July 2024
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# RAILROAD MEDICARE ADVISORY

Latest Part B News for Railroad Medicare

## What's Inside...



Continued >>

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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**.



A RRB-Contracted Specialty Medicare Administrative Contractor

PALMETTO GBA®
A CELERIAN GROUP COMPANY

## Ambulatory Surgical Center



## Fee Schedule and Reimbursement



## CMS MLN Information



## Self-Service Tools

# 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.

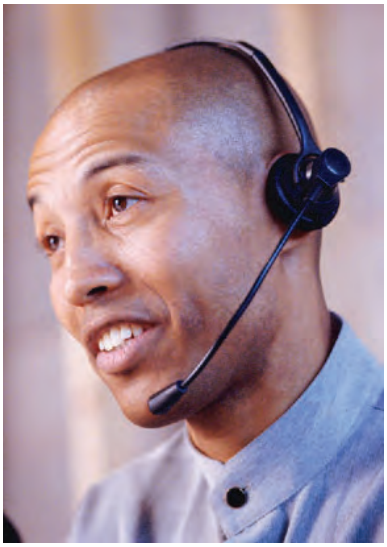
**You will be asked to provide the following information about the beneficiary:**

- 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.



# 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 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 |
|---|---|
| July 4, 2024 | Office closed / Independence Day |
| July 12, 2024 | PCC closed for training / 9:30 a.m. to 1:30 p.m. |
| July 26, 2024 | PCC closed for training / 9:30 a.m. to 1:30 p.m. |
| September 2, 2024 | Office closed / Labor Day |
| November 28, 2024 | Office closed / Thanksgiving Day |
| November 29, 2024 | Office closed / Day After Thanksgiving |
| December 24, 2024 | Office closed / Christmas Eve |
| December 25, 2024 | 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?

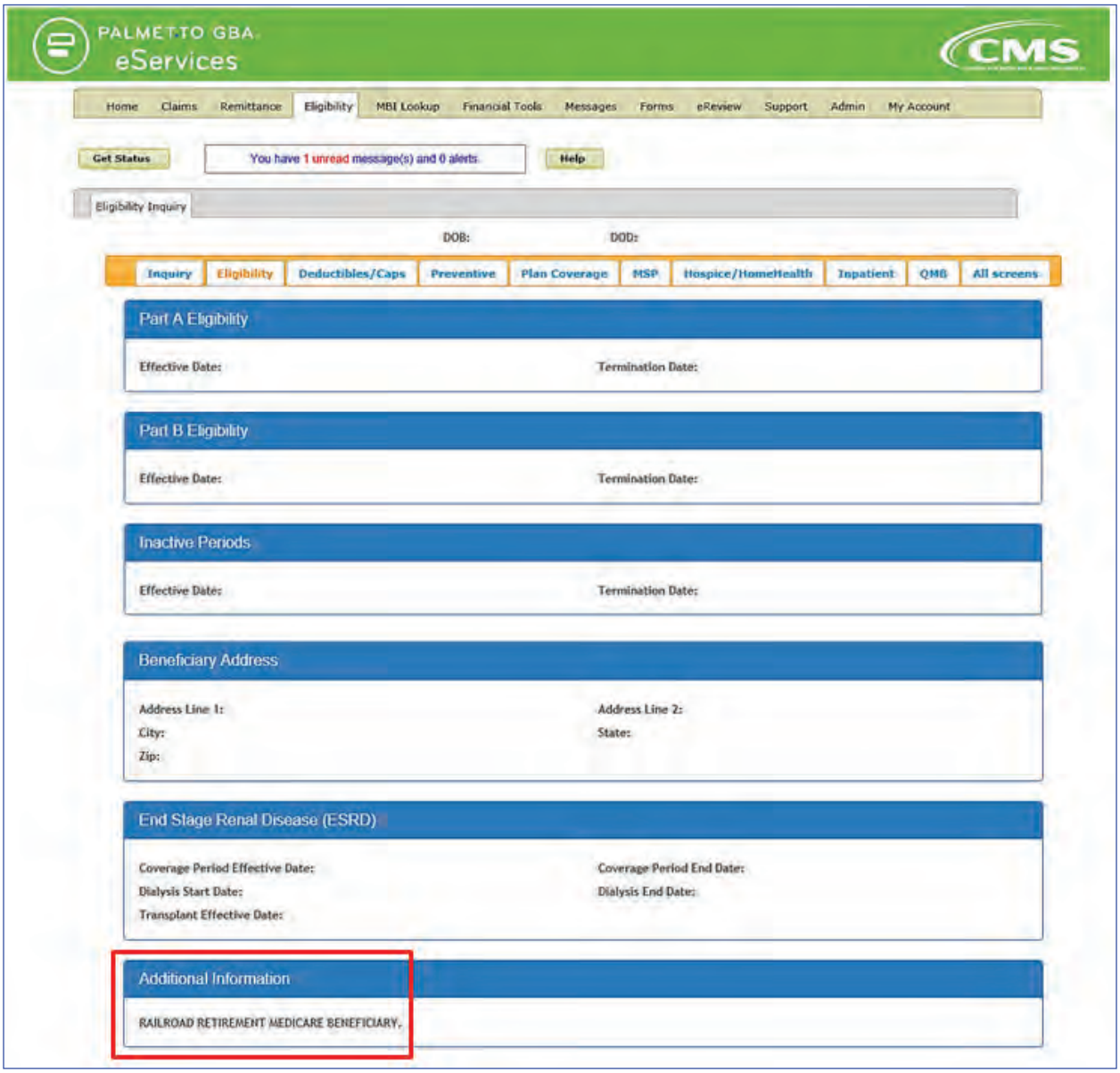
Railroad Medicare beneficiaries historically have had unique Medicare numbers, which made them easily distinguishable from Social Security Medicare patients. With today's Medicare Beneficiary Identifiers (MBIs), the you can't tell the difference by the MBI. Instead, the difference lies in the design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

Continued >>




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

- MBI website: https://www.cms.gov/Medicare/New-Medicare-Card/index


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

**Don’t Miss this Wonderful Opportunity!**

If you are in search of an opportunity to interact with and get answers to your Medicare billing, coverage and documentation questions from Palmetto GBA’s Provider Outreach and Education (POE) department, please see these educational offerings which have a question and answer session:

**CMS National Provider Enrollment Conference in San Diego - August 28 and 29**

Wednesday, August 28 & Thursday, August 29, from 8 am – 5 pm PT.

Register for the CMS National Provider Enrollment Conference at the San Diego Convention Center. Take advantage of this opportunity to meet with CMS and Medicare Administrative Contractor provider enrollment experts.
https://med.noridianmedicare.com/web/medicare/national-provider-enrollment-conference

# Palmetto GBA Educational Webinars Are Now In the Cvent Platform

Palmetto GBA is excited to announce that our online education events are now exclusively on the Cvent platform. Cvent is a national company that offers a multitude of event resources.

Registration through Cvent will have a new look but the information required to register for webinars will be the same. There are many benefits to you with this change to Cvent. The Cvent platform will provide the same look and feel for all events, allow for increased engagement, and after an initial registration is complete, your next registration will auto populate text fi elds making future event registration quick and easy. Cvent also allows us to create a new library of recorded webinars available. Many of the ON24 and Teams webinars will be rerecorded and placed into our new library to supply the most current and updated information.

Please select the link below to view step-by-step instructions that walk you through the process of registering for and then accessing a webinar in the Cvent Attendee Hub.

**Webinars 101** https://palmettogba.com/internet/eLearn6.nsf/Webinars101/story.html

# HCPCS Codes & Clinical Laboratory Improvement Amendments Edits: October 2024

Related CR Release Date: May 23, 2024
Effective Date: October 1, 2024
Implementation Date: October 7, 2024
MLN Matters Number: MM13620
Related Change Request (CR) Number: CR 13620 https://www.cms.gov/files/document/r12653CP.pdf
Related CR Transmittal Number: R12653CP
Related CR Title: Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits

**Affected Providers**
- Laboratories
- Physicians
- Hospitals billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients

**Action Needed**
Make sure your billing staff knows about:
- Discontinued HCPCS codes
- New HCPCS codes
- HCPCS codes subject to and excluded from CLIA edits

**Background**
The CLIA regulations require a facility to be appropriately certified for each test it performs. To make sure that Medicare & Medicaid only pay for laboratory tests performed in certified facilities, CMS edits each claim for a HCPCS code that's considered a CLIA laboratory test at the CLIA certificate level.

We discontinued the following HCPCS codes on October 1, 2023:

- 0357U - Artificial intelligence (AI)-enabled evaluation of 142 pairs of glycopeptide and product fragments in plasma to determine benefit from immunotherapy agents for skin cancer
- 0386U - Testing for risk of Barrett's esophagus progression to esophageal cancer
- 0397U - Cell-free DNA testing in plasma evaluating of at least 109 genes in non-small cell lung cancer.

We discontinued the following HCPCS codes on April 1, 2024:

- 0354U - Human papilloma virus (HPV), high-risk types (ie, 16, 18, 31, 33, 45, 52 and 58) qualitative mRNA expression of E6/E7 by quantitative polymerase chain reaction (qPCR)
- 0416U - Infectious agent detection by nucleic acid (DNA), genitourinary pathogens, identification of 20 bacterial and fungal organisms, including identification of 20 associated antibiotic-resistance genes, if performed, multiplex amplified probe technique, urine

We discontinued the following HCPCS codes on July 1, 2024:

Continued >>

- 0204U - Oncology (thyroid), mRNA, gene expression analysis of 593 genes (including BRAF, RAS, RET, PAX8, and NTRK) for sequence variants and rearrangements, utilizing fine needle aspirate, reported as detected or not detected
- 0353U - Infectious agent detection by nucleic acid (DNA), Chlamydia trachomatis and Neisseria gonorrhoeae, multiplex amplified probe technique, urine, vaginal, pharyngeal, or rectal, each pathogen reported as detected or not detected

The HCPCS codes that follow are all subject to CLIA edits. These lists don't include new HCPCS codes for waived tests or provider-performed microscopy procedures. These HCPCS codes all require a facility to have either a:

- CLIA certificate of registration - certificate type code 9
- CLIA certificate of compliance - certificate type code 1
- CLIA certificate of accreditation - certificate type code 3

A facility without a valid, current, CLIA certificate, with a current CLIA certificate of waiver (certificate type code 2) or with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4) isn't paid for these tests, unless a facility with a current certificate type code 2 or 4) bills the appropriate HCPCS service code with a QW modifier.

