Medicare A Connection

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction 9 Providers

September 2013

In this issue

First Coast's online tools hit the SPOT

Kay Allwardt manages billing for 56 physician offices representing 120 different Florida health care providers. Her team of 10 billing professionals processes an average of 1,500 Medicare fee for service claims each week.

In August 2012, her team volunteered to help test a new Medicare claims electronic portal with First Coast Service Options Inc. (First Coast). The SPOT (Secure Provider Online Tool), First Coast's Internet portal, gives health care providers access to essential Medicare claims processing information, including Medicare eligibility and benefits, claims status, payment history, data reports and online help.

Medicare fee-for-service claims do not represent a majority of claims processed by her team. However, Allwardt says the SPOT has helped improve business operations dramatically, making their work more efficient, lowering the number of denied claims, and improving the profitability of their business.

"The SPOT has improved our operations in tangible ways," she said. Of all the positive changes implemented by her team, Allwardt points to having access to the Medicare eligibility information through the SPOT as the biggest dividend. "We know if we bill for it, we are going to get paid," Allwardt says confidently.

> **"With the SPOT, we are able to make eligibility determinations right then and there."**
>
> *– Kay Allwardt, Billing manager*

"With the SPOT, we are able to make eligibility determinations right then and there. The system is live," Allwardt says. She has seen a big decline in the number of denials, specifically codes CO22 and CO24.

"We updated our hospice process. Prior to SPOT, we guessed at whether or not the episode of care involved hospice. SPOT gives us specific dates of service and the identification of the hospice provider. We have fewer denials because we have the information in real time," Allwardt said.

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The *Medicare A Connection* is published monthly by First Coast Service Options Inc.'s Provider Outreach & Education division to provide timely and useful information to Medicare Part A providers.

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Articles included in the *Medicare A Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

SPOT *(continued)*

The SPOT also features the ability to view a beneficiary's up-to-date benefit level. Allwardt says this convenience of having the beneficiaries Part B deductible information immediately available through the SPOT has greatly improved their account receivables. "We are able to see what checks are coming in and plan our work."

> **"SPOT is going to be a vital part of your operations. Get started with it now. It's going to save you so much. SPOT is helping us work smarter."**
>
> *– Kay Allwardt, Billing manager*

For providers and Medicare billing staff who have yet to sign up for access to the SPOT, Allwardt highly recommends jumping in as soon as possible.

"SPOT is going to be a vital part of your operations. Get started with it now. It's going to save you so much. It's already made our lives easier, quicker and more efficient. SPOT is helping us work smarter," Allwardt says.

To gain access to the SPOT, *click here*.

Provider options for submitting EHR incentive program quality data

Beginning in 2014, health care providers serving Medicare beneficiaries must report *clinical quality measures* (CQMs) to the Centers for Medicare & Medicaid Services (CMS) as outlined in the *Stage 2 final rule*.

According to information recently released by CMS, providers will be required to comply with the new level of reporting regardless of where they are in the implementation of electronic health record (EHR) systems in their practices or facilities.

Eligible professionals must report a total of six CQMs.

- Three core or alternate core measures (only report an alternate core measure if one of the core denominators is zero)
- Eligible hospitals must report a total of 15 CQMs
- Two measures that target emergency department throughput processes
- Seven measures that address the care of patients with stroke
- Six measures that address the care of patients with venous thromboembolism

Visit the *2014 CQMs Web page* for more information on these requirements, such as the number of CQMs and how to select which ones to report.

Providers participating in the Medicare EHR incentive programs may report CQMs through the *CMS attestation system*. Also, EPs may report through electronic reporting pilot for eligible professionals and hospitals may report through pilot programs through *QualityNet for hospitals*.

For more information on the clinical quality reporting program, visit the *EHR incentive program pages here*.

Information contained within this article was previously released in an edition of the weekly "CMS MLN Connects ™ Provider e-News."

Find fees faster: Try First Coast's fee schedule lookup

Find the fee schedule information you need fast - with First Coast's fee schedule lookup, located at *http://medicare.fcso.com/Fee_lookup/fee_schedule.asp.* This exclusive online resource features an intuitive interface that allows you to search for fee information by procedure code. Plus, you can find any associated local coverage determinations (LCDs) with just the click of a button.

Open payments overview for physicians and teaching hospitals

Provider types affected

This *MLN Matters*® article is intended for physicians and teaching hospitals submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) conducted an *MLN Connects*™ national provider call on August 8, 2013, for physicians and teaching hospitals to give an update on the Open Payments program policy, with a focus on third party payments and indirect payments as well as the physician resource toolkit. This article gives you an overview of the key points discussed.

Open Payments (Physician Payments Sunshine Act) requires manufacturers of pharmaceuticals or medical devices to publicly report payments made to physicians and teaching hospitals.

- Open Payments data collection began on August 1, 2013.
- Physicians and teaching hospitals may voluntarily enroll in the Open Payments program in order to monitor their data reported by industry.

Background

This article provides an overview of the Open Payments program for physicians and teaching hospitals. This information is a summary of the final rule implementing the Open Payments program

(Medicare, Medicaid, Children's Health Insurance Programs; Transparency Reports and Reporting of Physician Ownership or Investment Interests (CMS-5060-F), codified at 42 Code of Federal Regulations (CFR) Parts 402 and 403). This summary is not intended to override or take the place of the final rule, which is the official source for requirements and information on the program.

