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Contact information can be found on our website.
Medicare policies can be accessed from the Medical Policy Center section of our website. Providers without access to the Internet can request hard copies from National Government Services.

This bulletin should be shared with all health care practitioners and managerial members of the providers/suppliers staff. Bulletins issued during the last two years are available at no cost from our website.

CMS publishes the Quarterly Provider Update (QPU) at the beginning of each quarter to inform providers and suppliers:

- Regulations and major policies under development during the quarter
- Regulations and major policies completed or cancelled
- New or revised manual instructions

National Government Services – Articles for Part A and Part B Providers

LCD and Article Revisions for April 2019

The medical policies and related articles can be found in our Medical Policy Center.

Biomarker Testing for Neuroendocrine Tumors/Neoplasms (L37851)

National Government Services will not provide coverage for the oncology (gastrointestinal neuroendocrine tumors) real-time PCR expression analysis of 51 genes, utilizing whole peripheral blood, algorithm reported as a nomogram of tumor disease index (0007M) for its use in treating neuroendocrine tumors. It has not been accepted by most neuroendocrine treatment guidelines. Most important, this test has not been shown to result in improved outcomes for Medicare beneficiaries and thus is not medically necessary.

LCD L37851 was submitted for comment for J6 and JK from 10/17/2018–11/30/2018.

Category III CPT® Codes- Related to Category III CPT® Codes (L33392) (A56195)

CPT codes 0424T, 0425T, 0426T, 0427T, 0428T, 0429T, 0430T, 0431T, 0432T, 0433T, 0434T, 0435T and 0436T have been deleted from Group 1 (CPT Codes considered not medically necessary). Please refer to LCD L37929 (Transvenous Phrenic Nerve Stimulation in the Treatment of Central Sleep Apnea).

LCD L37929 was submitted for comment for J6 and JK from 10/17/2018–11/30/2018.

Genomic Sequence Analysis Panels in the Treatment of Non-Small Cell Lung Cancer (L36376)

L36376 has been retired, effective 3/31/2019. For dates of service on or after 4/1/2019, refer to the Genomic Sequence Analysis Panels in the Treatment of Solid Organ Neoplasms LCD (L37810).

Genomic Sequence Analysis Panels in the Treatment of Solid Organ Neoplasms (L37810)

Indications and Limitations of Coverage for Metastatic Colorectal Cancer (mCRC) have been provided:

Indications and Limitations of Coverage for patients with mCRC

Genomic Sequential Analysis Panel will be considered reasonable and necessary when the test is performed in a CLIA-certified laboratory qualified to perform high complexity testing, ordered by a treating physician, and the patient has:

1. metastatic CRC; and
2. is a candidate for intensive chemotherapy with an anti-EGFR biologic agent; and
3. has not had prior RAS/BRAF testing (except after initiation of anti-EGFR therapy with evidence of acquired resistance).

LCD L37810 was submitted for comment for J6 and JK from 10/17/2018–11/30/2018.

Transvenous Phrenic Nerve Stimulation in the Treatment of Central Sleep Apnea (L37929)

Central sleep apnea (CSA) is characterized by sleep disordered breathing associated with decreased or no respiratory effort accompanied by excessive daytime sleepiness, frequent nocturnal wakenings, or both. CSA due to hypoventilation occurs when the stimulus to breathe is removed in patients with compromised neuromuscular ventilator control. Chronic ventilatory failure due to neuromuscular or chest wall disease can produce central apneas or hypopneas and may occur in patients with central nervous system disease. Central sleep apnea syndromes (CSAS) due to a Cheyne-Stokes breathing pattern (CSBP) or Cheyne-Stokes respiration (CSR) has an absence of airflow and respiratory effort followed by hyperventilation resulting in a crescendo-decresendo pattern.

Further randomized trials are needed to test long-term safety, outcomes measured and cardiovascular outcomes. There is currently insufficient evidence to show transvenous phrenic neurostimulation is reasonable and necessary for the treatment of illness (SSA Section 1862 [a][1][A]) in the Medicare population.

LCD L37929 was submitted for comment for J6 and JK from 10/17/2018–11/30/2018.

National Government Services – Articles for Part A Providers

Intensity-Modulated Radiation Therapy Planning Services – A Billing Reminder

The MLN Matters® Special Edition Article SE18013 is intended for OPPS providers submitting claims for outpatient intensity-modulated radiation therapy (IMRT) planning to Medicare Administrative Contractors (MACs).