We added these HCPCS codes on April 1, 2023, and they're subject to CLIA edits:

- 0364U - Genomic sequence testing for presence or absence of cancer cells after treatment in leukemia or lymphoma
- 0365U - Test for 10 protein biomarkers for bladder cancer
- 0366U - Test for 10 protein biomarkers for recurrent bladder cancer
- 0367U - Test for 10 protein biomarkers for rapid recurrent, recurrent, or persistent bladder cancer after bladder surgery to remove a tumor
- 0368U - Test for risk of colorectal cancer
- 0369U - Test for 31 stomach and intestinal pathogens and identification of 21 antibiotic resistant genes
- 0370U - Test for 34 surgical wound microorganisms and identification of 21 antibiotic resistant genes
- 0371U - Test for 16 genitourinary bacterial organisms and 1 genitourinary fungal organism
- 0372U - Test for genitourinary pathogen antibiotic-resistance genes • 0373U - Test for 17 bacteria, 8 fungus, 13 virus, and 16 antibiotic-resistance genes associated with respiratory infection
- 0374U - Test for 21 bacterial and fungal genitourinary pathogens and identification of 21 associated antibiotic-resistance genes
- 0375U - Test for proteins to determine risk for ovarian cancer
- 0376U - Test to determine potential risk of prostate cancer spread and mortality
- 0377U - Test of lipoprotein profile in cardiovascular disease
- 0378U - Test for RFC1 (replication factor C subunit 1) in neurological conditions
- 0379U - Genomic testing for solid organ cancer
- 0380U - Test for adverse drug reactions and drug response
- 0381U - Test for monitoring maple syrup urine disease
- 0382U - Test for monitoring hyperphenylalaninemia
- 0383U - Test for monitoring tyrosinemia type I
- 0384U - Test for predictive risk of progression of high-stage kidney disease

Continued >>

- 0385U - Testing for risk of developing diabetic kidney disease

We added these HCPCS codes on July 1, 2023, and they're subject to CLIA edits.

- 0387U - Tissue evaluation for proteins to report risk of skin cancer progression
- 0388U - Next-generation sequencing in plasma of 37 cancer-related genes, with report for alteration detection in non-small cell lung cancer
- 0389U - Reverse transcription polymerase chain reaction (RT-qPCR) testing of blood for proteins, reported as a risk score for Kawasaki disease
- 0390U - Immunoassay of serum for proteins, reported as a risk score for preeclampsia;
- 0391U - DNA and RNA next-generation sequencing of tissue for 437 genes with algorithm quantifying immunotherapy response score
- 0392U - Evaluation of gene-drug interactions for 16 genes reported as impact of gene-drug interaction for each drug for depression, anxiety, attention deficit disorder
- 0393U - Detection of protein by seed amplification assay for neurological disorders;
- 0394U - Testing of plasma or serum for 16 perfluoroalkyl substances (PFAS) compounds
- 0395U - Multi-omics testing of plasma reported as risk of malignancy for lung nodules in early-stage lung cancer
- 0396U - Microarray testing of embryonic tissue for 300000 DNA single-nucleotide polymorphisms (SNPs), reported as a probability for single-gene germline conditions in pre-implantation genetic testing
- 0398U - DNA methylation analysis using polymerase chain reaction testing of tissue for genes specific to Barrett esophagus, reported as a risk score for progression to high grade dysplasia or cancer
- 0399U - Enzyme-linked assay detection in serum of IgG-binding antibody and blocking autoantibodies, using a functional blocking assay for IgG or IgM reported as positive or not detected in cerebral folate deficiency
- 0400U - Next-generation sequencing of DNA for 145 genes reported as carrier positive or negative in expanded carrier screening
- 0401U - Targeted variant genotyping using blood, saliva, or buccal swab of 9 genes for coronary heart disease reported as a risk score for a coronary event

We added these HCPCS codes on October 1, 2023, and they're subject to CLIA edits.

- 0402U - Detection of organisms causing sexually transmitted infection by multiplex amplified probe technique
- 0403U - mRNA expression profiling of 18 genes to detect potential risk of prostate cancer
- 0404U - Analysis of serum using immunoassay technique for thymidine kinase activity in breast cancer
- 0405U - Sequencing of methylation haplotype block markers in plasma in pancreatic cancer
- 0406U - Flow cytometry detection of 5 markers in sputum to evaluate potential for lung cancer
- 0407U - Measurement of soluble tumor necrosis factor receptor 1 (sTNFR1), soluble tumor necrosis receptor 2 (sTNFR2), and kidney injury molecule 1 (KIM-1) to evaluate risk of progressive decline in kidney function in diabetic chronic kidney disease
- 0408U - Detection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) by bulk acoustic wave biosensor immunoassay
- 0409U - Next-generation sequencing of DNA (80 genes) and RNA (39 genes) in plasma showing mutations and clinical actionability in solid tumor cancers
- 0410U - Whole genome sequencing of DNA in whole blood or plasma to detect pancreatic cancer

Continued >>

- 0411U - Genomic analysis of 15 genes to evaluate for psychiatric disorders
- 0412U - Measurement of AB42/40 ratio in plasma to evaluation for brain amyloid pathology
- 0413U - Optical genome mapping of DNA in blood or bone marrow for changes in copy number alterations, aneuploidy, and balanced/complex structural rearrangements in blood and lymphatic system abnormal tissue
- 0414U - Whole slide imaging analysis for 8 genes for evaluation of lung cancer
- 0415U - Test of biomarkers in blood combined with patient factors to determine a 5-year risk score for acute coronary syndrome
- 0417U - Whole genome sequence analysis of 335 nuclear genes in blood or saliva for detection of abnormalities associated with rare constitutional/heritable diseases
- 0418U - Image analysis of breast cancer cell specimen with autonomous assessment
- 0419U - Genomic sequence analysis of 13 genes in saliva for evolution of psychiatric disorders

We added these HCPCS codes on January 1, 2024, and they're subject to CLIA edits.

- 0420U - Oncology (urothelial), mrna expression profiling by real-time quantitative pcr of mdk, hoxa13, cdc2, igfbp5, and cxcr2 in combination with droplet digital pcr (ddpcr) analysis of 6 single-nucleotide polymorphisms (snps) genes tert and fgfr3, urine, algorithm reported as a risk score for urothelial carcinoma
- 0421U - Oncology (colorectal) screening, quantitative real-time target and signal amplification of 8 rna markers (gapdh, smad4, acy1, areg, cdh1, kras, tnfrsf10b, egln2) and fecal hemoglobin, algorithm reported as a positive or negative for colorectal cancer risk
- 0422U - Oncology (pan-solid tumor), analysis of dna biomarker response to anti-cancer therapy using cell-free circulating dna, biomarker comparison to a previous baseline pre-treatment cell-free circulating dna analysis using next-generation sequencing, algorithm reported as a quantitative change from baseline, including specific alterations, if appropriate
- 0423U - Psychiatry (eg, depression, anxiety), genomic analysis panel, including variant analysis of 26 genes, buccal swab, report including metabolizer status and risk of drug toxicity by condition
- 0424U - Oncology (prostate), exosome-based analysis of 53 small noncoding rnas (sncrnas) by quantitative reverse transcription polymerase chain reaction (rt-qpcr), urine, reported as no molecular evidence, low-, moderate- or elevated-risk of prostate cancer
- 0425U - Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis, each comparator genome (eg, parents, siblings)
- 0426U - Genome (eg, unexplained constitutional or heritable disorder or syndrome), ultra-rapid sequence analysis
- 0427U - Monocyte distribution width, whole blood (list separately in addition to code for primary procedure)
- 0428U - Oncology (breast), targeted hybrid-capture genomic sequence analysis panel, circulating tumor dna (ctdna) analysis of 56 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability, and tumor mutation burden
- 0429U - Human papillomavirus (hpv), oropharyngeal swab, 14 high-risk types (ie, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, and 68)
- 0430U - Gastroenterology, malabsorption evaluation of alpha-1-antitrypsin, calprotectin, pancreatic elastase and reducing substances, feces, quantitative
- 0431U - Glycine receptor alpha1 igg, serum or cerebrospinal fluid (csf), live cell-binding assay (lcba), qualitative
- 0432U - Kelch-like protein 11 (klhl11) antibody, serum or cerebrospinal fluid (csf), cell-binding assay, qualitative

