	JURISDICTION	COMMENT
A4206 - A4209	Medical, Surgical, and Self-Administered Injection Supplies	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.	
A4210	Needle Free Injection Device	DME MAC	
A4211	Medical, Surgical, and Self-Administered Injection Supplies	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.	
A4213 - A4215	Medical , Surgical, and Self-Administered Injection Supplies	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.	
A4216 - A4218	Saline	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.	
A4221 - A4239	Self-Administered Injection and Diabetic Supplies	DME MAC	
A4244 - A4250	Medical, Surgical, and Self-Administered Injection Supplies	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.	
A4252 - A4259	Diabetic Supplies	DME MAC	
A4265	Paraffin	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.	
A4280	Accessory for Breast Prosthesis	DME MAC	

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HCPCS	DESCRIPTION	JURISDICTION	COMMENT
A4281 - A4286	Accessory for Breast Pump	DME MAC	
A4305 - A4306	Disposable Drug Delivery System	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.	
A4310 - A4358	Incontinence Supplies/ Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Part B MAC. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.	
A4360 - A4437	Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Part B MAC. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.	
A4450 - A4452	Tape; Adhesive Remover	Part B MAC if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device. If other, DME MAC.	
A4453	Enema Catheter	DME MAC	
A4455 - A4456	Tape; Adhesive Remover	Part B MAC if incident to a physician's	

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NOTE: All HCPCs code listed have DME or joint MAC Jurisdiction. Any other codes not listed as DME MAC only or dual DME MAC/Part B MAC jurisdiction shall be considered to be A/B MAC (Part B) only jurisdiction.

HCPCS	DESCRIPTION	JURISDICTION	COMMENT
		service (not separately payable), or if supply for implanted prosthetic device. If other, DME MAC.	
A4458-A4459	Enema Bag/System	DME MAC	
A4461-A4463	Surgical Dressing Holders	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.	
A4465 - A4467	Non-elastic Binder and Garment, Strap, Covering	DME MAC	
A4481	Tracheostomy Supply	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.	
A4483	Moisture Exchanger	DME MAC	
A4490 - A4510	Surgical Stockings	DME MAC	
A4520	Diapers	DME MAC	
A4553 - A4554	Underpads	DME MAC	
A4555 - A4558	Electrodes; Lead Wires; Conductive Paste	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.	
A4559	Coupling Gel	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.	
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	DME MAC	
A4595	TENS Supplies	Part B MAC if incident to a physician's service (not separately payable). If other,	

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NOTE: All HCPCs code listed have DME or joint MAC Jurisdiction. Any other codes not listed as DME MAC only or dual DME MAC/Part B MAC jurisdiction shall be considered to be A/B MAC (Part B) only jurisdiction.

HCPCS	DESCRIPTION	JURISDICTION	COMMENT
		DME MAC.	
A4596	Electrical Stimulator Supplies	DME MAC	
A4600	Sleeve for Intermittent Limb Compression Device	DME MAC	
A4601-A4602	Lithium Replacement Batteries	DME MAC	
A4604	Tubing for Positive Airway Pressure Device	DME MAC	
A4605	Tracheal Suction Catheter	DME MAC	
A4606	Oxygen Probe for Oximeter	DME MAC	
A4608	Transtracheal Oxygen Catheter	DME MAC	
A4611 - A4613	Oxygen Equipment Batteries and Supplies	DME MAC	
A4614	Peak Flow Rate Meter	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.	
A4615 - A4629	Oxygen & Tracheostomy Supplies	Part B MAC if incident to a physician's service (not separately payable). If other, DME MAC.	
A4630 - A4640	DME Supplies	DME MAC	
A4649	Miscellaneous Surgical Supplies	Part B MAC if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.	

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NOTE: All HCPCs code listed have DME or joint MAC Jurisdiction. Any other codes not listed as DME MAC only or dual DME MAC/Part B MAC jurisdiction shall be considered to be A/B MAC (Part B) only jurisdiction.

HCPCS	DESCRIPTION	JURISDICTION	COMMENT
A4651 - A4932	Supplies for ESRD	DME MAC (not separately payable)	
A5051 - A5093	Additional Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Part B MAC. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.	
A5102 - A5200	Additional Incontinence and Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Part B MAC. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.	
A5500 - A5514	Therapeutic Shoes	DME MAC	
A6000	Non-Contact Wound Warming Cover	DME MAC	
A6010-A6024	Surgical Dressing	Part B MAC if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.	
A6025	Silicone Gel Sheet	Part B MAC if incident to a physician's service (not separately payable) or if supply	

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HCPCS	DESCRIPTION	JURISDICTION	COMMENT
		for implanted prosthetic device or implanted DME. If other, DME MAC.	
A6154 - A6411	Surgical Dressing	Part B MAC if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.	
A6412	Eye Patch	Part B MAC if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.	
A6413	Adhesive Bandage	Part B MAC if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.	
A6441 - A6457	Surgical Dressings	Part B MAC if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device or implanted DME. If other, DME MAC.	
A6501-A6512	Surgical Dressing	Part B MAC if incident to a physician's service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other, DME MAC	
A6513	Compression Burn Mask	DME MAC	
A6530 - A6549	Compression Gradient Stockings	DME MAC	
A6550	Supplies for Negative Pressure	DME MAC	

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HCPCS	DESCRIPTION	JURISDICTION	COMMENT
	Wound Therapy Electrical Pump		
A7000 - A7002	Accessories for Suction Pumps	DME MAC	
A7003 - A7039	Accessories for Nebulizers, Aspirators and Ventilators	DME MAC	
A7044 - A7047	Respiratory Accessories	DME MAC	
A7501-A7527	Tracheostomy Supplies	DME MAC	
A8000-A8004	Protective Helmets	DME MAC	
A9270	Noncovered Items or Services	DME MAC	
A9272	Disposable Wound Suction Pump	DME MAC	
A9273	Hot Water Bottles, Ice Caps or Collars, and Heat and/or Cold Wraps	DME MAC	
A9274 - A9278	Glucose Monitoring	DME MAC	**A9276-A9278 made valid for Medicare 1/1/23**
A9279	Monitoring Feature/Device	DME MAC	
A9280	Alarm Device	DME MAC	
A9281	Reaching/Grabbing Device	DME MAC	
A9282	Wig	DME MAC	
A9283	Foot Off Loading Device	DME MAC	
A9284- A9286	Non-electric Spirometer, Inversion Devices and Hygienic Items	DME MAC	
A9300	Exercise Equipment	DME MAC	
A9900	Miscellaneous DME Supply or Accessory	Part B MAC if used with implanted DME. If other, DME MAC.	
A9901	Delivery	DME MAC	

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HCPCS	DESCRIPTION	JURISDICTION	COMMENT
A9999	Miscellaneous DME Supply or Accessory	Part B MAC if used with implanted DME. If other, DME MAC.	
B4034 - B9999	Enteral and Parenteral Therapy	DME MAC	
E0100 - E0105	Canes	DME MAC	
E0110 - E0118	Crutches	DME MAC	
E0130 - E0159	Walkers	DME MAC	
E0160 - E0175	Commodes	DME MAC	
E0181 - E0199	Decubitus Care Equipment	DME MAC	
E0200 - E0239	Heat/Cold Applications	DME MAC	
E0240 - E0248	Bath and Toilet Aids	DME MAC	
E0249	Pad for Heating Unit	DME MAC	
E0250 - E0304	Hospital Beds	DME MAC	
E0305 - E0326	Hospital Bed Accessories	DME MAC	
E0328 - E0329	Pediatric Hospital Beds	DME MAC	
E0350 - E0352	Electronic Bowel Irrigation System	DME MAC	
E0370	Heel Pad	DME MAC	
E0371 - E0373	Decubitus Care Equipment	DME MAC	
E0424 - E0484	Oxygen and Related Respiratory Equipment	DME MAC	
E0485 - E0486	Oral Device to Reduce Airway Collapsibility	DME MAC	
E0487	Electric Spirometer	DME MAC	
E0500	IPPB Machine	DME MAC	

2023 Jurisdiction List for DMEPOS HCPCS Codes- January

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NOTE: Updated codes are in bold.

NOTE: The jurisdiction list includes codes that are not payable by Medicare. Please consult the Medicare contractor in whose jurisdiction a claim would be filed in order to determine coverage under Medicare.