This article provides a reminder to hospitals that bill for outpatient IMRT planning services to ensure that they bill correctly and avoid overpayments.

The Office of Inspector General (OIG) released a report on improper billing by hospitals for IMRT, titled Medicare Improperly Paid Hospitals Millions of Dollars For Intensity-Modulated Radiation Therapy Planning Services.

IMRT is an advanced type of radiation procedure used to treat difficult-to-reach tumors; IMRT planning is a computer-based method of developing a plan for delivering the radiation. Medicare makes a bundled payment to hospitals to cover a range of IMRT planning services that may be performed to develop an IMRT treatment plan. However, prior OIG reviews found that some hospitals improperly received separate payments for these services in addition to receiving the bundled payment.

IMRT is provided in two treatment phases, planning and delivery. Medicare pays hospitals under the outpatient prospective payment system (OPPS) a bundled payment for the planning phase. The bundled payment covers a range of services that may be performed as part of developing an IMRT treatment plan and the bundled payment covers these services regardless of when they are billed.

When IMRT is furnished to beneficiaries in a hospital outpatient department that is paid under the hospital OPPS, hospitals must remember that there is a wide range of claims processing

timeliness (CPT) codes that are considered to be included in the ambulatory payment classification (APC) payment for CPT code 77301 (IMRT planning).

Payment for the services identified by CPT codes 77014, 77280, 77285, 77290, 77295, 77306 through 77321, 77331 and 77370 are included in the APC payment for CPT code 77301 (IMRT planning).

The charges for these services should be included in the charge associated with CPT code 77301, even if the individual services associated with IMRT planning are performed on dates of service other than the date on which CPT code 77301 is reported.

You should not report these codes in addition to CPT code 77301 when provided prior to or as part of the development of the IMRT plan.

It is important that providers review their reporting procedures to ascertain how these services are being reported, and ensure that the services are not being unbundled, even if they are performed/provided on different dates of service.

Related Content

- Centers for Medicare & Medicaid Services Internet-Only Manual Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 200.3.1

Billing Reminders for OPPS Providers With Multiple Service Locations

Background

Does your hospital operate an off-campus outpatient, provider-based department?

If you answered yes to this question, then reviewing the information in this article, as well as Medicare Learning Network (MLN) Matters Articles MM9613, MM9907 and Special Edition (SE) Articles SE18002 and SE18023, is a must in order to understand the requirements and avoid issues with claim(s) being returned to provider (RTP) in the coming months.

As noted in SE18002, in order for Medicare physician fee schedule (MPFS) and outpatient prospective payment system (OPPS) payments to be accurate, the **service facility address** of the off-campus, outpatient, provider-based department of a hospital facility is used to determine the locality.

Section 603 of the Bipartisan Budget Act of 2015 (Public Law 114-74) indicates that, nonexcepted services provided at an off-campus, outpatient, provider-based department of a hospital were required to be identified as **nonexcepted items and services** billed on an institutional claim and to be paid under the MPFS.

- These services are identified by the use of modifier “PN” (nonexcepted services provided at an off-campus, outpatient, provider-based department of a hospital). The use of the “PN” modifier was required effective 1/1/2017 (MM9930).
- As a result of the above information, effective 1/1/2017, **excepted off-campus** provider-based departments of a hospital must continue to report existing modifier “PO” (services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items and services with a Healthcare Common Procedure Coding System (HCPCS) furnished.

Claim Filing Requirements

- Medicare outpatient service providers report the **service facility location for the off-campus, outpatient, provider-based** department of a hospital facility in the **2310E loop of the 837** institutional claim transaction.
- Direct Data Entry (DDE) users are also required to include **service facility location** (MAP171F), which can be accessed from claim page (3) and then press the (<F11/PF11>) key twice. SE18023 contains a screen shot of MAP171F.
- Paper submitters report the **service facility address** information in FL 1 on the 1450 paper claim for.

The Fiscal Intermediary Standard System (FISS) and the information in the Provider Enrollment, Chain and Ownership System (PECOS) will validate the service facility location to ensure services are being billed in a Medicare-enrolled location. This must be an **exact match** based on the information submitted on the CMS-855A application **and** verified through the USPS database. The USPS verified address will be entered into PECOS.