Continued >>

- 0433U - Oncology (prostate), 5 dna regulatory markers by quantitative pcr, whole blood, algorithm, including prostate-specific antigen, reported as likelihood of cancer
- 0434U - Drug metabolism (adverse drug reactions and drug response), genomic analysis panel, variant analysis of 25 genes with reported phenotypes
- 0435U - Oncology, chemotherapeutic drug cytotoxicity assay of cancer stem cells (cscs), from cultured cscs and primary tumor cells, categorical drug response reported based on cytotoxicity percentage observed, minimum of 14 drugs or drug combinations
- 0436U - Oncology (lung), plasma analysis of 388 proteins, using aptamer-based proteomics technology, predictive algorithm reported as clinical benefit from immune checkpoint inhibitor therapy
- 0437U - Psychiatry (anxiety disorders), mrna, gene expression profiling by rna sequencing of 15 biomarkers, whole blood, algorithm reported as predictive risk score
- 0438U - Drug metabolism (adverse drug reactions and drug response), buccal specimen, gene-drug interactions, variant analysis of 33 genes, including deletion/duplication analysis of cyp2d6, including reported phenotypes and impacted gene-drug interactions
- 81457 - Genomic sequence analysis panel of DNA for microsatellite instability in solid organ abnormal growth of tissue
- 81458 - Genomic sequence analysis panel of DNA for microsatellite instability and copy number of variants in solid organ abnormal growth of tissue
- 81459 - Genomic sequence analysis panel of DNA or combined DNA and RNA for copy number variants, microsatellite instability, tumor mutation burden, and rearrangements in solid organ abnormal growth of tissue
- 81462 - Genomic sequence analysis of DNA or combined DNA and RNA in plasma for copy number variants and rearrangements in solid organ abnormal growth of tissue
- 81463 - Genomic sequence analysis of DNA in plasma for copy number variants and microsatellite instability in solid organ abnormal growth of tissue
- 81464 - Genomic sequence analysis of DNA or combined DNA and RNA in plasma for copy number variants, microsatellite instability, tumor mutation burden, and rearrangements in solid organ abnormal growth of tissue
- 81517 - Test for detecting 3 biomarkers associated with risk for liver disease
- 82166 - Test for anti-mullerian hormone
- 86041 - Test for acetylcholine receptor binding antibody
- 86042 - Test for acetylcholine receptor blocking antibody
- 86043 - Test for acetylcholine receptor modulating antibody
- 86366 - Test for muscle-specific kinase antibody

We added these HCPCS codes on April 1, 2024, and they're subject to CLIA edits.

- 0439U - Crd chd dna alys 5 snp 3 dna
- 0440U - Crd chd dna alys 10 snp 6dna
- 0441U - Nfct ds bct fngl/viral semiq
- 0442U - Nfct ds respir nfctj mxachar_error
- 0443U - Neurflmnt lt chn ultrsens ia
- 0444U - Onc sld orgn neo tgsap 361
- 0445U - Abeta42 & ptau181 eclia csf
- 0446U - Ai ds sle alys 10 cytokine

Continued >>

- 0447U - Ai ds sle alys 11 cytokine
- 0448U - Onc lng&cln ca dna qual ngs
- 0449U - Car scr sev inh cond 5 genes

We're adding these HCPCS codes on July 1, 2024, and they're subject to CLIA edits.

- 0450U - ONC MM LC-MS/MS MONOC P-PRTN
- 0451U - ONC MM LC-MS/MS PEP ION QUAN
- 0452U - ONC BLDR MTHYL PENK LTE-QMSP
- 0453U - ONC CLRCT CA CFDNA QPCR ASY
- 0454U - RARE DS ID OPT GENOME MAPG
- 0455U - NFCT AGT STI MULT AMP PRB UR
- 0456U - AI RA NGS 19 GENES ANTI-CCP
- 0457U - PFAS 9 CMPND LCMS/MS PLS/SR
- 0458U - ONC BRST CA S100 A8&A9 ELISA
- 0459U - ABETA42 & TTAU ECLIA CSF
- 0460U - ONC WHL BLD/BUCC RTPCR 24GEN
- 0461U - ONC RXGENOM ALYS RTPCR 24GEN
- 0462U - MELATONIN LVL TST SLP STD7/9
- 0463U - ONC CRVX MRNA GENXPRSN 14BMK
- 0464U - ONC CLRCT SCR QRTSA DNA MRK
- 0465U - ONC URTHL CARC DNA QMSP 2GEN
- 0466U - CRD CAD DNA GWAS 564856 SNP
- 0467U - ONC BLDR DNA NGS 60GENchar_error
- 0468U - HEP NASH MIR34A5P .2M YKL40
- 0469U - RARE DS WHL GEN SEQ FTL SAMP
- 0470U - ONC OROP DETCJ MRD 8 DNA HPV
- 0471U - ONC CLRC CA 35 VRN KRASchar_error
- 0472U - CA VI PSP&SP1 ANTB SJÖGREN
- 0473U - ONC SLD TUM BLD/SLV 648 GENE
- 0474U - HERED PAN CA GSAP 88GENE NGS
- 0475U - HERED PRST8 CA GSAP 23 GENES

CR 13620 doesn't rescind or replace any previous instructions indicating that a laboratory with a valid CLIA certificate of waiver or CLIA certificate for provider-performed microscopy procedures be allowed to bill the above codes with the QW modifier.

MACs won't search their files to either retract payment for claims already paid, or to retroactively pay claims. However, they'll adjust claims you bring to their attention.

**More Information**
We issued CR 13620 to your MAC as the official instruction for this change.

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

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**Document History**

| Date of Change | Description |
|---|---|
| May 23, 2024 | Initial article released. |

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# Clinical Laboratory Fee Schedule & Laboratory Services Reasonable Charge Payment: Quarterly Update

Related CR Release Date: May 24, 2024
Effective Date: July 1, 2024
Implementation Date: July 1, 2024
MLN Matters Number: MM13613 Revised
Related Change Request (CR) Number: CR 13613
https://www.cms.gov/files/document/r12657CP.pdf
Related CR Transmittal Number: R12657CP

Related CR Title: Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment

What's Changed: We made no substantive changes to the Article other than to update the web address of the CR transmittal.

**Affected Providers**
- Physicians
- Hospitals
- Suppliers
- Other providers billing Medicare Administrative Contractors (MACs) for laboratory services they provide to Medicare patients

**Action Needed**
Make sure your billing staff knows about:
- Next private payor data reporting period of January 1, 2025 – March 31, 2025
- New and deleted HCPCS codes

**Background**

**Next CLFS Data Reporting Period for Clinical Diagnostic Laboratory Tests—DELAYED**

On November 16, 2023, Section 502 of the Further Continuing Appropriations and Other Extensions Act of 2024 https://www.congress.gov/bill/118th-congress/house-bill/6363 delayed data reporting requirements for clinical diagnostic laboratory tests (CDLTs) that aren't advanced diagnostic laboratory tests (ADLTs). It also delayed the phase-in of payment reductions under the CLFS from private payor rate implementation.

- The next data reporting period is January 1, 2025 – March 31, 2025. It will be based on the original data collection period of January 1, 2019 – June 30, 2019.
- We'll apply a 0% payment reduction for CY 2024 so that a CDLT that isn't an ADLT may not be reduced compared to the payment amount for that test in CY 2023. For CYs 2025-2027, payment may not be reduced by more than 15% per year compared to the payment amount established for a test the preceding year.
- After the next data reporting period, there's a 3-year data reporting cycle for CDLTs that aren't ADLTs, for example, 2028, 2031.

Continued >>

**ADLTs**
See ADLT Information
https://www.cms.gov/medicare/payment/fee-schedules/clinical-laboratory-fee-schedule-clfs/adlt-information for more information about these tests.

**New Codes Effective July 1, 2024 – Proprietary Laboratory Analysis (PLAs) and Additional New Codes**

See Tab A https://www.cms.gov/files/document/r12657cp.pdf of the table in CR 13613 for a list of new codes along with their short and long descriptors and type of service codes. These new codes are MAC-priced, where applicable, until they're nationally priced through the CLFS annual payment determination process. MACs only price PLA codes for laboratories within their jurisdiction.

**Deleted Codes Effective July 1, 2024**

We're deleting CPT codes 0204U and 0353U as of July 1, 2024.

**Note**: Your MAC won't search its files to retract payment or retroactively pay claims. They'll adjust claims you bring to their attention.

**More Information**
We issued CR 13613 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 |
|---|---|
| May 24, 2024 | We made no substantive changes to the Article other than to update the web address of the CR transmittal. |
| May 3, 2024 | Initial article released. |

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https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Product-Disclaimer

# National Coverage Determination 200.3: Monoclonal Antibodies for the Treatment of Alzheimer's Disease

Related CR Release Date: May 23, 2024
Effective Date: April 7, 2022
Implementation Date: June 24, 2024
MLN Matters Number: MM13598
Related Change Request (CR) Number: CR 13598
https://www.cms.gov/files/document/r12649CP.pdf
Related CR Transmittal Number: R12649CP
Related CR Title: National Coverage Determination (NCD) 200.3 - Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (AD)

**Affected Providers**

- Physicians
- Hospitals
- Other providers billing Medicare Administrative Contractors (MACs) for treatment of AD in Medicare patients

**Action Needed**

Make sure your billing staff knows about:

- FDA-approved monoclonal antibodies
- Criteria for coverage
- Coding information
- Claims processing instructions

**Background**

CR 13598 implements revisions to NCD 200.3, by updating Section 412 of the Medicare Claims Processing Manual, Chapter 32 https://www.cms.gov/files/document/r12649CP.pdf, to include associated claims processing instructions.

Effective April 7, 2022, CMS covers FDA-approved monoclonal antibodies directed against amyloid for the treatment of AD when you provide it in accordance with the coverage criteria below, under Coverage with Evidence Development (CED) for patients who have a clinical diagnosis of Mild Cognitive Impairment (MCI) due to AD or mild AD dementia, both with confirmed presence of amyloid beta pathology consistent with AD. See CR 12950
https://www.cms.gov/files/document/r11692ncd.pdf, Transmittal 11692, dated November 2, 2022, in addition to this CR.

Clinical trials, studies, or registries under NCD 200.3 are designed around a specific therapy being studied, for example, J0174 for Leqembi, and are assigned differing National Clinical Trial
(NCT) numbers. The NCT number could be 06058234, for example, default 99999999 NCT number, or another NCT number assigned to another trial, study, or registry under NCD 200.3. Future therapies with FDA approval that fall under NCD 200.3 that don't have a dedicated HCPCS code would be identified either by existing unspecified HCPCS codes J3490, J3590, or a dedicated HCPCS code once it's assigned.