NOTE: All HCPCs code listed have DME or joint MAC Jurisdiction. Any other codes not listed as DME MAC only or dual DME MAC/Part B MAC jurisdiction shall be considered to be A/B MAC (Part B) only jurisdiction.

HCPCS	DESCRIPTION	JURISDICTION	COMMENT
E0550 - E0585	Compressors/Nebulizers	DME MAC	
E0600	Suction Pump	DME MAC	
E0601	CPAP Device	DME MAC	
E0602 - E0604	Breast Pump	DME MAC	
E0605	Vaporizer	DME MAC	
E0606	Drainage Board	DME MAC	
E0607	Home Blood Glucose Monitor	DME MAC	
E0610 - E0615	Pacemaker Monitor	DME MAC	
E0617	External Defibrillator	DME MAC	
E0618 - E0619	Apnea Monitor	DME MAC	
E0620	Skin Piercing Device	DME MAC	
E0621 - E0636	Patient Lifts	DME MAC	
E0637 - E0642	Standing Devices/Lifts	DME MAC	
E0650 - E0676	Pneumatic Compressor and Appliances	DME MAC	
E0691 - E0694	Ultraviolet Light Therapy Systems	DME MAC	
E0700	Safety Equipment	DME MAC	
E0705	Transfer Board	DME MAC	
E0710	Restraints	DME MAC	
E0720 - E0745	Electrical Nerve Stimulators	DME MAC	
E0747 - E0748	Osteogenic Stimulators	DME MAC	
E0755- E0770	Stimulation Devices	DME MAC	
E0776	IV Pole	DME MAC	
E0779 - E0780	External Infusion Pumps	DME MAC	

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HCPCS	DESCRIPTION	JURISDICTION	COMMENT
E0781	Ambulatory Infusion Pump	DME MAC	
E0784	Infusion Pumps, Insulin	DME MAC	
E0791	Parenteral Infusion Pump	DME MAC	
E0830	Ambulatory Traction Device	DME MAC	
E0840 - E0900	Traction Equipment	DME MAC	
E0910 - E0930	Trapeze/Fracture Frame	DME MAC	
E0935 - E0936	Passive Motion Exercise Device	DME MAC	
E0940	Trapeze Equipment	DME MAC	
E0941	Traction Equipment	DME MAC	
E0942 - E0945	Orthopedic Devices	DME MAC	
E0946 - E0948	Fracture Frame	DME MAC	
E0950 - E1298	Wheelchairs	DME MAC	
E1300 - E1310	Whirlpool Equipment	DME MAC	
E1352 - E1392	Additional Oxygen Related Equipment	DME MAC	
E1399	Miscellaneous DME	Part B MAC if implanted DME. If other, DME MAC.	
E1405 - E1406	Additional Oxygen Equipment	DME MAC	
E1500 - E1625	Artificial Kidney Machines and Accessories	DME MAC (not separately payable)	
E1630 -E1699	Artifical Kidney Machines and Accessories	DME MAC (not separately payable)	
E1700 - E1702	TMJ Device and Supplies	DME MAC	
E1800 - E1841	Dynamic Flexion Devices	DME MAC	

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HCPCS	DESCRIPTION	JURISDICTION	COMMENT
E1902	Communication Board	DME MAC	
E2000	Gastric Suction Pump	DME MAC	
E2100 - E210**3**	Blood Glucose Monitors with special Features: Continuous Glucose Monitor	DME MAC	
E2120	Pulse Generator for Tympanic Treatment of Inner Ear	DME MAC	
E2201 - E2398	Wheelchair Accessories	DME MAC	
E2402	Negative Pressure Wound Therapy Pump	DME MAC	
E2500 - E2599	Speech Generating Device	DME MAC	
E2601 - E2633	Wheelchair Cushions and Accessories	DME MAC	
E8000 - E8002	Gait Trainers	DME MAC	
G0333	Dispensing Fee	DME MAC	
J0120 - J1094	Injection	Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.	
J1100-J2786	Injection	Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.	
J2788-J3570	Injection	Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.	
J7030 - J7131	Miscellaneous Drugs and Solutions	Part B MAC if incident to a physician's service or used in an implanted infusion pump.	

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HCPCS	DESCRIPTION	JURISDICTION	COMMENT
		If other, DME MAC.	
J7340	Carbidopa/Levodopa	Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.	
J7500 - J7599	Immunosuppressive Drugs	Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.	
J7604 - J7699	Inhalation Solutions	Part B MAC if incident to a physician's service. If other, DME MAC.	
J7799 -J7999	NOC Drugs, Other than Inhalation Drugs	Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.	
J8498	Anti-emetic Drug	DME MAC	
J8499	Prescription Drug, Oral, Non Chemotherapeutic	Part B MAC if incident to a physician's service. If other, DME MAC.	
J8501 - J8999	Oral Anti-Cancer Drugs	DME MAC	
J9000 - J9999	Chemotherapy Drugs	Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.	
K0001 - K0108	Wheelchairs	DME MAC	
K0195	Elevating Leg Rests	DME MAC	
K0455	Infusion Pump used for Uninterrupted Administration of Epoprostenal	DME MAC	
K0462	Loaner Equipment	DME MAC	

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HCPCS	DESCRIPTION	JURISDICTION	COMMENT
K0552 - K0605	External Infusion Pump Supplies ~~& Continuous Glucose Monitor~~	DME MAC	**K0553 and K0554 discontinued 12/31/22**
K0606 - K0609	Defibrillator Accessories	DME MAC	
K0669	Wheelchair Cushion	DME MAC	
K0672	Soft Interface for Orthosis	DME MAC	
K0730	Inhalation Drug Delivery System	DME MAC	
K0733	Power Wheelchair Accessory	DME MAC	
K0738	Oxygen Equipment	DME MAC	
K0739	Repair or Nonroutine Service for DME	Part B MAC if implanted DME. If other, DME MAC	
K0740	Repair or Nonroutine Service for Oxygen Equipment	DME MAC	
K0743 - K0746	Suction Pump and Dressings	DME MAC	
K0800 - K0899	Power Mobility Devices	DME MAC	
K0900	Custom DME, other than Wheelchair	DME MAC	
K1001- K1003	Devices	DME MAC	
K1004	Devices	DME MAC when the supplier considers the item DMEPOS. Part B MAC if the supplier considers the item something other than DMEPOS (e.g., supplies furnished incident to the professional service of a physician)	
K1005- K1006	Devices	DME MAC	
K1007	Devices	DME MAC when the supplier considers the item DMEPOS. Part B MAC if the supplier considers the item something other than DMEPOS (e.g., supplies furnished incident to the professional service of a physician)	

2023 Jurisdiction List for DMEPOS HCPCS Codes- January

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HCPCS	DESCRIPTION	JURISDICTION	COMMENT
K1009	Devices	DME MAC	
K1013	Devices	Part B MAC if a supply for or inserted by a licensed healthcare provider. If other, DME MAC	
K1014-K1026	Devices	DME MAC	
K1027	Devices	DME MAC when the supplier considers the item DMEPOS. Part B MAC if the supplier considers the item something other than DMEPOS (e.g., supplies furnished incident to the professional service of a physician)	
K1028-K1029	Devices	DME MAC	
K1031-K1033	Devices	DME MAC	
L0112 - L4631	Orthotics & Devices	DME MAC	
L5000 - L5999	Lower Limb Prosthetics	DME MAC	
L6000 - L7499	Upper Limb Prosthetics	DME MAC	
L7510 - L7520	Repair of Prosthetic Device	Part B MAC if repair of implanted prosthetic device. If other, DME MAC.	
L7600 - L8485	Prosthetics	DME MAC	
L8499	Unlisted Procedure for Miscellaneous Prosthetic Services	Part B MAC if implanted prosthetic device. If other, DME MAC.	
L8500 - L8501	Artificial Larynx; Tracheostomy Speaking Valve	DME MAC	
L8505	Artificial Larynx Accessory	DME MAC	

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NOTE: All HCPCs code listed have DME or joint MAC Jurisdiction. Any other codes not listed as DME MAC only or dual DME MAC/Part B MAC jurisdiction shall be considered to be A/B MAC (Part B) only jurisdiction.