Relationships between industry and physicians are common

Collaborations between physicians and the medical industry can be beneficial by promoting discovery and development of new technologies that improve health and/or lower costs. However, financial relationships may also influence professional judgment and conflicts of interest can potentially arise.

Section 6002 of the Affordable Care Act requires the establishment of a transparency program, known as Open Payments, which requires manufacturers of pharmaceuticals or medical devices to publicly report payments made to physicians and teaching hospitals, creating greater transparency around the financial relationships that occur among them.

The final rule, entitled "Medicare, Medicaid, Children's Health Insurance Programs; Transparency Reports and Reporting of Physician Ownership or Investment Interests," was published February 8, 2013.

This rule requires manufacturers of drugs, devices, biologicals, or medical supplies covered by Medicare, Medicaid or the Children's Health Insurance Program (CHIP) to report annually to the Centers for Medicare and Medicaid Services (CMS) payments or transfers of value provided to physicians or teaching hospitals. In addition, manufacturers and group purchasing organizations (GPOs) are required to report annually physician ownership or investment interests. CMS will publish manufacturers' and GPOs' submitted payment and ownership information on a public website.

Manufacturers and group purchasing organizations began to collect the required data on August 1, 2013, and will report the data to CMS by March 31, 2014.

Open Payments objectives and roles

The objectives of the program are to:

- Make financial relationships transparent on a national scale; and
- Give consumers the information needed to ask questions and make more informed decisions about their healthcare professionals.

CMS' role

- Remain neutral and present the data on a public website; and
- Ensure reporting and disclosures are complete, accurate, and clear.

Industry's role

Collect information on payments and other transfers of value, as well as ownership or investment interests held by physicians and their immediate family members.

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- Register and submit 2013 data to CMS in the first quarter of 2014.
- Report required annually to CMS;
- Correct disputed information.

Physicians' role

- Voluntarily keep track of payments and transfers of value made to them and be mindful of ownership and investment interests held by themselves or immediate family.
- Voluntarily register with CMS in order to receive notifications and information submitted by industry.
- Voluntarily review information for accuracy prior to public posting and dispute potentially inaccurate data.

Impact on physicians or teaching hospitals

Under the Open Payments program, a "physician" is any of the following types of professionals that are legally authorized by the state to practice, regardless of whether they are Medicare, Medicaid, or Children's Health Insurance Program (CHIP) providers:

- doctor of medicine;
- doctor of osteopathy;
- doctor of dentistry;
- doctor of dental surgery;
- doctor of podiatry;
- doctor of optometry; or
- doctor of chiropractic medicine.

Note: Medical residents are excluded from the definition of physicians for the purpose of this program, but Fellows are not excluded.

Under the Open Payments program, "teaching hospitals" are hospitals that received payment for Medicare direct graduate medical education (GME), inpatient prospective payment system (IPPS) indirect medical education (IME), or psychiatric hospital IME programs during the last calendar year for which this information is available and on the list posted annually by CMS. The teaching hospital list for Open Payments 2013 is posted at *http://go.cms.gov/openpayments* and will be updated annually.

As mentioned, industry will submit to CMS information on payments and other transfers of value, as well as ownership or investment interests held by physicians and their immediate family members. Ownership or investment interest generally includes: stock, stock options other than those received as compensation, until they are exercised; partnership shares; limited liability company memberships; and loans, bonds, or other financial instruments that are secured with an entity's property or revenue or a portion of that property or revenue.

The ownership or investment interest may be direct or indirect and through debt, equity, or other means. Certain exceptions apply (See section 403.902 definitions in the final rule.).

Ownership or investment interests of an immediate family member of a physician can also trigger reporting. Immediate family member of a physician is a spouse; natural or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-, mother-, daughter-, son-, brother-, or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.

Track and review your information

Physicians should track all interactions they have with industry involving payments or transfers of value to ensure accuracy. Physicians and teaching hospitals are not required to register with the program. However, voluntary registration will allow physicians and teaching hospitals to review their data prior to public release. They will also be able to dispute any data thought to be incorrect.

Physicians and teaching hospitals can register and nominate an authorized representative. The information needed to register is undergoing public review and comment through the Paperwork Reduction Act (PRA) process. The information will be finalized and officially released after completion of the PRA process. Physicians, teaching hospitals, and authorized representatives will be able to review and dispute information. Registration starts early 2014 and will remain open.

Physicians may initiate data disputes to correct inaccurate information any time before the end of the calendar year in which the information was publicly available. If the manufacturer or GPO can't resolve the dispute with the physician or teaching hospital and correct the data in the initial 45-day or subsequent 15-day period, the manufacturer or GPO and physician or teaching hospital should continue to seek a resolution.

Corrections from disputes initiated after 45 days may not be reflected in the initial public data. Data from unresolved disputes will still be posted publicly but will be marked as "disputed." CMS will monitor the dispute and resolution process and will update the public data

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at least once annually.