Continued >>

Effective with claims with dates of service of April 7, 2022, your MAC will accept claims with:

- ICD-10 diagnosis code Z00.6, along with 1 of the following diagnosis codes: G30.0, G30.1, G30.8, G30.9, G31.84, the Q0 or Q1 modifier, and condition code 30 (for institutional claims only).
- HCPCS J0174, Injection, lecanemab-irmb, 1 mg, (Leqembi®) or HCPCS J3490, J3590, or C9399 (for an FDA-approved therapy that's covered under NCD 200.3 that hasn't received a dedicated HCPCS code), or a dedicated HCPCS code, for any future FDA-approved therapies under NCD 200.3
- NCT 8-digit number or the default NCT number 99999999

Claims for monoclonal antibodies for the treatment of AD must be on types of bills 012X, 013X, or 085X.

MACs won't search for claims already processed, but they'll adjust claims you bring to their attention.

**More Information**

We issued CR 13598 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 |
|---|---|
| May 24, 2024 | Initial article released. |

# New Medicare Provider Specialty Codes (E1 and E2) and Payment for Marriage and Family Therapists and Mental Health Counselors

The purpose of this Change Request (CR) 13167 is (https://www.cms.gov/files/document/r12235otn.pdf) to establish new provider specialty codes and payment instructions for Marriage and Family Therapists and Mental Health Counselors, as authorized by Section 4121 of the Consolidated Appropriations Act, 2023. These payments begin January 1, 2024. All Marriage and Family Therapists and Mental Health Counselors billing Medicare will be required to enroll with Medicare.

# HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement: October 2024 Quarterly Update

Related CR Release Date: June 6, 2024
Effective Date: October 1, 2024
Implementation Date: October 7, 2024
MLN Matters Number: MM13661
Related Change Request (CR) Number: CR 13661
https://www.cms.gov/files/document/r12674CP.pdf
Related CR Transmittal Number: R12674CP
Related CR Title: October 2024 Quarterly Update to Healthcare Common Procedure Coding System (HCPCS) Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

**Affected Providers**
- SNFs
- Other providers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients

**Action Needed**
Make sure your billing staff knows about:
- Updates to the lists of HCPCS codes subject to the CB provision of the SNF prospective payment system (PPS)
- Additions and deletions of chemotherapy, customized prosthetic devices, and blood clotting factors from the Medicare Part A and Part B SNF files

Background
CMS periodically updates the lists of HCPCS codes excluded from the CB provision of the SNF PPS. We may pay providers, other than SNFs, for services excluded from SNF PPS and CB for patients, even in a SNF stay. Medicare won't pay for services not on the exclusion lists to any providers other than a SNF.

For non-therapy services, SNF CB applies only when you provide the services to a SNF resident during a covered Part A stay. However, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever provided to a SNF resident, regardless of whether Part A covers the stay. To make sure we make proper payment in all settings, Medicare systems must edit for services SNF patients get both included and excluded from SNF CB. The updated lists
https://www.cms.gov/medicare/coding-billing/skilled-nursing-facility-snf-consolidated-billing for institutional and professional billing are available.

**Part A File Updates Effective April 1, 2024**

**Major Category III. A. - Chemotherapy**
- J9075 - INJ, CYCLOPHOSPHAMIDE, NOS

Continued >>

- J9248 - INJ MELPHALAN (HEPZATO) 1 MG
- J9249 - INJ, MELPHALAN (APOTEX) 1 MG
- J9376 - INJ POZELIMAB-BBFG, 1 MG

Major Category III. D. – Customized Prosthetic devices
- L5783 - ADD LOW EXT MEC LIMB VOL SYS
- L5841 - ADDITION ENDOSKLETL KNEE-SHI

**Major Category III. E. – Certain Blood Clotting Factors:** J7165 - INJ, HUMAN-LANS,  PER I.U

**Deletion: Major Category III. A. – Chemotherapy**: J9070 - CYCLOPHOSPHAMIDE 100 MG INJ

**Part B File Updates Effective April 1, 2024**
This quarterly update includes additions to the Medicare Part B SNF CB files to add the following:

File 1
- J9075 - INJ, CYCLOPHOSPHAMIDE, NOS
- J9248 - INJ MELPHALAN (HEPZATO) 1 MG
- J9249 - INJ, MELPHALAN (APOTEX) 1 MG
- J9376 - INJ POZELIMAB-BBFG, 1 MG
- L5783 - ADD LOW EXT MEC LIMB VOL SYS
- L5841 - ADDITION ENDOSKLETL KNEE-SHI
- J7165 - INJ, HUMAN-LANS, PER I.U

**Deletion**: J9070 CYCLOPHOSPHAMIDE 100 MG INJ

**Note:** MACs won't search their files for incorrectly paid claims for HCPCS codes listed in CR 13661. They'll reopen and reprocess claims you bring to their attention.

**More Information**
We issued CR 13661 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 |
|---|---|
| June 6, 2024 | Initial article released. |

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# Medicare Benefit Policy Manual Update: DMEPOS Benefit Category Determinations

Related CR Release Date: June 13, 2024
Effective Date: January 1, 2024 - for 3 orthotic brace determinations; April 1, 2024 - for all other items, equipment and devices
Implementation Date: July 15, 2024
MLN Matters Number: MM13651
Related Change Request (CR) Number: CR 13651
https://www.cms.gov/files/document/r12684BP.pdf
Related CR Transmittal Number: R12684BP
Related CR Title: Manual Update Pub. 100-02 Medicare Benefit Policy, Chapter 15, Section 110.8 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Benefit Category Determinations

Affected Providers
- Physicians
- Suppliers
- Other providers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients

**Action Needed**
Make sure your billing staff knows about:
- Updates to Section 110.8, Medicare Benefit Policy Manual, Chapter 15
- Added DMEPOS items and their national benefit category determinations (BCDs)

**Background**
CR 13651 adds these DMEPOS items to the list of national BCDs in Chapter 15 https://www.cms.gov/files/document/r12684BP.pdf#page=4:

**Updated DMEPOS Benefit Category Determinations**

| ITEM | Benefit Category Determination | Effective Date |
|---|---|---|
| Addition, Endoskeletal Knee-Shin System, Polycentric, Pneumatic Swing, and Stance Phase Control | Prosthetic (Artificial Leg)-Prosthetic endoskeletal knee-shin system that provides pneumatic swing and stance control. | 4-1-24 |
| Addition to Lower Extremity, User Adjustable, Mechanical, Residual Limb Volume Management System | Prosthetic (Artificial Leg)-Added to a lower extremity prosthetic socket. | 4-1-24 |

Continued >>

| | | |
|---|---|---|
| Adhesive clip applied to the skin to secure external electrical nerve stimulator controller | Prosthetic Supply-Supply used with Prosthetic Device | 4-1-24 |
| Bilateral hip, knee, ankle, foot device, powered, includes pelvic component, single or double upright(s), knee joints any type, with or without ankle joints any type, includes all components and accessories, motors, microprocessors, sensors | Orthotic (Leg Brace)-Lower body exoskeleton system worn to enable ambulation for user with disorders such as paralysis. | 1-1-24 |
| Complex Rehabilitative Power Wheelchair Accessory, Power Seat Elevation System, Any Type | DME--Component of a complex rehabilitative power wheelchair that raises and lowers a user while in a seated position to varying amounts of vertical height. | 4-1-24 |
| Fertility cycle (contraception & conception) tracking software application, fda cleared, per month, includes accessories (e.g., thermometer) | No DMEPOS Benefit Category—Software applications (apps) are not devices, equipment, or supplies and do not fall under a DMEPOS benefit category. | 4-1-24 |
| Home Ventilator, dual-function respiratory device, also performs additional function of cough stimulation, includes all accessories, components and supplies for all functions | DME-- Assists with ventilation and cough stimulation and falls under the multi-function ventilator definition in 42 CFR section 414.222(f)(1). | 4-1-24 |
| Integrated lancing and blood sample testing cartridges for home blood glucose monitor, per month | DME--Supply used with Durable Medical Equipment. | 4-1-24 |
| Mechanical Vibration Device for Massage Stimulation | No DMEPOS Benefit Category--Mechanical vibration devices for massage stimulation are personal comfort items excluded from Medicare coverage by section 1862(a)(6) of the Social Security Act. | 4-1-24 |

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| | | |
|---|---|---|
| Fertility cycle (contraception & conception) tracking software application, fda cleared, per month, includes accessories (e.g., thermometer) | No DMEPOS Benefit Category—Software applications (apps) are not devices, equipment, or supplies and do not fall under a DMEPOS benefit category. | 4-1-24 |
| Neuromodulation Stimulator System, adjunct to rehabilitation therapy regime | DME--Neuromodulation stimulator device designed to assist with gait deficit. | 4-1-24 |
| Neuromodulation Stimulator System, adjunct to rehabilitation therapy regime, mouthpiece | DME--Supply used with Durable Medical Equipment | 4-1-24 |
| Pessary, disposable, any type | Prosthetic Device--Pessary for temporary, nonsurgical management of pelvic organ prolapse in females. | 4-1-24 |
| Powered upper extremity range of motion assist device, elbow, wrist, hand with single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated | Orthotic (Arm Brace)-Motorized, microprocessor controlled, elbow-wrist-hand device used for patients experiencing complications of stroke or other neurological/neuromuscular injury and illness. | 1-1-24 |
| Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocessor, sensors, all components and accessories, custom fabricated | Orthotic (Arm Brace)-Motorized, microprocessor controlled, elbow-wrist-hand-finger device used for patients experiencing complications of stroke or other neurological/neuromuscular injury and illness. | 1-1-24 |
| Rehab system with interactive Interface Providing Active Assistance in Rehabilitation Therapy, includes all components and accessories, motors, microprocessors, sensors | DME--Device provides rehabilitation to hand or foot. | 4-1-24 |
| Thoracic, pectus carinatum orthosis, sternal compression, rigid circumferential frame with anterior and posterior rigid pads, custom fabricated | Orthotic (Brace) | 4-1-24 |

Continued >>

| | | |
|---|---|---|
| Transcutaneous tibial nerve stimulator | DME--Device performs transcutaneous tibial nerve stimulation. | 4-1-24 |
| Upper extremity rehabilitation system providing active assistance to facilitate muscle re-education, include microprocessor, all components and accessories | DME--Device assists to facilitate muscle re-education. | 4-1-24 |
| Walker component for extra power to ambulate harder terrain outside the home, folding, adjustable or fixed height | No DMEPOS benefit category--Item assists with extra power to ambulate harder terrain outside the home (i.e. uphill, grassy field, longer distances). Item does not serve a medical purpose for use in the home. | 4-1-24 |

For claims for items and services billed using HCPCS codes for miscellaneous DMEPOS items and services (For example: A9999, B9999, E1399, K0108, L3999), the MACs will determine if the item or service falls within 1 of the benefit categories for DMEPOS and whether or not the item or service is excluded from coverage per Section 1862 of the Social Security Act https://www.ssa.gov/OP_Home/ssact/title18/1862.htm and other Medicare laws, regulations, and program instructions. These determinations are made on an individual, claim-by-claim basis.