HCPCS	DESCRIPTION	JURISDICTION	COMMENT
L8507	Voice Prosthesis, Patient Inserted	DME MAC	
L8509	Voice Prosthesis, Inserted by a Licensed Health Care Provider	Part B MAC for dates of service on or after 10/01/2010. DME MAC for dates of service prior to 10/01/2010	
L8510	Voice Prosthesis	DME MAC	
L8511 - L8515	Voice Prosthesis	Part B MAC if used with tracheoesophageal voice prostheses inserted by a licensed health care provider. If other, DME MAC	
L8701-L8702	Assist Device	DME MAC	
L9900	Miscellaneous Orthotic or Prosthetic Component or Accessory	Part B MAC if used with implanted prosthetic device. If other, DME MAC.	
Q0144	Azithromycin Dihydrate	Part B MAC if incident to a physician's service. If other, DME MAC.	
Q0161 - Q0181	Anti-emetic	DME MAC	
Q0510 - Q0514	Drug Dispensing Fees	DME MAC	
Q2049-Q2050	Doxorubicin	Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.	
Q2052	IVIG Demonstration	DME MAC	
Q4074	Inhalation Drug	Part B MAC if incident to a physician's service. If other, DME MAC.	

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HCPCS	DESCRIPTION	JURISDICTION	COMMENT
Q5101-Q5121	Injection	Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.	
Q9991-Q9992	Injection	Part B MAC if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.	
V2020 - V2025	Frames	DME MAC	
V2100 - V2513	Lenses	DME MAC	
V2520 - V2523	Hydrophilic Contact Lenses	Part B MAC if incident to a physician's service. If other, DME MAC.	
V2524- V2525	Hydrophilic Contact Lenses	DME MAC	
V2530 - V2531	Contact Lenses, Scleral	DME MAC	
V2599	Contact Lens, Other Type	Part B MAC if incident to a physician's service. If other, DME MAC.	
V2600 - V2615	Low Vision Aids	DME MAC	
V2623 - V2629	Prosthetic Eyes	DME MAC	
V2700 - V2780	Miscellaneous Vision Service	DME MAC	
V2781	Progressive Lens	DME MAC	
V2782 - V2784	Lenses	DME MAC	
V2786	Lens	DME MAC	
V2797	Vision Supply	DME MAC	

2023 Jurisdiction List for DMEPOS HCPCS Codes- January

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NOTE: All HCPCs code listed have DME or joint MAC Jurisdiction. Any other codes not listed as DME MAC only or dual DME MAC/Part B MAC jurisdiction shall be considered to be A/B MAC (Part B) only jurisdiction.

HCPCS	DESCRIPTION	JURISDICTION	COMMENT
V2799	Miscellaneous Vision Service	Part B MAC if supply for an implanted prosthetic device. If other, DME MAC	
V5336	Repair/Modification of Augmentative Communicative System or Device	DME MAC	

Travel Allowance Fees for Specimen Collection: 2023 Updates

Related CR Release Date: January 6, 2023
Effective Date: January 1, 2023
Implementation Date: January 23, 2023
MLN Matters Number: MM13071
Related Change Request (CR) Number: CR 13071 https://www.cms.gov/files/document/r11778CP.pdf
Related CR Transmittal Number: R11778CP
Related CR Title: Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens and New Updates for 2023

Affected Providers
- Laboratories
- Laboratory technicians
- Other providers billing Medicare Administrative Contractors (MACs) for specimen collection services for Medicare patients

Action Needed
Make sure your billing staffs knows about:
- Specimen collection fees and travel allowances for 2023
- Other policy updates and reminders

Background
Medicare Part B pays a specimen collection fee and travel allowance, when medically necessary, for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act (the Act) https://www.ssa.gov/OP_Home/ssact/title18/1833.htm. CMS bases payment for these services on the clinical laboratory fee schedule (CLFS).

Specimen Collection Policy
We finalized an increase to the nominal fee for specimen collection based on the Consumer Price Index for all Urban Consumers (CPI-U). For CY 2023, the general specimen collection fee will increase from $3 to $8.57 and as required by Protecting Access to Medicare Act of 2014 (PAMA), we'll increase this by $2.00 for those specimens you collect from a Medicare patient in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA). This gives a $10.57 specimen collection fee for those patients. We finalized a policy to update this fee amount annually by the percent change in the CPI-U.

Also, we're clarifying that to be eligible for a specimen collection fee, the specimen must be:
- Used to perform a Clinical Diagnostic Laboratory Test (CDLT) paid under the CLFS regulations at 42 CFR 414.523 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-G/section-414.523
- Collected by a trained technician from a Medicare patient who's homebound or is a non-hospital inpatient, but only when no qualified personnel are available at the facility to collect the specimen
- Collected as a blood specimen through venipuncture or a urine sample collected by catheterization

Continued >>

A specimen collection fee isn't payable for any other specimen types, including blood samples where the cost of collecting the specimen is minimal (such as a throat culture or a routine capillary puncture for clotting or bleeding time). This fee won't be paid to anyone who didn't extract the specimen. We only allow 1 collection fee for each type of specimen for each patient encounter, regardless of the number of specimens drawn. If you draw different types or multiple specimens from 1 patient, only 1 specimen collection fee would be allowed. When a series of specimens is required to complete a single test (for example, glucose tolerance test), we treat the series as a single encounter.

The trained technician must personally draw the specimen. Medical necessity for such services exists where a trained technician draws a blood specimen from a homebound or an institutionalized patient. A patient doesn't need to be bedridden to be homebound.

The phrase "trained technician" refers to those staff providing specimen collection services. However, "trained technician" doesn't mandate certain educational requirements. For the purposes of the specimen collection provisions, the term includes a phlebotomist.

As a reminder, the HCPCS codes that describe specimen collection are:
- 36415 - Collection of venous blood by venipuncture
- G0471 - Collection of venous blood by venipuncture or urine sample by catheterization from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA)
- P9612 - Catheterization for collection of specimen(s), (single patient), all places of services
- P9615 - Catheterization for collection of specimen(s), (multiple patients)

Travel Allowance Policy
We pay a travel allowance when we pay a specimen collection fee. Travel for simple pickup of specimens or for specimen collection that doesn't require the services of trained technicians isn't considered in the calculation of the travel allowance. This means that the travel allowance amount may be paid only if a specimen collection fee is also payable. For example, we'd pay no travel allowance if a trained technician merely performs a messenger service to pick up a specimen drawn by other technicians.

Only Medicare patients (including Medicare Advantage) should be considered in the calculation and payment of the travel allowance. Don't include non-Medicare patients in the calculation of the travel allowance.

Travel Allowance Eligible Miles
Eligible miles are those miles traveled that may be included in the calculation to decide the travel allowance amount. Eligible miles start at the laboratory or the starting point of the trained technician's travel for specimen collection and end at the laboratory or the ending point of the trained technician's travel for specimen collection.

Eligible miles don't include miles traveled for any purpose unrelated to specimen collection, such as collecting specimens from non-Medicare patients or for personal reasons.

As a reminder, effective January 1, 2022, we made permanent the option for laboratories to maintain electronic documentation of miles traveled for the purposes of covering the transportation and personnel expenses for trained technicians to travel to the location of an individual to collect a specimen sample. This option for laboratories to maintain electronic documentation applies to specimen collection for any CDLT. Laboratories

Continued >>

need to be able to produce electronic documentation in a form and manner they can share with MACs and should continue to consult with their local MACs regarding the format and process for submission of this information if necessary.

Travel Allowance Mileage Rate

The Act requires the travel allowance to cover both the "transportation" and "personnel expenses" for trained personnel to travel to the location of an individual to collect a sample. The travel allowance mileage rate shows both of these components.

The "transportation" component of the travel allowance mileage rate equals the IRS standard mileage rate. The IRS updates and issues standard mileage rates on a periodic basis.

The "personnel expenses" component of the travel allowance mileage rate is the trained technician's personnel expenses based on a wages-per-mile amount.

Effective January 1, 2023, we use the latest wage data published in the Bureau of Labor Statistics (BLS)-defined category of phlebotomist to establish the personnel expense component of the travel allowance mileage rate.

We calculate a per-mile amount to derive the approximate number of miles traveled by the trained technician each hour by using an average driving speed. The average miles-per-hour driving speed is multiplied by the trained technician's estimated wages, as described above, and the result would be an amount that represents wages per mile, which are the personnel expenses associated with travel for specimen collection. We use an average driving speed of 40 miles per hour, as most of the travel related to specimen collection would be in local and residential areas.