Here is the specific physician information that is reported by the industry:

- Full legal name (as it appears in National Plan and Provider Enumeration System (NPPES);
- Primary practice and specialty;
- Primary business address;
- National provider identifier (NPI) as it appears in NPPES;
- State professional license number(s);
- E-mail address;
- Information about the covered product: name(s) of the related covered drug, device, biological, or medical supply;
- Information about the payment: amount, date, form, and nature of payment or other transfer of value; number of payments; and, if designated or assigned to a third party, the name of individual or entity the physician assigns the payment to; and
- How the payment was made ("form of payment"): Cash or cash equivalent; in kind items or services; stock or stock options or any other ownership interest; dividend, profit or other return on investment indicated to receive the payment.
- In addition, the industry must report why the physician or teaching hospital received the payment ("nature of payment"), e.g.:
- Charitable contribution;
- Compensation for services other than consulting;
- Consulting fees;
- Current or prospective ownership or investment interest
- Direct compensation for serving as faculty or as a speaker for a medical education program (accredited and non-accredited programs);
- Education;
- Entertainment;
- Food and beverage;
- Gifts;
- Grant;
- Honoraria;
- Research;
- Royalty or license;
- Space rental or facility fees; and/or
- Travel and lodging.
- Types of payments in the Open Payment program
- This program captures payments or other transfers of value:
- Paid directly to physicians and teaching hospitals (known as "direct payments");
- Paid indirectly to physicians and teaching hospitals (known as "indirect payments"); and
- Payments designated by physicians or teaching hospitals

Direct payments are payments or other transfers of value provided by the applicable manufacturer or applicable group purchasing organization directly to covered recipients or physicians holding an ownership or investment interest. Here are examples of direct payments: to be paid to another party (known as third party payments)

1. University Teaching Hospital accepts a $10,000 grant paid by check from ABC drug manufacturer on August 5, 2013. The manufacturer reports:

- University Teaching Hospital name, address, and TIN from the teaching hospital list published annually by CMS; and
- Payment information: form of payment, date of payment, and nature of payment.

2. Root Canal Specialty, LLC, contracts with Dr. Jane White to speak at three dental school lectures on the 5th of August, September, and October in 2013 for $5,000 per lecture. During the discussion, Dr. White will market Root Canal Specialty's prescription toothpaste, SparkleRx. The manufacturer reports:

- Dr. Jane White information: name, business address, NPI, license number, primary and specialty type; and
- Payment information: Form of payment, date of

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payment, amount of payment, nature of payment, drug information, and marketed name of the covered drug (SparkleRx).

Indirect payments are those payments or other transfers of value made by a manufacturer (or GPO) to a physician or teaching hospital through an intermediary.

The manufacturer (or GPO) requires, instructs, directs, or otherwise causes the third party to provide the payment to a physician or teaching hospital. Information about the intermediary will not be reported under this program. Here are examples of indirect payments:

1. Root Canal Specialty, LLC, provides $10,000 to a dental specialty society on October 12, 2013, requesting the award to be split between the two dentists, chosen by the dental specialty society. The manufacturer reports the following information about the two dentists:

- Name, address, NPI, license number, specialty ($5,000 will be attributed to each dentist that receives the award); and
- Payment information: form of payment, date of payment, and nature of payment.

2. Asthma Relief, LLC, contracts with an advertisement agency to create a newsletter valued at $35, regarding cutting edge treatments for asthma. The newsletter is targeted toward top prescribers of Asthma Relief, LLC, drugs, and is provided December 7, 2013.

The manufacturer reports the following information about top prescribers:

- Name, address, NPI, license number, specialty ($35 will be attributed to two medical doctors that are provided the newsletter); and
    - Payment information: form of payment, date of payment, and nature of payment.

Third party payments are payments or other transfer of value provided to a third party at the request of or designated on behalf of a physician or teaching hospital. Here is an example of a third party payment:

Asthma Relief, LLC, provides Dr. Henry Jones with a $500 check for serving as a speaker at a round table discussing easybreathingRx and runfreeRx on August 5, 2013. Dr. Jones requests that Asthma Relief, LLC provide the compensation to a charity. The manufacturer reports the following information about the doctor:

- Dr. Henry Jones information: name, address, NPI, license number, specialty ($500 will be attributed Dr. Henry Jones);
- Payment information: form of payment, date of payment, and nature of payment, indication that the payment was designated to an entity and that

the entity was a charity, as well as the name of the entity; and

- Drug information: the marketed name of the covered drugs (easybreathingRx, runfreeRx).

Compensation for speaking at a CME program is not required to be reported, if all of the following conditions are met:

- The program meets the accreditation or certification requirements and standards of the Accreditation Council for Continuing Medical Education (ACCME), the American Academy of Family Physicians (AAFP), the American Dental Association's Continuing Education Recognition Program (ADA CERP), the American Medical Association (AMA), or the American Osteopathic Association (AOA);
- The manufacturer does not directly pay the physician speaker; and
- The manufacturer does not select the physician speaker nor does it provide the third party vendor with a distinct, identifiable set of individuals to be considered as speakers for the accredited or certified continuing education program.

Other indirect payments associated with CME programs include meals, travel and lodging, tuition fees, educational materials included in CME tuition fees, and educational materials not include in CME tuition fees.

For certified or accredited programs:

- For physician-attendees: report meals, travel and lodging, and educational materials not included in CME tuition fees. Do not report tuition fees and educational materials included in CME tuition fees.
- For physician-faculty/speakers: do not report meals, travel and lodging, tuition fees, educational materials included in CME tuition fees, and educational materials not included in CME tuition fees.

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For non-accredited or non-certified programs:

For physician-attendees and for physician-faculty and speakers: report meals, travel and lodging, tuition fees, educational materials included in CME tuition fees, and educational materials not included in CME tuition fees.

Items that directly benefit patients or are intended to be used by or with patients, including the value of a manufacturer's services to educate patients regarding a covered drug, device, biological, or medical supply, are not required to be reported. (See section 403.904 reports of payments or other transfers of value to physician or teaching hospitals of the final rule.) Here are two examples of educational materials:

- A manufacturer or GPO transfers a textbook to a physician or teaching hospital. This is reportable in the Open Payments program because it does not directly benefit patients.
- Manufacturer or GPO transfers a wall model or anatomical model to a physician or teaching hospital. This is not reportable in the Open Payments program because it directly benefits patients.