**More Information**

We issued CR 13651 to your MAC as the official instruction for this change.
See the 2023 Second Biannual meeting information
http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/HCPCSPublicMeetings for more details on these new DMEPOS BCDs.

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

**Document History**

| Date of Change | Description |
|---|---|
| June 13, 2024 | Initial article released. |

# DMEPOS Fee Schedule: July 2024 Quarterly Update

Related CR Release Date: June 13, 2024
Implementation Date: July 1, 2024
Effective Date: July 1, 2024 - except for fee schedules for HCPCS codes E2298 and K1007 effective April 1, 2024
MLN Matters Number: MM13658
Related Change Request (CR) Number: CR 13658
https://www.cms.gov/files/document/r12685CP.pdf
Related CR Transmittal Number: R12685CP
Related CR Title: July Quarterly Update for 2024 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

**Affected Providers**

- Suppliers
- Other providers billing Medicare Administrative Contractors (MACs) for DMEPOS they provide to Medicare patients

**Action Needed**

Make sure your billing staff knows about:

- Updates to CY 2024 fee schedule amounts for new and existing DMEPOS codes
- Changes in payment policy
- New fee schedule information for HCPCS codes K1007 and E2298

**Background**

CMS updates the DMEPOS fee schedule quarterly to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies.
Sections 1834(a), (h), and (i) of the Social Security Act https://www.ssa.gov/OP_Home/ssact/title18/1834.htm (the Act) require payment for certain DMEPOS on a fee schedule basis. Payment on a fee schedule basis is a regulatory requirement at 42 CFR 414.102 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-C/section-414.102 for parenteral and enteral nutrition (PEN), splints, casts and intraocular lenses (IOLs) inserted in a physician's office. The DMEPOS and PEN fee schedule files contain HCPCS codes subject to fee schedule adjustments using information on the payment determined for these items under the DMEPOS Competitive Bidding Program (CBP), as well as codes that aren't subject to the CBP or fee schedule adjustments.

Effective January 1, 2024, the DMEPOS fee schedule file includes national payment amounts for lymphedema compression treatment items established in accordance with Section 1834(z) of the Act and regulations at 42 CFR 414.1650 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-Q/section-414.1650.

The Consolidated Appropriations Act (CAA), 2023

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Section 4139 of the CAA, 2023 https://www.congress.gov/117/plaws/publ328/PLAW-117publ328.pdf#page=1468, required us to base the fee schedule amounts for items and services you provide in non-rural contiguous Non-Competitive Bidding Areas (CBAs) to continue on a blend of 75% of the adjusted fee schedule amounts and 25% of the unadjusted fee schedule amounts for claims with dates of service for the remainder of the Coronavirus Disease (COVID-19) Public Health Emergency (PHE) or December 31, 2023, whichever is later.

The COVID-19 PHE ended on May 11, 2023. Therefore, effective January 1, 2024, we base the fee schedule amounts for these items and services of the fee schedule amounts adjusted per 42 CFR 414.210(g) https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-D/section-414.210. Additional details are available in the Home Health Prospective Payment System https://www.cms.gov/medicare/payment/fee-schedules/dmepos-fee-schedule/dmepos-laws-regulations final rule.

Effective January 1, 2024, there's a gap period https://www.cms.gov/medicare/payment/fee-schedules/dmepos-competitive-bidding in the DMEPOS CBP. All Medicare Round 2021 DMEPOS CBP contracts for off-the-shelf (OTS) back braces and OTS knee braces expired on December 31, 2023.

During the gap period, payment for items and services included in the CBP are equal to 80% of the lesser of the supplier's charge or the fee schedule amount for the item. According to 42 CFR 414.210(g)(10), the fee schedules for items and services provided in former CBAs are based on the Single Payment Amounts (SPAs) in effect in the CBA on the last day before the CBP contract period of performance ended, increased by the projected percentage change in the Consumer Price Index Urban (CPI-U) for the 12-month period on the date after the contract periods ended. We increase the fee schedule amounts once every 12 months on the anniversary date of the first day after the contract period ended with the CPI-U.

For items where we awarded contracts in Round 2021, for CY 2024, the fee schedule amounts for items provided in areas that were CBAs as of December 31, 2023, are adjusted based on the SPAs for each specific CBA, increased by the projected percentage change in the CPI-U of 2.9% for the 12-month period ending January 1, 2024. For items that were included in Round 2021 but where contracts weren't awarded in Round 2021 of the CBP, the 2023 adjusted fee schedule amounts increased by the projected CPI-U of 2.9% for CY 2024.

A former CBA ZIP Code file contains the CBA ZIP Codes used in pricing a claim for an item provided in a CBA, which we update on a quarterly basis as necessary. Effective January 1, 2024, the former CBA ZIP Code file contains the ZIP Codes for the CBAs in Round 2021.

**2. DMEPOS Rural ZIP Codes**

The ZIP Code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule

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payment applicability for codes with rural and non-rural fee schedule amounts adjusted per 42 CFR 414.210(g).

The DMEPOS Rural ZIP Code file contains the ZIP Codes designated as rural areas. ZIP Codes for non-contiguous Metropolitan Statistical Areas (MSAs) aren't included in the DMEPOS Rural ZIP code file. Updates to the DMEPOS Rural ZIP Code file occur on a quarterly basis as necessary. Regulations at 42 CFR 414.202 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-D/section-414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50% of the total geographical area of the ZIP code is estimated to be outside any MSA. A rural area also includes any low population density ZIP Code within an MSA that's excluded from a CBA established for that MSA.

**3. Additional Information on the 2024 DMEPOS Fee Schedules is Available the Following MLN Matters Articles:**

- MM13463 https://www.cms.gov/files/document/mm13463-dmepos-fee-schedule-cy-2024-update.pdf - January 2024 Update for DMEPOS Fee Schedule
- MM13574 https://www.cms.gov/files/document/mm13574-dmepos-fee-schedule-april-2024-quarterly-update.pdf - April 2024 Update for DMEPOS Fee Schedule

CR 13658 provides updates for the following files:

- DMEPOS fee schedule file for July 2024 (Quarter 3)
- DMEPOS Rural ZIP Code file for July 2024 (Quarter 3)

There are no updates to the DMEPOS PEN fee schedule file for 2024 (Quarter 3).

These updates will be available as Public Use Files (PUFs) https://www.cms.gov/medicare/payment/fee-schedules/dmepos/dmepos-fee-schedule for State Medicaid Agencies, managed care organizations, and other interested parties.

**4. Codes Added and Deleted**

We're not adding or deleting any codes from the DMEPOS fee schedule file, effective July 1, 2024.

**a. Fee Schedules HCPCS Level II Code K1007**

On February 29, 2024, we issued the final determinations for the Second Biannual (B2) 2023 HCPCS Application Cycle. A final payment determination wasn't made then for HCPCS Level II code K1007 (bilateral hip, knee, ankle, foot device, powered, includes pelvic component, single or double upright[s], knee joints any type, with or without ankle joints any type, includes all components and accessories, motors, microprocessors, sensors). We subsequently got data that supported finalizing a payment determination for this code.

On April 11, 2024, we announced fee schedule amounts for HCPCS code K1007, which are effective for claims

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with dates of service as of April 1, 2024. The fee schedule amounts for the HCPCS Level II code K1007 http://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/current-prior-years-level-ii-coding-decisions are in the July 2024 (Quarter 3) DMEPOS fee schedule file.

**b. Fee Schedules HCPCS Level II Code E2298**

We established payment on a purchase basis for capped rental wheelchair accessory codes provided for use with complex rehabilitative power wheelchairs. These accessories are
considered as part of the complex rehabilitative power wheelchair and associated lump sum purchase option set forth at 42 CFR 414.229(a)(5)
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-D/section-414.229. Effective April 1, 2024, HCPCS Level II code E2298 (Complex rehabilitative power wheelchair accessory, power seat elevation system, any type) is eligible for payment on a purchase basis when provided for use with a complex rehabilitative power wheelchair.

We've revised the fee schedule amounts for HCPCS Level II code E2298 (complex rehabilitative power wheelchair accessory, power seat elevation system, any type) to correct the fee schedule calculations. The revised 2024 capped rental price for code E2298 is approximately $201.40 for months 1-3 and $151.05 for months 4-13 for a total of $2,114.70 for 13 months of continuous use. The revised corrected fees are in the July 2024 (Quarter 3) DMEPOS Fee Schedule file.

Your MAC will adjust processed claims for code E2298
http://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/current-prior-years-level-ii-coding-decisions with dates of service on or after April 1, 2024, if you bring them to your MAC's attention.