Updates to the Travel Allowance Mileage Rate

The travel allowance mileage rate for CY 2023 is $1.11, based on:

- The IRS standard mileage rate, which is $0.655, plus
- The most recent median BLS-published hourly wage for phlebotomists, which is $17.97 divided by 40 to represent an average miles-per-hour driving speed, which is $0.45

Travel Allowance Bases: Flat-Rate and Per-Mile

We pay a travel allowance in 1 of 2 ways:

- Flat-rate travel allowance
- Per-mile travel allowance

Flat-Rate Travel Allowance

The flat-rate travel allowance basis applies when the trained technician travels 20 eligible miles or less to and from 1 location for specimen collection from 1 or more Medicare patients.

Laboratories bill Medicare using HCPCS code P9604 to get the flat-rate travel allowance amount, prorated by the number of patients for whom we pay a specimen collection fee. The flat-rate trip basis travel allowance of $11.10.

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Per-Mile Travel Allowance
The per-mile travel allowance basis applies in 2 circumstances:

- When the round-trip travel to 1 location is greater than 20 eligible miles for specimen collection from 1 or more patients
- When travel is to more than 1 location, regardless of the number of miles traveled.

Laboratories bill Medicare using HCPCS code P9603 to get the per-mile travel allowance amount, prorated by the number of patients for whom we pay a specimen collection fee.

Calculation: Flat-rate Travel Allowance Basis
For flat-rate travel allowance basis, the travel allowance amount calculation is the travel allowance mileage rate multiplied by 10 and divided by the number of patients for whom a specimen collection fee is paid.

Dividing by the number of patients makes sure that the flat-rate travel allowance amount is apportioned to each patient getting specimen collection services and that payment is calculated in an operationally feasible manner, as a laboratory must submit a claim for each patient to get the travel allowance. This allows for a fixed payment amount to be apportioned to the number of patients for whom a specimen collection fee is paid in a single location.

Calculation: Per-mile Travel Allowance Basis
The calculation for the per-mile travel allowance amount is equal the number of eligible miles multiplied by the travel allowance mileage rate, divided by the number of patients for whom we paid a specimen collection fee.

To calculate the per-mile travel allowance amount, the laboratory would first calculate the total number of eligible miles that the trained technician traveled.

The eligible miles would be multiplied by the travel allowance mileage rate, then divided by the number of patients for whom a specimen collection fee is paid. This quotient yields a prorated travel allowance amount for each patient. The laboratory then submits a claim billing HCPCS code P9603 for payment of the per-mile travel allowance amount for each patient for whom a specimen collection fee is paid.

More Information
Neither the annual deductible nor the 20% coinsurance for Medicare apply to the specimen collection or travel allowance amount for CDLTs.

Your MAC will adjust previously paid travel allowance claims with dates of service on or after January 1, 2023, in order to apply the updated payment rate. Your MAC will initiate those adjustments within 60 days, if claims are paid at the prior year's rates before their systems have the new rates.

We issued CR 13071 to your MAC as the official instruction for this change. CR 13071 has detailed examples that demonstrate each travel allowance method, especially when 2 or more patients get services on the same trip.

For more information, find your MACs' website. https://www.cms.gov/MAC-info

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Document History

Date of Change	Description
January 9, 2023	Initial article released.

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National Coverage Determination 110.24: Chimeric Antigen Receptor T-cell Therapy

MLN Matters Number: MM12928 Revised
Related CR Release Date: December 30, 2022
Related CR Transmittal Number: R11774CP
Related Change Request (CR) Number: 12928
Effective Date: January 1, 2022
Implementation Date: January 31, 2023
Related CR Title: National Coverage Determination (NCD 110.24): Chimeric Antigen Receptor (CAR) T-cell Therapy

What's Changed: We revised the Article to clarify that providers shouldn't bill more than 1 unit per HCPCS code as we show in dark red on page 1.

Provider Types Affected

This MLN Matters Article is for physicians, other providers, and suppliers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

Make sure your billing staff knows about these changes for CAR T-cell Therapy (CAR-T) billing:

- Include additional place of service (POS) codes for office and independent clinics
- Bill in 0.1-unit fractions
- Don't bill more than 1 unit per HCPCS code
- Use 3 modifiers, including new modifier -LU

Background

The implementing CR 12177 https://www.cms.gov/files/document/r10891cp.pdf didn't allow for processing CAR-T claims in the Part B physician office and independent clinics. In that CR, CMS only allowed CAR-T claims in Part A inpatient and hospital-affiliated POS that were Risk Evaluation and Mitigation Strategies (REMS)-approved. CR 12928 https://www.cms.gov/files/document/r11774CP.pdf allows POS codes 11 (Office) and 49 (Independent Clinic) on CAR-T claims as long as they are REMS-approved.

Additionally, we can't process CAR-T related HCPCS codes in the current Multi-Carrier System (MCS) system because the field length for the dollar amount in MCS is only 7 digits (line item or total maximum is 99999.99). CAR-T products need to bill as 1 unit with a dollar amount of 8 digits (999999.99). This isn't a problem when a single HCPCS code can be billed for multiple units or when a Part B provider is billing multiple HCPCS codes. The issue arises when, based on the code description, you bill CAR-T products as a single unit of 1 therapeutic dose. For example, Q2041 = 1 unit = $448,316.40.

To bill CAR-T claims correctly in the Part B setting, divide the CAR-T HCPCS codes by 10 and bill in 0.1-unit fractions. Bill a total of 10 fractional units to reach the total Medicare allowed payment amount. Depending on the Medicare allowed payment for the CAR-T HCPCS code, some providers may submit 5 separate claims for 0.2 units on each claim.

Continued >>

To attest that you're a REMS-approved facility, you must use 3 modifiers:

- Modifier -LU: Fractionalized payment CAR T-cell therapy
- Modifier -76: Repeat procedure or service by same physician or other qualified healthcare professional
- Modifier -KX: Requirements specified in the medical policy have been met

New HCPCS modifier -LU is in the January 2023 HCPCS Update and is effective retroactively for use on claims with dates of service on or after January 1, 2022. As we add more codes for current and future FDA-approved CAR T-cell therapies, we'll update CMS HCPCS accordingly https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update.

Note: Part A Outpatient Prospective Payment System providers don't need to change their billing. They'll continue to bill 1 unit for the CAR T-cell products themselves.

The use of non-FDA-approved autologous T-cells with at least 1 CAR continues to be non-covered. Autologous treatment for cancer with T-cells expressing at least 1 CAR is also non-covered when the NCD criteria aren't met. We'll cover routine costs in clinical trials that use CAR T-cell therapy as an investigational agent that meet requirements in NCD 310.1 effective August 7, 2019, https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=1&ncdver=2&fromdb=true.

We remind you that the use of allogenic T-cells from healthy donors aren't autologous CAR T-cell treatments and you shouldn't bill those as autologous CAR-T treatments.

See the following websites for specific REMS facility information:

- Kymriah® https://www.us.kymriah.com/treatment-center-locator/
- Yescarta® https://www.yescarta.com/find-a-treatment-center
- Tecartus™ https://www.tecartushcp.com/car-t-cell-therapy/mantle-cell-lymphoma/treatment-center-locator
- Breyanzi® https://www.celltherapy360.com/locations
- ABECMA® https://www.celltherapy360.com/locations
- CARVYKTI™ https://www.carvyktihcp.com/treatment-centers

For complete billing details, see the revised Chapter 32, Section 400.2 of the Medicare Claims Processing Manual https://www.cms.gov/files/document/r11774CP.pdf#page=37, which is part of CR 12928.

More Information

We issued CR 12928 to your MAC as the official instruction for this change.

For more information, find your MAC's website. https://www.cms.gov/MAC-info

Document History

Date of Change	Description
January 5, 2023	We revised the Article to clarify that providers shouldn't bill more than 1 unit per HCPCS code as we show in dark red on page 1.
December 1, 2022	Initial article released.

Ambulatory Surgical Center Payment System: January 2023 Update

Related CR Release Date: January 17, 2023
Effective Date: January 1, 2023
Implementation Date: January 3, 2023
MLN Matters Number: MM13041 Revised
Related Change Request (CR) Number: CR 13041 https://www.cms.gov/files/document/r11786cp.pdf
Related CR Transmittal Number: R11786CP
Related CR Title: January 2023 Update of the Ambulatory Surgical Center (ASC) Payment System

What's Changed: A revision to CR 13041 added CPT codes 50970, 50972, 50974 to Table 2 and deleted CPT code Q4228 from Table 10. We made no substantial changes to the Article.