Physician tools & resources

CMS' goals include creating awareness about the Open Payments program among physicians, providing useful and easy to understand information about Open Payments and providing resources that will support physicians.

CMS is creating awareness about the Open Payments through:

- Hosting national provider calls – see the schedule of calls at *http://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html*;
- Keeping national professional associations abreast of program developments; and
- Leveraging national publications, the *Medicare Learning Network*® and existing CMS contractors educational and outreach efforts.

Mobile applications (apps)

Two free mobile applications (apps) to aid physicians and industry in tracking data collected for Open Payments are available for Apple (iOS) and Android:

- Open Payments Mobile for Physicians
- Open Payments Mobile for Industry

See *MLN Matters*® special edition article, SE1329, for details on these Apps. SE 1329 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1329.pdf*.

CME modules

CME modules are accessible via MedScape. They are accredited by the Accreditation Council for Continuing Medical Education. A link to CME modules is available at *http://go.cms.gov/openpayments*.

CME activity #1: Are you ready for the national physician payment transparency program?

CME activity #2: The physician payment transparency program and your practice.

Educational brochures

Brochures are available for physicians and patients about Open Payments. They are available at *http://go.cms.gov/openpayments*.

- Pub #11709-P: Information Physicians Can Use on: Open Payments (Physician Payments Sunshine Act)
- Pub #11710: Information Patients Can Use on: Open Payments
- MLN Matters® SE1303 "Information on the National Physician Payment Transparency Program: Open Payments," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1303.pdf*.

Other publications

The Sunshine Act – Effects on Physicians," Agrawal, et. al., New England Journal of Medicine, NEJM 2013; 368:2054-2057, is available at *http://www.nejm.org/doi/full/10.1056/NEJMp1303523*.

For more information, contact the Help Desk at *openpayments@cms.hhs.gov* or visit us at *http://go.cms.gov/openpayments*.

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SNFs' PEPPER in the mail

Skilled nursing facilities initiating compliance programs are encouraged to review PEPPER reports recently sent to each facility by the Centers for Medicare & Medicaid Services (CMS). These free provider-specific comparative data reports help identify billing practices which may be at risk for administrative review.

CMS began mailing PEPPER to skilled nursing facilities in August 2013. PEPPER, or program for evaluating payment patterns electronic report, provides facility-specific data statistics for services provided to Medicare beneficiaries. PEPPERs compare a SNF's claims data statistics with aggregate statistics from similar facilities in the state, Medicare administrative jurisdiction, and around the United States.

Facilities with billing patterns at or above the national 80th percentile are identified as "outliers." CMS encourages facilities that spot outliers on their PEPPER to review Medicare payment policy to ensure provided services are medically necessary and that medical record documentation supports services billed.

SNFs that are a part of a short-term acute care hospital may access their PEPPER electronically through the hospital QualityNet system. CMS mailed hard copy PEPPER reports for free-standing SNFs and SNFs administered through long-term acute care hospitals and inpatient rehabilitation facilities on August 30, 2013.

SNF administrators are encouraged to review the *SNF PEPPER User's Guide*. More information is also available on the *PEPPER website*.

Information contained within this article was previously released in an edition of the weekly "CMS MLN Connects ™ Provider e-News."

'Transitioning to ICD-10' video slideshow now available

On June 20, the Centers for Medicare & Medicaid Services (CMS) regional offices hosted webinars on "Transitioning to ICD-10." These webinars are now available as video slideshows on the CMS YouTube Channel and cover the background and impact of ICD-10 on industry, CMS ICD-10 implementation, how CMS is working with the states, how CMS is partnering with industry, best practices, frequently asked questions, resources, and contact information. The change to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act and will take place on October 1, 2014.

The *Eastern event* was specifically for healthcare professionals, coders and organizations operating within the CMS regions I, II, III and IV which include the following states: AL, CT, DC, DE, FL, GA, KY, LA, MA, MD, ME, MS, NC, NH, NJ, NY, PA, RI, SC, TN, VA, VT, and WV.

Information contained within this article was previously released in an edition of the weekly "CMS MLN Connects ™ Provider e-News."

CMS proposes PPS for federally qualified health centers

On September 18, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would establish methodology and payment rates for a prospective payment system (PPS) for federally qualified health center (FQHC) services under Medicare Part B beginning October 1, 2014, in compliance with the statutory requirements of the Affordable Care Act.

CMS is proposing payment to FQHCs based on a single encounter-based per diem rate per Medicare beneficiary. The encounter-based per-diem rate would be calculated based on an average cost per encounter and is estimated to be $155.90, subject to change in the final rule based on more current data.

The rate would be adjusted for geographic differences in the cost of services by adopting the geographic practice cost indices (GPCI) used to adjust payment under the physician fee schedule (PFS).

In addition, the rate would be adjusted (increased by approximately 33 percent) for greater intensity and resource use when an FQHC furnishes care to a patient that is new to the FQHC or to a beneficiary receiving a comprehensive initial Medicare visit (i.e., an initial preventive physical examination or an initial annual wellness visit). FQHCs would transition into the PPS beginning October 1, 2014, based on their cost reporting periods.