**More Information**

We issued CR 13658 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 |
|---|---|
| June 13, 2024 | Initial article released. |

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# Ambulatory Surgical Center Payment Update – July 2024

Related CR Release Date: June 13, 2024
Effective Date: July 1, 2024
Implementation Date: July 1, 2024
MLN Matters Number: MM13656
Related Change Request (CR) Number: CR 13656
https://www.cms.gov/files/document/r12673CP.pdf
Related CR Transmittal Number: R12673CP
Related CR Title: July 2024 Update of the Amublatory Surgical Center (ASC) Payment System

**Affected Providers**
- ASCs
- Physicians
- Suppliers
- Other providers billing Medicare Administrative Contractors (MACs) for services provided to Medicare patients

**Action Needed**
Make sure your billing staff knows about these payment system updates for July:
- New CPT and HCPCS codes
- Coverage of Elios System for patients with primary open-angle glaucoma
- Skin substitutes

**Background**
CR 13656 provides changes to and billing instructions for various payment policies implemented in the July 2024 ASC payment system update. The changes are:

**1. ASC Devices Offset from Payment Changes Effective January 1, 2024**
Section 1833(t)(6)(D)(ii) of the Social Security Act https://www.ssa.gov/OP_Home/ssact/title18/1833.htm (the Act) requires CMS deduct from passthrough payments for devices in the hospital Outpatient Prospective Payment System (OPPS) an amount that shows the device portion of the Ambulatory Payment Classifications (APC) payment amount. This deduction is the device offset, or the portions of the APC amount that's associated with the cost of the pass-through device. The device offset from payment represents a deduction from pass-through payments for the applicable pass-through device.

**a. New Device HCPCS Code C1606 Effective July 1, 2024**

CMS preliminarily approved a new device (HCPCS code C1606) for pass-through status under the OPPS with an effective date of July 1, 2024. This code is also payable in the ASC setting.
We discuss the device application of C1606 in the CY 2025 OPPS/ASC proposed and final rules. C1606, along with its descriptors and ASC payment indicator, are in Table 1 of CR 13656
https://www.cms.gov/files/document/r12673CP.pdf#page=10.

Continued >>

The list of CPT codes performed with C1606 is in the July 2024 ASC code pair file https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc-payment/asc-code-pairs.

**b. Expiring OPPS Pass-through Status for Device Category HCPCS Code C1761 Effective July 1, 2024**
Categories of devices are eligible for transitional pass-through payments for at least 2, but not more than 3 years under the OPPS. We apply this policy in the ASC payment system also.

The device category HCPCS code C1761 will remain active, however, we include its payment in the primary service starting July 1, 2024. The ASC payment indicator (PI) for C1761 will change from J7 to N1, effective July 1, 2024. Don't separately bill for packaged codes (ASC PI=N1) since they aren't reportable under the ASC payment system.

**2. Separately Payable HCPCS Codes for Drugs and Biologicals Effective July 1, 2024**
We're adding 17 new drug and biological HCPCS codes effective July 1, 2024. We're also deleting several HCPCS codes on June 30, 2024. These HCPCS codes, as well as their descriptors and ASC PIs, are in Table 2 of CR 13656 https://www.cms.gov/files/document/r12673CP.pdf#page=10.

**3. Medicare Category B Investigational Device Exemption (IDE) Coverage of Elios System to Reduce Intraocular Pressure in Patients with Primary Open-Angle Glaucoma**
On November 30, 2023, we granted Medicare coverage, as a Category B IDE study, for the clinical trial associated with Elios Vision's System to reduce intraocular pressure in patients with primary open-angle glaucoma as a standalone surgical procedure. The code describing this standalone surgical procedure is CPT code 0621T (Trabeculostomy ab interno by laser). Based on Medicare coverage approval, we're assigning it ASC PI of J8 retroactive to January 1, 2024. Table 3 of CR 13656 https://www.cms.gov/files/document/r12673CP.pdf#page=11 lists the code descriptor and ASC PI for 0621T.

We posted Information associated with the clinical study on the CMS approved IDE studies https://www.cms.gov/Medicare/Coverage/IDE/Approved-IDE-Studies webpage.

**a. HCPCS J7353 Separately Payable Retroactive to January 1, 2024**
The ASC PI for HCPCS code J7353 is reassigned from N1 to K2 retroactive to January 1, 2024. The code, descriptors, and ASC PIs are in Table 4 of CR 13656 https://www.cms.gov/files/document/r12673CP.pdf#page=11.

**b. Expiring OPPS Pass-through for Certain Drugs and Biologicals Packaged in ASCs Effective July 1, 2024**
HCPCS codes for certain drugs and biologicals in the OPPS will have their pass-through status end on June 30, 2024, at which point they'll be packaged. These HCPCS codes are currently separately payable in the ASC and will also be packaged (ASC PI = N1) effective July 1, 2024. These codes are in Table 5 of CR 13656 https://www.cms.gov/files/document/r12673CP.pdf#page=12. Remember you don't bill packaged codes.

**c. New CPT Category III Codes Effective July 1, 2024**
The AMA releases CPT Category III codes twice per year – in January, for implementation beginning the following July, and in July, for implementation beginning the following January.
We're adding 6 new separately payable CPT Category III codes in the ASC setting that the AMA released in

Continued >>

January 2024 for implementation on July 1, 2024. The codes, along with their descriptors and ASC PIs, are in Table 6 of CR 13656 https://www.cms.gov/files/document/r12673CP.pdf#page=12.

**d. HCPCS Codes for Certain Drugs Deleted as of June 30, 2024**

We'll delete 4 additional HCPCS codes on June 30, 2024. These codes are in Table 7 of CR 13656 https://www.cms.gov/files/document/r12673CP.pdf#page=13.

**e. HCPCS Codes for Drugs and Biologicals with Payment Indicator Changes to Packaged, Effective July 1, 2024**

Per OPPS policy, we'll package 4 drug and biological HCPCS codes effective July 1, 2024. We'll change the ASC PI to N1, effective July 1, 2024. These HCPCS codes and ASC PIs are in Table 8 of CR 13656 https://www.cms.gov/files/document/r12673CP.pdf#page=13.

**f. HCPCS J0401 Descriptor Change as of July 1, 2024**

HCPCS code J0401 has a descriptor change effective July 1, 2024. The old and new descriptors for J0401 are in Table 9 of CR 13656 https://www.cms.gov/files/document/r12673CP.pdf#page=13.

**g. HCPCS C9167 Descriptor Change Retroactive to April 1, 2024**

We changed the descriptor for C9167 retroactive to April 1, 2024. The old and new descriptors for C9167 are in Table 10 of CR 13656 https://www.cms.gov/files/document/r12673CP.pdf#page=13.

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

For CY 2024, payment in the ASC setting for most drugs and biologicals is made at a single rate of ASP + 6% (or ASP plus 6% or 8% of the reference product for biosimilars). We update payments for drugs and biologicals based on ASPs quarterly as later-quarter ASP submissions become available. Updated payment rates effective July 1, 2024, are in the July 2024 update of ASC Addendum BB https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html.

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

We may correct some drugs and biologicals with payment rates based on the ASP methodology retroactively. These retroactive corrections typically occur quarterly. We'll make the list of drugs and biologicals https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Restated-Payment-Rates.html with corrected payment rates available on the first day of the quarter. If you think you got an incorrect payment for drugs and biologicals impacted by these corrections, you can ask your MAC to adjust the previously processed claims.

**4. Skin Substitutes**

We package the payment for skin substitute products that don't qualify for hospital OPPS passthrough status into the OPPS payment for the associated skin substitute application procedure. This policy also applies to the ASC payment system. We package skin substitute products into 2 groups:

1. High-cost skin substitute products – Only use these when you perform 1 of the skin application procedures described by CPT codes 15271-15278.

Continued >>

2. Low-cost skin substitute products – Only use these when you perform 1 of the skin application procedures described by HCPCS codes C5271-C5278.

We assign new skin substitute HCPCS codes into the low-cost skin substitute group unless we've OPPS pricing data showing the cost of the product is above either of these:

- The mean unit cost of $47
- The per day cost of $807 for CY 2024

**a. New Skin Substitute Products as of July 1, 2024**

There are 23 new skin substitute HCPCS codes effective July 1, 2024. These codes are in Table 11 of CR 13656 https://www.cms.gov/files/document/r12673CP.pdf#page=14.

Don't separately bill for packaged skin substitutes since you can't report packaged codes under the ASC payment system.

**b. Skin Substitute Product Codes Deleted Effective June 30, 2024**

We're deleting 2 skin substitute products, as of June 30, 2024. These codes are in Table 12 of CR 13656 https://www.cms.gov/files/document/r12673CP .pdf#page=15.

**5. Coverage Determinations**

The fact that we assign a HCPCS code and payment rate to a drug, device, procedure, or service under the ASC payment system doesn't imply coverage by the Medicare Program, but indicates only how we pay for the product, procedure, or service if covered by the Program. MACs decide whether 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 whether it's excluded from payment.

**More Information**

We issued CR 13656 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 |
|---|---|
| June 13, 2024 | Initial article released. |

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# Hospital Outpatient Prospective Payment System: July 2024 Update

Related CR Release Date: May 31, 2024
Effective Date: July 1, 2024
Implementation Date: July 1, 2024
MLN Matters Number: MM13632
Related Change Request (CR) Number: CR 13632
https://www.cms.gov/files/document/r12665cp.pdf
Related CR Transmittal Number: R12665CP
Related CR Title: July 2024 Update of the Hospital Outpatient Prospective Payment System (OPPS)

**Affected Providers**
- Physicians
- Hospitals
- Suppliers
- Other providers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients

**Action Needed**
Make sure your billing staffs know about these payment system updates for July:
- New CPT and HCPCS codes
- Covered devices for OPPS pass-through payments
- Drugs, biologicals, and radiopharmaceuticals
- Skin substitutes

**Background**
CR 13632 gives instructions on coding changes and policy updates effective July 1, 2024, for the OPPS. The OPPS changes are:

**1. Update for COVID-19 Monoclonal Antibody Therapy Product and Administration Code**
On March 22, 2024, the FDA released an Emergency Use Authorization (EUA) for the emergency use of PEMGARDA (pemivibart) for the pre-exposure prophylaxis of COVID-19 in certain adults and adolescents. The HCPCS code for PEMGARDA is Q0224. The HCPCS code for the service to administer PEMGARDA in health care settings is M0224. These codes along with their descriptors are in Table 1 of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=10.