As noted in SE18023, in the first round of testing reason codes **34977** (claim service facility address doesn't match provider practice file address) and **34978** (off-campus provider claim line that contains a HCPCS must have a PN or PO) were activated. The service facility location has to be an **exact match** on what was verified with the USPS database and entered into PECOS. During the short first round of testing, it was noted that most of the errors associated with the reason codes had to do with spelling variations.

- In PECOS, the word verified and entered was "Road" as part of their address, but the provider entered "Rd" or "Rd." as part of their address on the claim submission.
- In PECOS, the word verified and entered was "STE" as part of their address, but the provider entered "Suite" as part of their address on the claim submission.

Providers must ensure that **all** practice locations are present in PECOS and if any locations are not in PECOS then the providers needs to submit the 855A to add the location(s). Providers can review their practice locations in PECOS to ensure that their service facility address for their off-campus provider department location provided on claims is an **exact match.**

Final Reminders

- OPPS providers billing with the PO and/or PN modifier for their off-campus, outpatient, provider-based department must bill the correct service facility address as indicated in PECOS. The PECOS verified location (Rd, Road, RD, Dr, Drive, DR, Ste, Ste# Suite, Suite#, St, Street, ST) **must** be an **exact match**.
- Make sure all off-campus, outpatient, provider-based department locations are present in PECOS and if not submit the CMS-855A application to add the address(es)
- Review **all** MM and SE articles include in this article for a complete history and all instructions
- Watch for additional information to be released in April 2019 that will assist providers with these new reason codes

Make sure you understand the impacts and have all the appropriate updates made prior to reason codes 34977 and 34978 being reactivated in the coming months and causing issues and delaying your hospital's claim payments.

Registration Open for the 2019 Home Health and Hospice Medicare Summit: Compliance = Success

Registration for the third annual National Government Services (NGS) Medicare Summit is now open on our website. The Medicare Summit is a full two-day conference to provide education for home health plus hospice (HH+H) agencies about the Medicare benefit. In addition to specifically tailored presentation for HH+H clinical and billing we will also offer classes related to provider enrollment, audit and reimbursement, medical review and Medicare Secondary Payer (MSP). You will not want to miss this opportunity for education from your Medicare Administrative Contractor (MAC). This two-day conference will offer an early bird registration of only $149 through 7/31/2019. Discounted hotel rates will be available. Visit our Webinars, Teleconferences & Events page for more information and registration.

Who Should Attend?

Home health and hospice staff members that will benefit from this event include administrators, Chief Executive Officers (CEOs), Chief Financial Officers (CFOs), quality and compliance officers and nurse managers. This two-day conference will include a variety of HH+H education topics as well as vendors from around the United States.

Day 1 – The opening general session will provide a unique opportunity for attendees to receive information directly from NGS, the National Hospice and Palliative Care Organization (NHPCO) and the National Association for Home Care & Hospice (NAHC) regarding updates on regulatory and policy changes. This dynamic partnership allows you to hear directly from your MAC and National Associations about regulatory changes that may impact your agency. This will be an opportunity you won't want to miss to have your questions answered by our panel of experts.

Day 2 – During the opening general session, Michael Dorris, NGS Jurisdiction Affairs Manager, will provide the most up-to-date Medicare hot topics from Centers for Medicare & Medicaid Services (CMS) and legislative information though leaders on improving the original Medicare and Medicare HH+H benefits for Medicare providers and beneficiaries.

Event Information

Date

9/17/2019–9/18/2019

Venue

The Orleans Hotel and Conferencing Center
4500 Tropicana Avenue
Las Vegas, NV 89103

Home Health and Hospice Billing Workshop Opportunity

Are you a new biller? New agency? Need help with the fundamentals of Medicare billing for home health and hospice? If you answered yes to any of these questions, you will not want to miss the National Government Services home health and hospice (HHH) workshop.

NGS will be offering a one-day HHH billing workshop in Las Vegas, Nevada on 9/16/2019. Sessions offered during the one-day billing workshop will provide basic billing instructions for new billers and new agencies regarding the Medicare benefit. The cost to attend one home health or hospice billing workshop is $75.00. Registration is now open and limited to 40 attendees in each session.

The billing workshops will be the day before the annual HHH Medicare Summit. You must register via the annual Medicare Summit registration portal. During registration, you will be able to select the billing workshop only, a billing workshop and full conference or the full conference only. When selecting a billing workshop, you will select either a home health or a hospice track. For the full two-day conference, you will be able to choose the classes you want to attend. Visit our Webinars, Teleconferences & Events for more information.