This proposed rule also amends the Clinical Laboratory Improvement Amendments (CLIA) of 1988 to be in alignment with the Taking Essential Steps for Testing (TEST) Act of 2012, proposing the regulatory changes needed to fully implement the TEST Act. This proposed rule outlines the framework for the application of sanctions in proficiency testing (PT) referral cases.

The proposed rule will be published in the September 23 *Federal Register*. CMS will accept comments on the proposed rule until November 18, 2013, and will respond to them in a final rule to be issued in 2014.

Additional information is available in the *CMS press release*, *fact sheet*, and *proposed rule*.

SOURCE: PERL 201309-03

Advance beneficiary notice of noncoverage, Form CMS-R-131

Provider types affected

This *MLN Matters*® article is intended for physicians, providers (including home health agencies) and suppliers that submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (MACs), regional home health intermediaries (RHHIs), home health & hospice, Medicare administrative contractors (HHH MACs), and durable medical equipment Medicare administrative contractors (DME MACs)) for services to original Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8404 which provides:

1) instructions for home health agency (HHA) use of the advance beneficiary notice of non-coverage (ABN) to replace the outgoing home health advance beneficiary notice (HHABN), Form CMS-R-296, Option Box 1;
2) ABN issuance guidelines for therapy services and therapy specific examples; and
3) minor editorial changes to clarify existing manual instructions regarding ABN issuance.

Home health agencies and therapy providers should make sure that their health care and billing staff are aware of these ABN policy changes.

All other providers should note that there have been no substantive changes to the ABN form or general instructions for issuance and can reference MM7821 (available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7821.pdf*) for general ABN information.

Background

Section 1879 of the Social Security Act (the Act) protects fee-for-service (FFS) beneficiaries from payment liability (in certain situations) unless the beneficiary is given advance notice of his/her potential liability. The ABN informs beneficiaries about such possible non-covered charges and fulfills this notification requirement when limitation of liability (LOL) applies.

The Centers for Medicare & Medicaid Services (CMS) is expanding use of the ABN to include issuance by home health agency (HHA) providers for Part A and Part B items and services. The ABN will replace the home health advance beneficiary notice (HHABN), Form CMS-R-296, option box 1 that is currently used by HHAs.

The mandatory date for all HHAs to begin use of the ABN and discontinue use of the HHABN will be posted at *http://cms.gov/Medicare/Medicare-General-Information/BNI/HHABN.html*. The guidelines for ABN use published in Chapter 30, Section 50 of the *Medicare Claims Processing Manual* and the ABN form instructions apply to HHAs unless otherwise noted.

Key points from Chapter 30, section 50

HHA use of ABN – general use

HHAs are required to issue an ABN to original Medicare beneficiaries in specific situations where "limitation on liability" (LOL) protection is afforded under Section 1879 of the Act for items and/or services that the HHA believes Medicare will not cover (see Table 1.)

In these circumstances, if the beneficiary chooses to receive the items/services in question and Medicare does not cover the home care, HHAs may use the ABN to shift liability for the non-covered home care to the beneficiary.

ABNs are not used in managed care; however, when a beneficiary transitions to Medicare managed care from original Medicare during a home health episode, ABN issuance is required when there are potential charges to the beneficiary that fall under the LOL projections.

HHAs should contact their RHHI if they have questions on the ABN or related instructions, since RHHIs process home health claims for original Medicare. The following chart summarizes the statutory provisions related to ABN issuance for LOL purposes.

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Table 1 - Statutory provisions related to ABN issuance for LOL purposes

Application of LOL for the home health benefit citation from the Act	Brief description of situation	Recommended explanation for "Reason Medicare May Not Pay" section of ABN
Section 1862(a)(1)(A)	Care is not reasonable and necessary	Medicare does not pay for care that is not medically reasonable and necessary.
Section 1862(a)(9)	Custodial care is the only care delivered	Medicare does not usually pay for custodial care, except for some hospice services.
Section 1879(g)(1)(A)	Beneficiary is not homebound	Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit
Section 1879(g)(1)(B)	Beneficiary does not need skilled nursing care on an intermittent basis	Medicare requires part-time or intermittent need for skilled nursing care in order to cover services under the home health benefit

If one of the above situations applies and the beneficiary chooses to receive the home care items/services that may not be covered by Medicare, HHAs must issue the ABN to the beneficiary to notify him/her of potential financial responsibility.

In addition, when Medicare considers an item or service experimental (e.g., a "research use only" or "investigational use only" laboratory test), payment for the experimental item or service is denied under Section 1862(a)(1) of the Act as not reasonable and necessary. In circumstances such as this, the beneficiary must be given an ABN.

HHA triggering events

HHAs may be required to provide an ABN to an Original Medicare beneficiary when a triggering event occurs. Table 2 outlines triggering events specific to HHAs.

Table 2 – Triggering events for ABN issuance by HHAs*

Event	Description
Initiation	When an HHA expects that Medicare will not cover an item and/or service delivered under a planned course of treatment from the start of a spell of illness, OR before the delivery of a one-time item and/or service that Medicare is not expected to cover.
Reduction	When an HHA expects that Medicare coverage of an item or service will be reduced or stopped during a spell of illness while continuing others, including when one home health discipline ends but others continue.
Termination	When an HHA expects that Medicare coverage will end for all items and services in total.

*ABN issuance is only required when the HHA is going to provide the beneficiary with the item or service that is being initiated, reduced, or terminated as described in this Table. If the beneficiary does not want the item or service that is being initiated, reduced, or terminated, no ABN is required.