Affected Providers
This MLN Matters Article is for:
- ASCs
- Other providers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients

Action Needed
Make sure your billing staff knows about:
- New HCPCS C-codes on the ASC covered procedures list
- New HCPCS codes for drugs and biologics
- Skin substitute product assignments to high and low-cost groups

Background
The changes for the January 2023 ASC Payment system are:
1. New Device Pass-Through Categories Effective January 1, 2023
Section 1833(t)(6)(B) of the Social Security Act (the Act) https://www.ssa.gov/OP_Home/ssact/title18/1833.htm requires that, under the Outpatient Prospective Payment System (OPPS), categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Also, Section 1833(t)(6)(B)(ii)(IV) of the Act requires CMS to create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

For the January 2023 update, we approved 3 new devices for pass-through status under the OPPS and are establishing the new device categories in the ASC payment system. HCPCS codes C1747, C1826, and C1827 are effective January 1, 2023. Table 1 of CR 13041 https://www.cms.gov/files/document/r11786cp.pdf#page=14 includes the HCPCS code, code descriptors, and ASC Payment Indicators (PI).

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Also, we're updating the device category long descriptor for device HCPCS code C1831, which was effective October 1, 2021, from "Personalized, anterior and lateral interbody cage (implantable)" to "Interbody cage, anterior, lateral or posterior, personalized (implantable)" effective January 1, 2023.

a. New Device Offset from Payment for the Following HCPCS Codes Effective January 1, 2023
Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from OPPS pass-through payments for devices an amount that shows the device portion of the ambulatory payment classification (APC) payment amount. This deduction is known as the device offset, or the portion(s) of the APC amount that's associated with the cost of the pass-through device.

We've decided that offsets are associated with the costs of the new device categories described by the HCPCS codes in Table 2 of CR 13041 https://www.cms.gov/files/document/r11786cp.pdf#page=14. Always bill each device in these categories in the ASC setting with 1 of the associated CPT codes in Table 2. The associated devices, procedures, and offset percentages are in the January 2023 ASC code pair file https://www.cms.gov/medicare/ambulatory-surgical-center-asc-payment/asc-code-pairs.

2. MiVu Mucosal Integrity Testing System: Clarification on the Reporting of HCPCS Code C9777
In the CY 2022 OPPS/ASC final rule (86 FR 63517 and 63558) https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientpps/cms-1753-fc, we stated that when you perform both a MiVu test and an esophagoscopy or esophagogastroduodenoscopy (EGD) test together, Hospital Outpatient Departments must report only HCPCS code C9777 and shouldn't report a separate HCPCS code for the esophagoscopy or EGD. The January 2023 OPPS update clarified this policy to show that a diagnostic esophagoscopy or EGD is included in HCPCS code C9777, and shouldn't be reported separately. This policy is in effect in ASCs starting January 1, 2023.

3. New ASC Procedures effective January 1, 2023
There are 26 new procedures that are separately payable in the ASC setting. The CPT codes, descriptors, and ASC PIs are in Table 3 of CR 13041 https://www.cms.gov/files/document/r11786cp.pdf#page=17. The ASC payment rates for the codes are in the January 2023 ASC Addenda AA and BB https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment/11_addenda_updates.

4. ASC Special Payment Policy for OPPS Complexity-Adjusted Comprehensive Ambulatory Payment Classifications (C–APCs)
In the CY 2023 OPPS/ASC final rule, we finalized the ASC special payment policy for OPPS complexity adjusted C–APCs. We're making a complexity adjustment in the payment rate for primary surgical procedure and packaged add-on code combinations eligible for complexity adjustments under the OPPS and also performed in the ASC setting through the assignment of new HCPCS C-codes. Due to claims processing system limitations at this time, we're using the billing of these new C-codes, as a workaround, to provide a complexity adjustment to ASCs when performing these specific code pairs. Table 4 of CR 13041 https://www.cms.gov/files/document/r11786cp.pdf#page=21 shows the new HCPCS C-codes, descriptors, and ASC PIs. We added these new C-codes to the ASC covered procedures list.

Table 5 of CR 13041 https://www.cms.gov/files/document/r11786cp.pdf#page=33 shows the specific HCPCS code combinations that correspond to the new C-codes. When you perform the assigned primary procedure and secondary add-on procedure HCPCS codes together during an encounter, you must now bill the new C-code to

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which these procedures are paired rather than the individual procedures HCPCS codes. (Of note, ASCs already don't bill packaged codes; ASC PI=N1).

We put more information related to these code pairs, including descriptors and PIs, in a supplemental crosswalk table https://www.cms.gov/license/ama?file=/files/zip/cy-2023-final-asc-code-pair-crosswalk-table.zip to the CY 2023 OPPS/ASC final rule.

5. Drugs, Biologicals, and Radiopharmaceuticals

a. Newly Established HCPCS Codes for Drugs and Biologicals as of January 1, 2023

We're establishing 15 new drug and biological HCPCS codes on January 1, 2023. These HCPCS codes as well as the descriptors and ASC PIs are in Table 6 of CR 13041 https://www.cms.gov/files/document/r11786cp.pdf#page=36.

b. HCPCS Codes for Drugs Deleted on December 31, 2022

We're deleting 2 separately payable drug HCPCS codes won December 31, 2022. These HCPCS codes are: C9142 and J9044. Long descriptor and ASC PI are in Table 7 of CR 13041 https://www.cms.gov/files/document/r11786cp.pdf#page=37.

c. HCPCS Code Q5124 Separately Payable Effective October 1, 2022

We identified an error with the October 2022 ASC drug file resulting in the HCPCS code Q5124 (Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg) assigned an ASC PI=K5 (Items, codes, and services for which pricing information and claims data isn't available. No payment made.). The correct ASC PI for this code was K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.) effective October 1, 2022. We're reissuing the October 2022 ASC drug file with HCPCS code Q5124 assigned ASC PI=K2.

This correction is retroactively effective to October 1, 2022. If you performed this service with dates of service starting October 1, 2022 - December 31, 2022, and we denied your claim as not payable you may request reprocessing of this code from your Part B MAC. Table 8 of CR 13041 https://www.cms.gov/files/document/r11786cp.pdf#page=37 lists the HCPCS code, descriptors, ASC PI, and effective date.

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

For CY 2023, we continue making payment for nonpass-through drugs and biologicals at a single rate of Average Sales Price (ASP) + 6%. This provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug or biological. We'll update payments for drugs and biologicals based on ASPs on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective January 1, 2023, are in the January 2023 update of ASC Addendum BB.

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

Some drugs and biologicals with payment rates based on ASP methods may have their payment rates corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payment rates will be accessible on the first date of the quarter at Restated Drug and Biological

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Payment Rates https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Restated-Payment-Rates.

If you think you may have gotten an incorrect payment for drugs and biologicals impacted by these corrections you may request your MAC to adjust the previously processed claims.

f. New Modifier "JZ" Available for Use as of January 1, 2023

Starting January 1, 2023, modifier JZ will be available for voluntary provider use when no amount of drug is discarded from a single dose or single use packaging. ASCs must report the JZ modifier for all applicable drugs with no discarded drug amounts starting no later than July 1, 2023. Table 9 of CR 13041 https://www.cms.gov/files/document/r11786cp.pdf#page=37 displays the modifier and descriptors.

6. Skin Substitutes

The payment for skin substitute products that don't qualify for hospital OPPS pass-through status are packaged into the OPPS payment for the associated skin substitute application procedure. This policy also applies to the ASC payment system. We show the skin substitute products in 2 groups:

- High-cost skin substitute products - only use these in combination with the performance of 1 of the skin application procedures described by CPT codes 15271-15278.
- Low-cost skin substitute products for packaging purposes - only use these in combination with the performance of 1 of the skin application procedures described by HCPCS code C5271-C5278.