Effective March 22, 2024, CMS assigned Q0224 to status indicator “L” (Not paid under OPPS.
Paid at reasonable cost; not subject to deductible or coinsurance). Effective March 22, 2024, we assigned M0224 to status indicator “S” (Paid under OPPS; separate APC payment), Ambulatory Payment Classification (APC) 1506 (New Technology - Level 6 ($401 - $500)).

**Note**: We didn’t create a HCPCS code describing the service to administer PEMGARDA in the home or residence setting since the EUA states, “PEMGARDA should only be administered in settings in which

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healthcare providers have immediate access to medications to treat a severe hypersensitivity reaction, such as anaphylaxis, and the ability to activate the emergency medical system (EMS), as necessary."

Patient cost-sharing doesn't apply to the PEMGARDA product code or the administration of the dose of PEMGARDA in a health care setting.

**2. CPT Proprietary Laboratory Analyses (PLA) Coding Changes Effective July 1, 2024**

The American Medical Association (AMA) CPT Editorial Panel established 26 new PLA codes, specifically, CPT codes 0450U-0475U, effective July 1, 2024. Table 2 of CR 13632 lists the long descriptors and status indicators for the codes. For more information on OPPS status indicators, see OPPS Addendum D1 of the CY 2024 OPPS/Ambulatory Surgical Center (ASC) final rule for the latest definitions.

**3. OPPS Device Pass-Through**

**a. New Device Pass-Through Categories Effective July 1, 2024**

Section 1833(t)(6)(B) of the Social Security Act https://www.ssa.gov/OP_Home/ssact/title18/1833.htm (the Act) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. The Act requires us to create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

We preliminarily approved 2 new devices for pass-through status under the OPPS with an effective date of July 1, 2024. We preliminarily approved HCPCS codes C1605 and C1606 as part of the device pass-through quarterly review process.

We'll discuss the device applications associated with HCPCS codes C1605 and C1606 in the CY 2025 OPPS/ASC proposed and final rules. Table 3A of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=17 has the long descriptor, status indicator, APC, and offset amount for these 2 HCPCS codes.

We're also adding these 2 new device category codes and their pass-through expiration dates to Table 4 of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=25. Table 4 has the complete list of device category HCPCS codes and definitions used for present and previous transitional pass-through payment.

**b. Clarification for an Existing Device Pass-Through Category C1601**

As we discussed in Section IV.A.2. New Device Pass-Through Applications for CY 2024 of the CY 2024 OPPS/ASC final rule with comment period, we approved HCPCS code C1601 (Endoscope, single-use (i.e. disposable), pulmonary, imaging/illumination device (insertable)), as a new device category for pass-through status under the OPPS, with an effective date of January 1, 2024.

As referenced in the code descriptor for HCPCS code C1601, this category is specific to devices that are single-use (in other words, disposable) devices and doesn't include reprocessed devices, including devices that may be referred to as "reprocessed single-use devices" or any other devices used more than once regardless of how the device is described.

**c. Clarification for an Existing Device Pass-through Category C1602**

As we discussed in Section IV.A.2. New Device Pass-Through Applications for CY 2024 of the CY 2024 OPPS/ASC final rule with comment period, we approved HCPCS code C1602 (Orthopedic/device/drug matrix/

Continued >>

absorbable bone void filler, antimicrobial-eluting (implantable)), as a new device category for pass-through status under the OPPS, with an effective date of January 1, 2024.

**d. Updates for Device Offset Amounts to an Existing Device Code C1604**

Section 1833(t)(6)(D)(ii) of the Act requires that we deduct from pass-through payments for devices an amount that reflects the device portion of the APC payment amount. This deduction is known as the device offset, or the portions of the APC amount that are associated with the cost of the pass-through device. The device offset from payment represents a deduction from pass-through payments for the applicable pass-through device.

Effective January 1, 2024, we pair CPT code 0505T to be billed with HCPCS code C1604, as listed in the January 2024 Update of the Hospital OPPS, CR 13488 https://www.cms.gov/files/document/r12421cp.pdf, Transmittal 12421, dated December 21, 2023.

Note: We're updating the device offset amount for the CPT code paired with HCPCS code C1604 $0.00, effective January 1, 2024.

**e. Expiring Pass-through Status for Device Category HCPCS Code C1761 Effective July 1, 2024**

As specified in Section 1833(t)(6)(B) of the Act, under the OPPS, categories of devices are eligible for transitional pass-through payments for at least 2, but not more than 3 years. For the July 2024 update, the pass-through status period for 1 device category, HCPCS code C1761, will expire on June 30, 2024. This device category HCPCS code will remain active; however, its payment will be included in the primary service. Table 3B https://www.cms.gov/files/document/r12665cp.pdf#page=25 and Table 4 of CR 13632 have the long descriptor associated with HCPCS code C1761.

For OPPS billing, we use charges related to packaged services for outlier and future rate setting. So, we advise hospitals to report the device category HCPCS codes on the claim whenever they're provided in the outpatient setting. As we state in Section 10.4 of the Medicare Claims Processing Manual, Chapter 4 https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c04.pdf#page=23, it's extremely important that hospitals report all HCPCS codes consistent with their descriptors, CPT and CMS instructions, and correct coding principles, as well as all charges for all services they provide, whether payment for the services is made separately or is packaged.

Table 4 of CR 13632 has the entire list of current and historical device category codes created since August 1, 2000.

**4. New CPT Category III Codes Effective July 1, 2024**

The AMA releases CPT Category III codes twice per year: in January, for implementation starting the following July, and in July, for implementation starting the following January.

For the July 2024 update, we're implementing 34 new CPT Category III codes that the AMA released in January 2024 for implementation on July 1, 2024. The status indicators and APC assignments for these codes are in Table 5 of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=30.

**5. Medicare Category B Investigational Device Exemption (IDE) Coverage of Elios System to Reduce Intraocular Pressure in Patients with Primary Open-Angle Glaucoma**

Continued >>

On November 30, 2023, we granted Medicare coverage, as a Category B IDE study, for the clinical trial associated with Elios Vision's Elios System to reduce intraocular pressure in patients with primary open angle glaucoma as a standalone surgical procedure. Currently, the code to describe this standalone surgical procedure is CPT code 0621T (Trabeculostomy ab interno by laser). Based on the Medicare coverage approval, we're revising the code payment assignment from status indicator "E1" (not covered/not payable by Medicare) to APC 5492 (Level 2 Intraocular Procedures) and OPPS status indicator "J1" (Hospital Part B Services Paid Through a Comprehensive APC; paid under OPPS.) effective January 1, 2024.

Table 6 of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=34 shows the information associated with the clinical study, which is also posted on the CMS approved IDE studies website https://www.cms.gov/Medicare/Coverage/IDE/Approved-IDE-Studies.

Table 7 of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=35 lists the long descriptor, status indicator, and APC assignment for CPT code 0621T.

**6. New HCPCS Code Describing Endoscopic Defect Closure Within the Entire Gastrointestinal Tract Including Upper Endoscopy or Colonoscopy When Performed**

We created HCPCS code C9901 to describe endoscopic defect closure within the entire gastrointestinal tract including upper endoscopy or colonoscopy when performed. Table 8 of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=35 lists the official long descriptor, status indicator, and APC assignment for HCPCS code C9901.

**7. Drugs, Biologicals, and Radiopharmaceuticals**

**a. New CY 2024 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status Effective July 1, 2024**

We're creating 6 new HCPCS codes for reporting drugs and biologicals in the hospital outpatient setting, where there haven't been specific codes available starting on July 1, 2024. These drugs and biologicals will get drug

https://www.cms.gov/files/document/r12665cp.pdf#page=36.

**b. Existing CY 2024 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Receiving Pass-Through Status Retroactive to January 1, 2024**

HCPCS code J7353 will get drug pass-through status retroactive to January 1, 2024. See Table 10 of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=36.

**c. Existing HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals with Pass-Through Status Ending on June 30, 2024**

There are 11 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals in the outpatient setting that will have their pass-through status end on June 30, 2024. These HCPCS codes are in Table 11 of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=36. Effective July 1, 2024, the status indicator for these codes is changing from "G" to "K" or "N."

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**d. Newly Established HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals as of July 1, 2024**
Table 12 of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=37 lists 49 new drug, biological, and radiopharmaceutical HCPCS codes we're establishing on July 1, 2024.

**e. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Deleted as of June 30, 2024**
Table 13 of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=39 lists 4 drug, biological, and radiopharmaceutical HCPCS codes we're deleting on June 30, 2024.

**f. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals Changing Payment Status on July 1, 2024**
Table 14 of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=39 lists 9 drug, biological, and radiopharmaceutical HCPCS codes with a revised payment status on July 1, 2024. It was too late to change the status indicator for the HCPCS code J9324 from status indicator "E2" to status indicator "K," APC 0782, in the July 2024 Integrated Outpatient Code Editor (I/OCE) Update, due to the operational timelines. We'll include this change in the October 2024 I/OCE Update retroactive to July 1, 2024.

**g. HCPCS Codes for Drugs, Biologicals, and Radiopharmaceuticals with Descriptor Changes as of July 1, 2024**
Table 15 of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=40 lists 3 drug, biological, and radiopharmaceutical HCPCS codes with a substantive descriptor change as of July 1, 2024.

**h. HCPCS Code for Drugs, Biologicals, and Radiopharmaceuticals with a Descriptor Change Retroactive to April 1, 2024**
We changed the descriptor for HCPCS code C9167 retroactive to April 1, 2024, as we show in Table 16 of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=40.