HHA initiations

The HHA must issue a beneficiary an ABN prior to delivering care that is usually covered by Medicare, but in this particular instance, the item or service may not be or is not covered by Medicare because:

- The care is not medically reasonable and necessary;
- The beneficiary is not confined to his/her home (is not considered homebound);
- The beneficiary does not need skilled nursing care on an intermittent basis; or
- The beneficiary is receiving custodial care only.

Note: If the HHA believes that Medicare will not (or may not) pay for care for a reason other than ones listed directly above, issuance of the ABN is not required.

Initiation example: A beneficiary requires skilled nursing wound care three times weekly; however, she is not confined to the home. She wants the care done at her home by the HHA.

The HHA must issue the ABN to this beneficiary before providing the home care that will not be paid for by Medicare. This allows the beneficiary to make an informed decision on whether to receive the non-

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Advance *(continued)*

covered care, and to accept the financial obligation.

An ABN, signed at initiation of home health care for items and/or services not covered by Medicare, is effective for up to a year; as long as the items/services being given remain unchanged from those listed on the notice.

Any one-time care that is provided and completed in a single encounter is considered an initiation in terms of triggering events, and is subject to ABN issuance requirements if applicable. When an HHA performs a beneficiary's initial assessment prior to admission but does not admit him/her; an ABN is not required if there is no charge for the assessment. However, if an HHA charges for an assessment, it must provide notice to the beneficiary before performing and charging for this service.

Since Medicare has specific requirements for payment of home health services, there may be occasions in which a payment requirement is not met, and therefore, the HHA expects that Medicare will not pay for the services. The HHA cannot use the ABN to transfer liability to the beneficiary when there is concern that a billing requirement may not be met. (For example, a home health agency cannot issue an ABN at initiation of home care services in order to charge the beneficiary if the provider face to face encounter requirement is not met.)

HHA reductions

Reductions involve any decrease in services or supplies, such as frequency, amount, or level of care that an HHA provides and/or that is part of the plan of care (POC). If a reduction occurs for an item or service that will no longer be covered by Medicare, but the beneficiary wants to continue to receive the item or service and will assume the financial charges, the HHA must issue the ABN prior to providing the non-covered items or services. (Technically, this is an initiation of non-covered services following a reduction of services).

Reduction with subsequent initiation example: A beneficiary requires physical therapy (PT) for gait retraining five times per week for two weeks, then reduce to three times weekly for two weeks. After two weeks of PT, the beneficiary wants to continue therapy five times a week even though this amount of therapy is no longer medically reasonable and necessary. The HHA would issue an ABN so that he understands the situation and can consent to financial responsibility for the PT not covered by Medicare.

HHA terminations

A termination is the cessation of all HHA-provided Medicare covered services. If a beneficiary wants to continue receiving home health care that will not be covered by Medicare for any of the statutory reasons listed in Table 1 and a physician orders the services; the HHA must issue the beneficiary an ABN in order

to charge the beneficiary or a secondary insurer. If the beneficiary will not be getting any further home care after discharge, there is no need for ABN issuance.

When all Medicare covered home health care is terminated, HHAs may sometimes be required to deliver the notice of Medicare provider non-coverage, (NOMNC), CMS-10123. The NOMNC informs beneficiaries of the right to an expedited determination by a quality improvement organization (QIO) if they feel that termination of home health services is not appropriate. Detailed information and instructions for issuing the NOMNC can be found on the CMS website under the link for "FFS ED Notices" at *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html*.

If a beneficiary requests a QIO review upon receiving a NOMNC, the QIO will make a fast decision on whether covered services should end. If the QIO decides that Medicare covered care should end and the beneficiary wishes to continue receiving care from the HHA even though Medicare will not pay, an ABN must be issued since this would be an initiation of non-covered care.

If a beneficiary is eligible for both original Medicare and Medicaid (dually eligible) or is covered by original Medicare and another insurance program or payer (such as waiver programs, Office on Aging funds, community agencies (e.g., Easter Seals) or grants), ABN requirements still apply.

Effect of other insurers/payers

For example, when a beneficiary is a dual eligible and receives home health services that are covered only under Medicaid, but are not covered by Medicare for one of the reasons listed in Table 1; an ABN must be issued at the initiation of this care to inform the beneficiary that Medicare will likely deny the services.

Some States have specific rules regarding HHA completion of liability notices in situations where dual eligible beneficiaries need to accept liability for Medicare non-covered care that Medicaid will cover. Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is

(continued on next page)

Advance *(continued)*

recognized as the "payer of last resort" (meaning other Federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid assumes any remaining charges).

On the ABN, the first check box under the "options" section indicates the choice to bill Medicare and is equivalent to the third checkbox on the outgoing HHABN. HHAs serving dual eligibles should comply with existing HHABN State policy within their jurisdiction as applicable to the ABN unless the State instructs otherwise.

Note: If a state has issued a directive to select the third checkbox on the HHABN, HHAs must mark the first check box when issuing the ABN.

Where there is no state specific directive, HHAs are permitted to instruct beneficiaries to select option 1 on the ABN when a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer. HHAs may add a statement in the "*Additional information*" section to help a dual eligible better understand the payment situation such as, "We will submit a claim for this care to your other insurance," or "Your medical assistance plan will pay for this care."

HHAs may also use the *Additional information* on the ABN to include agency specific information on secondary insurance claims or a blank line for the beneficiary to insert secondary insurance information. Agencies can pre-print language in the *Additional information* section of the notice.