We assign new skin substitute HCPCS codes into the low-cost skin substitute group unless we have OPPS pricing data showing the cost of the product is above either the mean unit cost of $47 or the per day cost of $837 for CY 2023.

a. New Skin Substitute Products as of January 1, 2023

There are 4 new skin substitute HCPCS codes active as of January 1, 2023. These are HCPCS codes Q4236, Q4262, Q4263, and Q4264. The codes are packaged and are assigned to the low-cost skin substitute group. These new packaged codes are in Table 10 of CR 13041 https://www.cms.gov/files/document/r11786cp.pdf#page=37.

Note that ASCs shouldn't separately bill for packaged skin substitutes (ASC PI=N1) since packaged codes aren't reportable under the ASC payment system.

b. Deletion of HCPCS Code C1849 (Skin substitute, synthetic, resorbable, per square centimeter) Effective December 31, 2022

HCPCS code C1849 (Skin substitute, synthetic, resorbable, per square centimeter) has been deleted as of December 31, 2022. HCPCS code C1849 is in Table 10 of CR 13041.

c. Skin Substitute Assignments to High Cost and Low Costs Groups for CY 2023

Table 10 also lists the skin substitute products and their assignment as either a high-cost or a low-cost skin substitute product, when applicable.

7. HCPCS Codes with ASC PI Changes from Non-Payable to Payable in CY2023

The 18 HCPCS codes in Table 11 of CR 13041 https://www.cms.gov/files/document/r11786cp.pdf#page=41

Continued >>

have non-payable ASC PIs in CY2022 and are moving to payable effective January 1, 2023. These codes aren't in other tables of CR 13041.

8. Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the ASC payment system doesn't imply coverage by the Medicare Program, but shows only how the product, procedure, or service may be paid if covered by the program. MACs decide if a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs decide that it's reasonable and necessary to treat the patient's condition and if it's excluded from payment.

More Information

We issued CR 13041 to your MAC as the official instruction for this change.

For more information, find your MACs' website. https://www.cms.gov/MAC-info

Document History

Date of Change	Description
January 17, 2023	A revision to CR 13041 added CPT codes 50970, 50972, 50974 to Table 2 and deleted CPT code Q4228 from Table 10. We made no substantial changes to the Article.
December 22, 2022	Initial article released.

Colorectal Cancer Screening Tests: Changes to Coinsurance for Related Procedures

MLN Matters Number: MM12656 Revised
Related CR Release Date: December 29, 2022
Related CR Transmittal Number: R11772OTN
Related Change Request (CR) Number: 12656
Effective Date: January 1, 2022
Implementation Date: January 1, 2023
Related CR Title: Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter as Certain Colorectal Cancer Screening Tests

Note: We revised this Article due to a revised CR 12656. The CR changes didn't affect the contents of the Article. We did change the CR release date, transmittal number and the CR web address. All other information remains the same.

Provider Types Affected
This MLN Matters Article is for physicians, hospitals, and other providers billing Medicare Administrative Contractors (MACs) for colorectal screening tests they do for Medicare patients.

Provider Action Needed
Make sure your billing staff knows about:
- Phasing out coinsurance for certain colorectal cancer screening procedures that become a diagnostic or therapeutic service

Background
Section 122 of Division CC of the Consolidated Appropriations Act (CAA) of 2021 https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf#page=1776, Waiving Medicare Coinsurance for Certain Colorectal Cancer Screening Tests, amends Section 1833(a) of the Act to offer a special coinsurance rule for screening flexible sigmoidoscopies and colonoscopies. The reduced coinsurance is being phased-in starting January 1, 2022.

Currently, planned colorectal cancer screening tests are free. However, if you add a procedure in the same clinical encounter as a result of the colorectal cancer screening, the patient pays a coinsurance.

Starting January 1, 2023, CMS will gradually reduce coinsurance for procedures performed:
- In connection with a colorectal cancer screening test
- As a result of a screening test
- In the same clinical encounter as the screening test

When a screening colorectal cancer procedure, G0104, G0105, or G0121 has the PT modifier submitted on the claim line item with HCPCS codes 10000 – 69999, G0500, 00811, or CPT code 99153 for diagnostic colonoscopy, or diagnostic flexible sigmoidoscopy, or other procedure to indicate that a screening colorectal

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cancer procedure, HCPCS G0104, G0105, or G0121, has become a diagnostic or therapeutic service, coinsurance is reduced or waived.

The reduced coinsurance applies regardless of the code you bill.

For dates of service in CYs:
- 2023–2026, coinsurance is 15%
- 2027–2029, coinsurance is 10%
- Starting 2030, no coinsurance

More Information
We issued CR 12656 to your MAC as the o fficial instruction for this change.
https://www.cms.gov/files/document/r11772OTN.pdf

For more information, find your MAC's website. https://www.cms.gov/MAC-info

Document History

Date of Change	Description
December 30, 2022	We revised this Article due to a revised CR 12656. The CR changes didn't affect the contents of the Article. We did change the CR release date, transmittal number and the CR web address. All other information remains the same.
September 29, 2022	We revised this Article due to a revised CR 12656. The CR changes didn't affect the contents of the Article. We did change the CR release date, transmittal number and the CR web address. All other information remains the same.
April 29, 2022	Initial article released.

MLN Connects™

MLN Connects contains a week's worth of Medicare-related messages instead of many different messages being sent to you throughout the week. This notification process ensures planned, coordinated messages are delivered timely about Medicare-related topics.

MLN Connects™ for December 22, 2022
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2022-12-22-mlnc

MLN Connects™ for January 5, 2022
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2023-01-05-mlnc

MLN Connects™ for January 12, 2022
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2023-01-12-mlnc

MLN Connects™ for January 19, 2022
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2023-01-19-mlnc

MLN Connects™ for January 26, 2022
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2023-01-26-mlnc

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 articles, educational tools, booklets, fact sheets, web-based training courses (many of which offer continuing education credits) – all available to you free of charge!

You can find links to the following resources on the CMS MLN web page at:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo

- Publications & Multimedia
- Events & Training
- News & Updates
- Association Continuing Education Credit

MLN Connects Electronic Mailing List
Subscribe to the MLN Connects weekly email newsletter for all national Fee-for-Service (FFS) program news, including MLN Matters Article and MLN product updates.

To subscribe to the service:
1. Go to https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819. Enter you email address and select Submit.
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.

CMS Provider Minute Videos

The Medicare Learning Network has a series of CMS Provider Minute Videos (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia) on a variety of topics, such as psychiatry, preventive services, lumbar spinal fusion, and much more. The videos offer tips and guidelines to help you properly submit claims and maintain sufficient supporting documentation. Check the site often as CMS adds new videos periodically to further help you navigate the Medicare program.

Get Your Railroad Medicare News Electronically

Register now to receive customized daily or weekly emails on the latest Medicare news and Palmetto GBA features.

How to register to receive Palmetto GBA Railroad Medicare email updates:
Subscribing to our email updates is quick, easy and free! Go to https://tinyurl.com/RailroadMedicareEmailUpdates. Enter your email address and select the topics you are interested in receiving updates about. Complete the CAPTCHA equation and submit.

Note: After you click "Submit", a confirmation email will be sent to your email address. Please use the link provided in the email to confirm your registration.

PTAN Lookup and Request Tool

Want to verify if you have a Railroad Medicare Provider Transaction Access Number (PTAN)? Need to request a Railroad Medicare PTAN for new provider? You can do both through our "PTAN Lookup and Request Tool" at https://www.PalmettoGBA.com/RR/PTAN. This tool first validates the provider identification information you enter — local Part B MAC PTAN, National Provider Identifier (NPI) and Tax Identification Number (TIN) — against enrollment information in our files. If a match is found, the tool retrieves and releases the Railroad Medicare PTAN. If a match is not found, the tool gives providers the option to request a new Railroad Medicare PTAN.