**i. Drugs and Biologicals with Payments Based on Average Sales Price (ASP)**
For CY 2024, payment for the majority of non-pass-through drugs, biologicals, and therapeutic radiopharmaceuticals is at a single rate of ASP + 6% (or ASP plus 6 or 8% of the reference product for biosimilars). In CY 2024, a single payment of ASP plus 6% 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 (or ASP plus 6 or 8% of the reference product for biosimilars).

We update payments for drugs and biologicals based on ASPs on a quarterly basis as later quarter ASP submissions are available. Effective July 1, 2024, payment rates for many drugs and biologicals have changed from the values published in the CY 2024 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from third quarter of CY 2023. In cases where adjustments to payment rates are necessary, changes to the payment rates will be made to the July 2024 Fiscal Intermediary Standard System (FISS) release. We're not publishing the updated payment rates in CR 13632.

However, the updated payment rates effective July 1, 2024, are in the July 2024 update of the OPPS Addendum A and Addendum B
https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/addendum-a-b-updates updates.

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**j. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates**
Some drugs and biologicals paid based on ASP methodology will have payment rates that we correct retroactively. These retroactive corrections typically occur on a quarterly basis. See the list of drugs and biologicals with corrected payments rates https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/restated-drug-biological-payment-rates on the first date of the quarter for these corrected rates. You may resubmit claims affected by adjustments to a previous quarter's payment files.

**8. Skin Substitutes**
The payment for skin substitute products that don't qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. For payment packaging purposes, we divide the skin substitute products into 2 groups:

1. High cost skin substitute products
2. Low cost skin substitute products

New skin substitute HCPCS codes are assigned into the low-cost skin substitute group unless we have pricing data that shows the cost of the product is above either the mean unit cost of $47 or the per day cost of $807 for CY 2024.

**a. New Skin Substitute Products as of July 1, 2024**
Table 17 of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=40 lists 23 new skin substitute HCPCS codes that will be active as of July 1, 2024.

**b. Skin Substitute Product Codes Deleted Effective June 30, 2024**
Table 18 of CR 13632 https://www.cms.gov/files/document/r12665cp.pdf#page=41 lists 2 skin substitute product codes we're deleting as of June 30, 2024.

**9. Coverage Determinations**
As a reminder, the fact that we assign a HCPCS code and a payment rate under the OPPS to a drug, device, procedure, or service doesn't 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's reasonable and necessary to treat the patient's condition and whether it's excluded from payment.

**More Information**
We issued CR 13632 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 |
|---|---|
| June 3, 2024 | Initial article released |

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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 May 30, 2024
https://www.cms.gov/training-education/medicare-learning-network/newsletter/2024-05-30-mlnc

MLN Connects™ for June 6, 2024
https://www.cms.gov/training-education/medicare-learning-network/newsletter/2024-06-06-mlnc

MLN Connects™ for June 13, 2024
https://www.cms.gov/training-education/medicare-learning-network/newsletter/2024-06-13-mlnc

MLN Connects™ for June 20, 2024
https://www.cms.gov/training-education/medicare-learning-network/newsletter/2024-06-20-mlnc


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- Publications & Multimedia
- Web-Based Training
- MLN Matters® Articles
- MLN Connects® Newsletter
- Provider Compliance

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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.

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**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

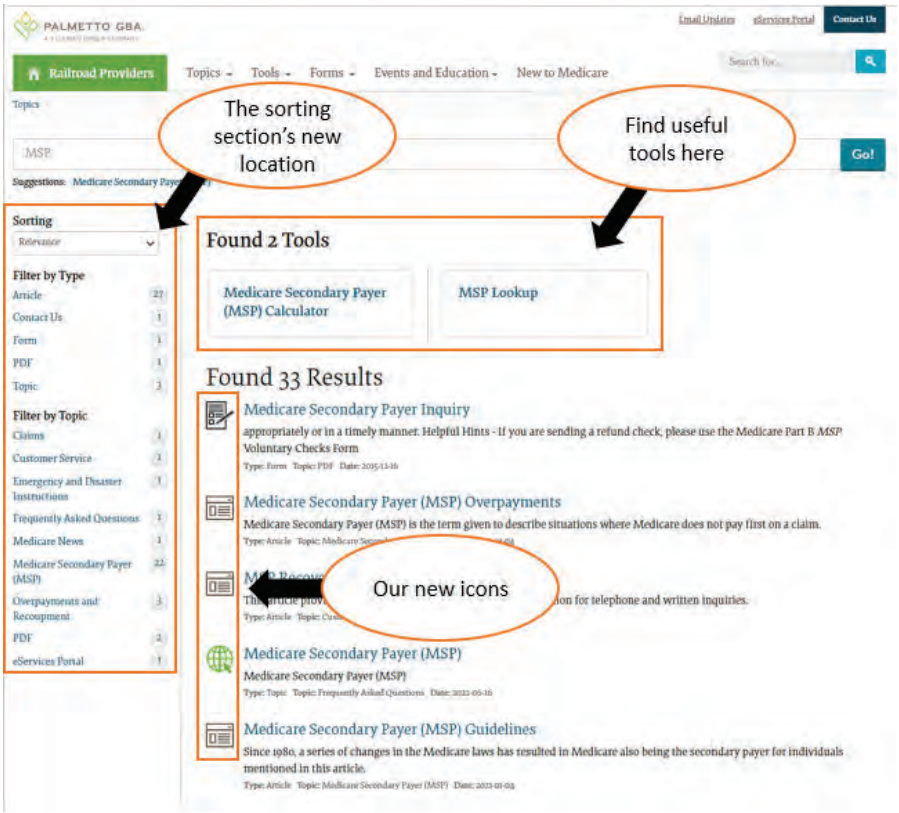
# We Made Exciting Changes to Your Search Experience

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.

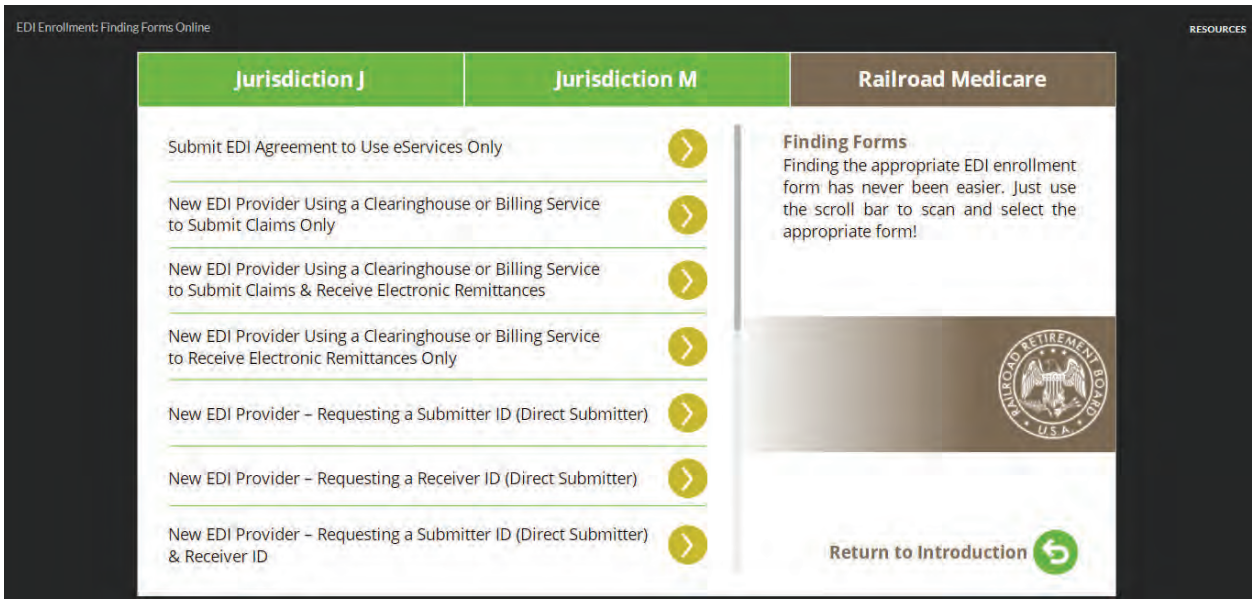
The goal of the ePass is to ease provider burden by eliminating the need to repeatedly authenticate the same provider each time you contact the IVR in a given day.

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.




Continued >>


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.

All Railroad Medicare Providers and their staff can give immediate feedback about their customer experience by completing the MAC Customer Experience (MCE) surveys.

To provide feedback for the Palmetto GBA Railroad Medicare website and the Palmetto GBA eServices portal, complete the online experience MCE survey by using the blue FEEDBACK button that appears on the right side of each web page and portal screen, or accept the pop-up invitation when it presents itself.

You can also provide feedback for your experience with selected areas by selecting the green "Your Opinion Matters / Share Your Feedback" button on the right side of select topic website pages or select one of the survey links below:
- Appeals experience (Redetermination — 1st level appeals - https://tinyurl.com/MCEAppeals
- Electronic Data Interchange (EDI) experience - https://tinyurl.com/MCEEDI
- Medical Review Targeted Probe and Educate (TPE) experience - https://tinyurl.com/MCEMRTPE
- Prior Authorization experience - https://tinyurl.com/MCEPriorAuth
- Provider Outreach and Education (POE) experience - https://tinyurl.com/MCEProvOutreachEduc
- Written General Correspondence experience - https://tinyurl.com/MCEWrittenCorr
- Additional surveys will be added in the future

When completing an MCE survey, please be sure to add details about your experience so we know exactly what you liked or what we could do better. 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 providers.

# Railroad Medicare Customer Information and Outreach

## Important Telephone Numbers

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

**Provider Contact Center**
**888-355-9165**
**Select Option 5**

**Telephone Reopenings**
**888-355-9165**
**Select Option 4**

**Provider Enrollment**
**888-355-9165**
**Select Option 3**

**Electronic Data Interchange (EDI)**
**Technical Support**
**888-355-9165**
**Select Option 2**

**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**