HHA exceptions to ABN notification requirements

ABN issuance is NOT required in the following HHA situations:

- Initial assessments (in cases where beneficiaries are not admitted) for which HHAs do not charge;
- Care that is never covered by Medicare under any circumstances (i.e., an HHA offers complimentary hearing aid cleaning and maintenance);
- Telehealth monitoring used as an adjunct to regular covered HH care; or
- Non-covered items/services that are part of care covered in total under a Medicare bundled payment (e.g., HH prospective payment system (PPS) episode payment).

Other HHA ABN guidance

1. ABN for voluntary notice by HHAs

HHAs may use the voluntary ABN, as a courtesy, to alert beneficiaries of impending financial obligation for items and services that are never covered by Medicare as described in the *Medicare Claims Processing Manual*, Chapter 30 (Financial Liability Protections), Section 50.3.2 (Voluntary ABN Uses).

2. Effect of initial payment determinations on liability

An ABN informs a beneficiary of his/her HHA's expectation with regard to Medicare coverage. If the care described on the ABN is actually provided, Medicare makes a payment determination on the items and/or services at issue when adjudicating the related claim. Such adjudications may uphold the provider's expectation, in which case the beneficiary will remain liable for payment if agreeing to accept this liability based on a valid ABN. However, adjudication may not conform to the provider's expectation, in which case the decision made on the claim supersedes the expectation given on the ABN. That is, Medicare may cover and pay for care despite the HHA's expectation, or deny the claim and find the provider liable. In such cases, if the HHA collected funds from the beneficiary, the HHA must promptly refund the appropriate amount to the beneficiary.

3. Use of abbreviations

When completing the ABN, HHAs must avoid using abbreviations in the body of the notice unless the abbreviation is already spelled out elsewhere. For example, an abbreviation such as "PT" that can have multiple meanings in a home health setting (part-time, physical therapy, prothrombin time) should be spelled out at least once on the ABN next to the abbreviation of the word(s). When this is done, the abbreviation can be used again on the notice. ABNs containing abbreviations that are not defined in this manner on the notice may be invalidated by contractors.

4. Cost estimate

HHAs should follow the ABN form instruction guidelines for providing cost estimates for items or services. The cost estimate must be a good faith estimate based on agency charges and the expected frequency and duration of each service. Cost estimates per visit or per number of visits weekly

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Advance *(continued)*

are acceptable. A difference in the cost estimate and actual cost will not automatically invalidate the ABN. The cost estimate must give the beneficiary an idea of what his/her out of pocket costs might be if s/he chooses to receive the care listed on the ABN.

Cost estimate examples:

- $440 for 4 weekly nursing visits in 1/13.
- $260 for 3 physical therapy visits 1/3-1/7/13.
- $50 for spare right arm splint.

When more than one item and/or service is at issue, the HHA must enter separate cost estimates for each item or service as clearly as possible, including information on the period of time involved when appropriate.

Outpatient therapy services use of the ABN

Section 603(c) of the American Taxpayer Relief Act (ATRA) amended Section 1833(g)(5) of the Act to provide limitation of liability protections to beneficiaries receiving outpatient therapy services on or after January 1, 2013, when services are denied and the services provided are in excess of therapy cap amounts and don't qualify for a therapy cap exception. This amendment affected financial liability for certain therapy services that exceed the cap.

Prior to the ATRA amendment, claims for therapy services at or above therapy caps that did not qualify for a coverage exception were denied as a benefit category denial, and the beneficiary was financially liable for the non-covered services. CMS had encouraged suppliers and providers to issue a voluntary ABN as a courtesy; however, ABN issuance wasn't required for the beneficiary to be held financially liable.

Now, with this ATRA amendment to the Act, the provider/supplier must issue a valid, mandatory ABN to the beneficiary before providing services above the cap when the therapy coverage exceptions process isn't applicable. ABN issuance allows the provider to charge the beneficiary if Medicare doesn't pay. If the ABN isn't issued when it is required and Medicare doesn't pay the claim, the provider/supplier will be liable for the charges.

Therapists are required to issue an ABN to beneficiaries before providing them therapy that is not medically reasonable and necessary, regardless of the therapy cap. Statutory changes (mentioned above) mandate ABN issuance when therapy services are not medically reasonable and necessary and exceed the cap amount. Policies for mandatory ABN issuance for services below the therapy cap remain unchanged. If a beneficiary will be getting therapy services that will not be covered by Medicare because the services are not medically necessary, an ABN must be issued before the services are provided so that the beneficiary can choose whether to obtain the services and accept financial responsibility for them.

Therapy cap is not met – ABN mandatory example: A beneficiary has been receiving physical therapy (PT) three times per week, and currently, he has achieved all his PT goals established in the plan of care (POC). The total amount applied to his therapy cap this year is $780. He requests continued PT services two times per week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that will not be covered by Medicare because they are no longer medically necessary.

Therapy cap has been met – ABN mandatory example: A beneficiary has recently been receiving physical therapy (PT) three times per week, and she has achieved all her PT goals established in the POC. The total amount applied towards her therapy cap this year is $1,900. She requests continued PT services two times a week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that are not medically necessary and exceed the cap in order for the therapist to transfer liability and charge the beneficiary.

In cases such as these, if Medicare denies the claim and a valid ABN was issued, financial liability shifts to the beneficiary. If the provider fails to issue an ABN for therapy that is not medically necessary, the provider will be held financially liable if Medicare denies the claim.