Please review the following resources before using the PTAN Tool:

- Using Railroad Medicare's online "PTAN Lookup and Request Tool" https://www.palmettogba.com/palmetto/rr.nsf/DID/AK7K447304
- Railroad Medicare PTAN Lookup and Request Tool FAQs https://www.palmettogba.com/palmetto/rr.nsf/DID/KB6799Q6E8

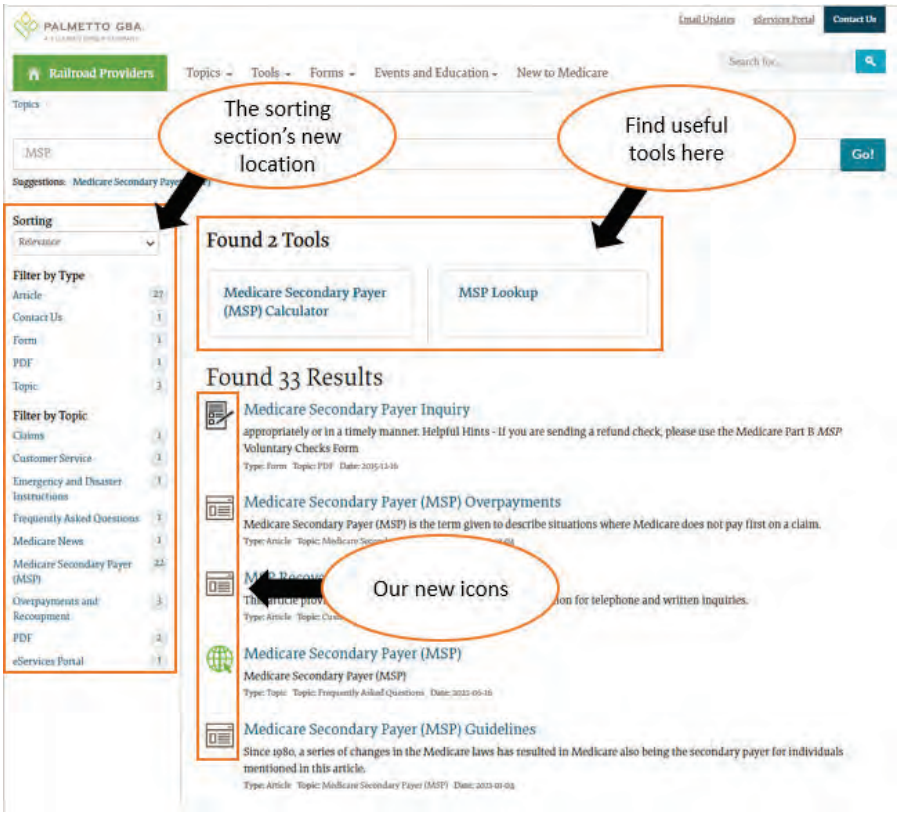
We Made Exciting Changes to Your Search Experience

Palmetto GBA is pleased to announce improvements to our website's search engine. While the function and location of our search tool will remain the same, we have added features to make the search experience more intuitive. These include:

- Our sorting section is migrating from the right-hand to the left-hand side of the screen. The section itself is also revamped to make it easier to locate the information you need.
- We have created new, user-friendly icons to help you quickly navigate search results
- Useful results and tools are now shown at the top of the page, making locating these features less of a hassle

These enhancements were made with you in mind. Palmetto GBA strives to improve the customer experience based on the feedback we receive from our providers.

Our new look is below:



Keep Your Railroad Medicare Enrollment Record Up to Date

As a Medicare provider, you are responsible for notifying Medicare of changes to the information in your Medicare enrollment record, including provider name and address changes. Incorrect information in your enrollment file could lead to claim rejections or correspondence being delivered to an incorrect address.

Railroad Medicare does not automatically receive updates you make to your enrollment record with your Part B Medicare Administrative Contractor (MAC). Please notify Railroad Medicare promptly of any enrollment changes once those changes have been made by your Part B MAC.

Types of Enrollment Changes to Report to Railroad Medicare include:

- Provider name changes
- Practice name changes
- Billing address changes
- Practice address changes
- Practice location added (only if the additional practice location is in a different contractor locality, or you have been assigned a new NPI for the location)
- Provider has retired
- Provider has left group

Railroad Medicare cannot accept enrollment changes by telephone. You can find instructions for faxing or mailing enrollment changes to Railroad Medicare on our Provider Enrollment Update an Enrollment Record webpage at https://www.palmettogba.com/palmetto/rr.nsf/DID/H4AZXTC6NU.

Using ePass in the Railroad Medicare Interactive Voice Response (IVR) Unit

Provider authentication by Provider Transaction Access Number (PTAN), National Provider Identifier (NPI) and Tax Identification Number (TIN) is required before the Palmetto GBA Interactive Voice Response (IVR) Unit is authorized to release Railroad Medicare claim status information, financial information, patient eligibility information, or to order a copy of a remittance advice.

An “ePass” is an eight-digit code you will be prompted to receive or enter each time you choose the IVR options for claims, finance, eligibility or duplicate remittance advice. When you choose option 2 to receive an ePass, you will be assigned an ePass code for the provider’s PTAN/NPI/TIN combination you enter. You can then enter that ePass in the IVR for the remainder of the day in order to authenticate that provider. This eliminates the need to repeatedly enter the same PTAN, NPI and TIN into the IVR.

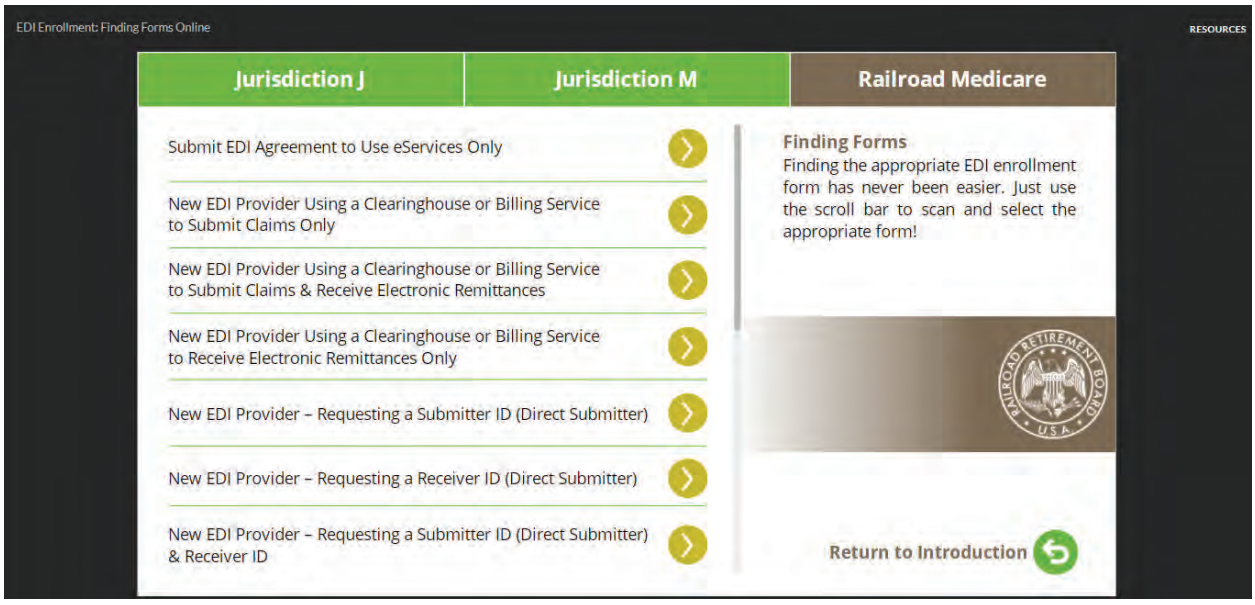
The goal of the ePass is to ease provider burden by eliminating the need to repeatedly authenticate the same provider each time you contact the IVR in a given day.

We hope this service will be effective and helpful to you.

Electronic Data Interchange (EDI) Enrollment: Help Completing Online Forms

Did you know Palmetto GBA offers online enrollment to our Electronic Data Interchange (EDI)? The EDI Online Enrollment Tool allows you to submit the EDI enrollment forms electronically online. Once the forms have been completed, you will receive a tracking number. This tracking number can be used to check the status of your request using our EDI Request for Enrollment Status Tool. Please allow 15 days for processing before checking status.

Our new EDI Enrollment: Finding Forms Online interactive tool provides a quick shortcut to all of the forms you need for enrollment. To get started on the tool, choose the Railroad Medicare tab. Then choose from the list of actions. Click on the yellow arrow icon to see a list of the answers you will need to select on the EDI Online Enrollment Tool for the action selected.



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If you need additional assistance completing EDI enrollment, Palmetto GBA has dedicated representatives available to provide technical assistance and answer questions about EDI. Our Provider Contact Center (PCC) representatives can be reached at 888-355-9165 (Monday – Friday, 8:30 a.m. to 4:30 p.m. ET for all time zones with the exception of PT, which receives services from 8 a.m. to 4 p.m.).

To connect with an EDI representative, select option 2 from the main menu for EDI/eServices. Then select option 0 for technical assistance with electronic billing, electronic remittance advice (ERA) and other EDI issues.

EDI representatives are also available to chat when the green "Chat Now" icon is visible in the lower right corner of an EDI resource webpage.

EDI Online Enrollment Tool -
https://www.palmettogba.com/internet/PCIDN.nsf/R?OpenAgent&DID=BXEPDW14&url=yes

EDI Enrollment: Finding Forms Online Tool –
https://www.palmettogba.com/internet/PCIDN.nsf/R?OpenAgent&DID=C7QGRA26&url=yes

EDI Request for Enrollment Status Tool –
https://www.palmettogba.com/internet/PCIDN.nsf/R?OpenAgent&DID=BBJQE954&url=yes&v3=yes

Online Options for Researching, Refunding and Requesting Offsets of Overpayments

Need information about an overpayment? Looking for an alternative to sending an overpayment refund by check? Use our eServices Financial Tools!

Our Overpayment Data function allows you to check for overpayment balances, adjustment details, collections, and recoupments online. To show you how beneficial this tool is, we are providing you with a short video walkthrough of the benefits and features of our Overpayment Data function. We hope you enjoy this visual and see how a small part of eServices can be of great service to you. You can find the video demo here: https://palmettogba.com/palmetto/rr.nsf/DID/7GZUWJTJTI.

In addition to researching your overpayments online, you can use the following eServices Financial Forms:

- Use the eServices eCheck function to send payments electronically via ACH to Palmetto GBA
- Use the eOffset function to request an immediate offset when you receive a demanded overpayment or make a permanent request for all future demanded overpayments

You can find details about using these helpful Financial Tools in the eServices User Manual at http://www.palmettogba.com/eservicesuserguide.

eDelivery Reminder: Are You Getting Your Greenmail?

Palmetto GBA would like to remind providers that you have the option to receive letters electronically through eServices. Gaining access to these letters is a simple process! To start receiving your Medicare letters, such as Medical Review Additional Documentation Request (ADR) letters and first level appeal Medicare Redetermination Notices (MRNs) electronically, you must be signed up for our eServices online provider portal. Once you have signed into eServices, select the Admin tab, next you can choose your eDelivery preferences. Just click the drop down box to choose eDelivery of the letters you would like to receive via greenmail. You can also select "User Email Notification" to start receiving emails when your letters are available in eServices for you. Selecting this choice is so easy and allows you to receive your letters faster!

With the resumption of Targeted Probe and Educate (TPE) reviews on September 1, 2021, providers with an active eServices account will automatically receive their TPE notification letters, TPE ADR letters and TPE review results letters via eDelivery.

Once you have chosen the eDelivery option, all of the letters you selected will come to you electronically, even if you sent in your request via fax or mail.

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 888-355-9165 (Monday – Friday, 8:30 a.m. to 4:30 p.m. ET for all time zones with the exception of PT, which receives services from 8 a.m. to 4 p.m.).

To connect with an eServices representative:

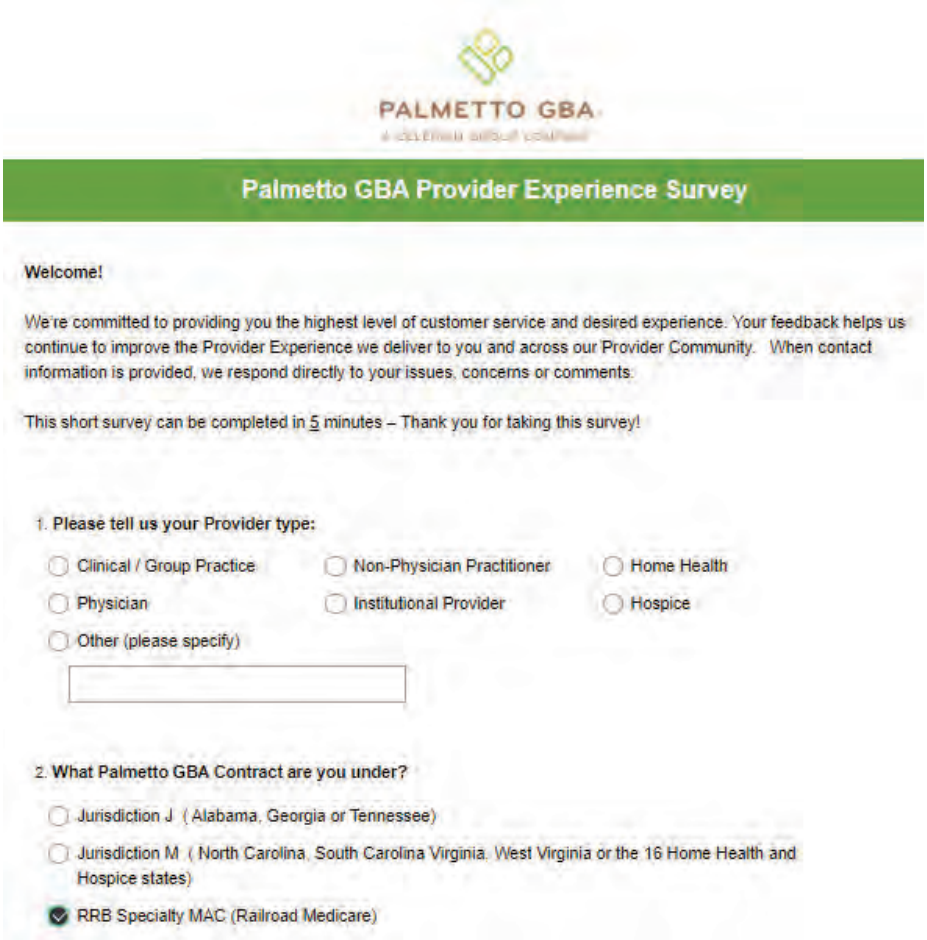
- Press 2 for EDI/eServices, then
- Press 1 for eServices inquiries

Tell Us What You Think of Our Service

If your experience with Railroad Medicare was awesome or not, we'd like to hear from you! Telling us what we do well lets us know what we should keep doing, and telling us how we can improve gives us room to grow. Just visit our website and take our Palmetto GBA/Railroad Medicare Provider Experience survey at https://www.surveymonkey.com/r/JPYHTDN. Here you can provide feedback on your most recent interaction with Railroad Medicare that occurred via telephone, chat, email, mail or social media (Facebook, Twitter or LinkedIn). We value your comments and opinions, and we look forward to a culture of continuous improvement in the way we conduct business and serve our customers.

Our survey has eight easy questions and takes about three minutes to complete (if that). Those three minutes can help us coach a Palmetto GBA team member to give a customer an awesome experience every time they contact Railroad Medicare.

We thank you in advance for your participation!


PALMETTO GBA

Palmetto GBA Provider Experience Survey

Welcome!

We're committed to providing you the highest level of customer service and desired experience. Your feedback helps us continue to improve the Provider Experience we deliver to you and across our Provider Community. When contact information is provided, we respond directly to your issues, concerns or comments.

This short survey can be completed in 5 minutes – Thank you for taking this survey!

1. **Please tell us your Provider type:**

- ○ Clinical / Group Practice
- ○ Non-Physician Practitioner
- ○ Home Health
- ○ Physician
- ○ Institutional Provider
- ○ Hospice
- ○ Other (please specify)

2. **What Palmetto GBA Contract are you under?**

- ○ Jurisdiction J (Alabama, Georgia or Tennessee)
- ○ Jurisdiction M (North Carolina, South Carolina Virginia, West Virginia or the 16 Home Health and Hospice states)
- ● RRB Specialty MAC (Railroad Medicare)

Railroad Medicare Customer Information and Outreach

Important Telephone Numbers

Interactive Voice Response (IVR) System
877-288-7600

Provider Contact Center
888-355-9165

Telephone Reopenings
888-355-9165

Electronic Data Interchange (EDI)
Technical Support
888-355-9165

Provider Enrollment
888-355-9165

Palmetto GBA
Railroad Medicare
P.O. Box 10066
Augusta, GA 30999-0001

www.PalmettoGBA.com/RR

Beneficiary Contact Center
800-833-4455
TTY 877-566-3572