Additional information

The official instruction, CR 8404, issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2782CP.pdf*. The revised portions of the *Medicare Claims Processing Manual* are a part of CR 8404.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8404
Related Change Request (CR) #: CR 8404
Related CR Release Date: September 6, 2013
Effective Date: December 9, 2013
Related CR Transmittal #: R2782CP
Implementation Date: December 9, 2013

Disclaimer - This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Diagnosis reporting on religious nonmedical health care institution claims

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8350 which informs Medicare contractors about enforcement in Medicare systems of longstanding diagnosis coding instructions on religious nonmedical health care institution (RNHCI) claims. It also clarifies diagnosis code reporting on RNHCI claims for the ICD-10 transition. Make sure that your billing staffs are aware of these changes.

Background

While coding of diagnoses is not consistent with the nonmedical nature of religious nonmedical heath care institution (RNHCI) services, the presence of diagnosis codes is a requirement for standard claims transactions. Longstanding instructions in the *Medicare Claims Processing Manual*, Chapter 3, Section 170, direct RNHCIs to use the following pair of ICD-9 diagnosis codes to satisfy the claim requirement:

- Principal diagnosis: 799.9 “other unknown and unspecified cause”
- Other diagnosis: V62.6 “refusal of treatment for reasons of religion or conscience”

RNHCI claims received on or after January 1, 2014 (with any claim “through” date prior to October 1, 2014), will be returned to the provider if they do not contain the above ICD-9 principal diagnosis and first other diagnosis codes.

The implementation of ICD-10 effective October 2014 will require RNHCI to instead report the following pair of ICD-10 diagnosis codes to satisfy the claim requirement: claim “through” date prior to October 1, 2014), will be returned to the provider if they do not contain the above ICD-9 principal diagnosis and first other diagnosis codes.

- Principal diagnosis: R69 “illness, unspecified”
- Other diagnosis: Z53.1 “procedure and treatment not carried out because of patient’s decision for reasons of belief”

RNHCI claims received with a claim “through” date on or after October 1, 2014, will be returned to the provider if they do not contain the above ICD-10 principal diagnosis and first other diagnosis codes or if they contain any ICD-9 code.

Additional information

The official instruction, CR 8350 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2765CP.pdf*.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8350
Related Change Request (CR) #: CR 8350
Related CR Release Date: August 16, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2765CP
Implementation Date: January 6, 2014

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This section of *Medicare A Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction 9 (J9) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical coverage Web page at *http://medicare.fcso.com/Landing/139800.asp* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Contents

Advance beneficiary notice

- **Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an advance beneficiary notification (ABN) signed by the beneficiary. **Note:** Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.
- **Modifier GA** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.
- All claims not meeting medical necessity of a local coverage determination (LCD) must append the billed service with **modifier GA or GZ.**

New LCDs

Psychological and neuropsychological tests – new LCD

LCD ID number: L33688 (Florida/Puerto Rico/U.S. Virgin Islands)

This new local coverage determination (LCD) has been developed as a result of the medical review issues identified in the documentation associated with claims for psychiatric services regarding unnecessary and incorrect billing for psychological and neuropsychological tests: *Current Procedural Terminology*® (*CPT*®) codes *96101-96125* and Healthcare Common Procedure Coding System (HCPCS) code G0451).

The documentation reviewed consisted mostly of evaluations of the mental status that can be performed within the psychiatric diagnostic evaluation (e.g., *CPT*® codes *90791, 90792*).

In conclusion, the contractor recognized the need to create this LCD because the documentation reviewed consisted mainly of services that should not be classified separately as psychological or neuropsychological tests and should have been coded as part of the psychiatric/psychological clinical exam or interview.

This new LCD was developed to address the indications and limitations of coverage and/or medical necessity, procedure and diagnosis codes, documentation requirements, and utilization guidelines for psychological and neuropsychological tests.

Effective date

This new LCD is effective for services rendered **on or after October 14, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage databases at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting *LCD Attachments* in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction (J9), please click *here*.

Revision to LCDs

Bisphosphonates and monoclonal antibodies in the treatment of osteoporosis and their other indications – revision to Part A LCD

LCD ID number: L32110 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications was most recently revised July 1, 2013.

Since that time, a revision was made under the *Indications and Limitations of Coverage and/or Medical Necessity* section of the LCD to add the new Food and Drug Administration (FDA) label indication for treatment of adults and skeletally mature adolescents with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity.

Also, a revision was made under the *ICD-9 Codes that Support Medical Necessity* section of the LCD, subtitled "HCPCS Codes J0897 (Xgeva®)" to add diagnosis code 238.0 (Neoplasm of uncertain behavior of bone and articular cartilage). In addition, the *Documentation Requirements*, *Utilization Guidelines*, *Sources of Information and Basis for Decision* sections of the LCD, and *Coding Guidelines* attachment were updated.

Effective date

This LCD revision is effective for claims processed **on or after October 11, 2013 ,** for services rendered **on or after June 13, 2013.**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage databases at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting *LCD Attachments* in the "Jump to Section…" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction (J9), please click *here*.

Revision to LCDs

Noncovered services – revision to the Part A LCD

LCD ID number: L28991 (Florida)
LCD ID number: L29023
(Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered services was most recently revised August 14, 2013. Since that time, the following revisions have been made to the LCD:

- Based on the Centers for Medicare & Medicaid Services (CMS) change request 8249 and the approval by the Food and Drug Administration (FDA), *Current Procedural Terminology®* (*CPT®*) code *90685* was removed from the "Drugs and Biologicals" section of the LCD. This LCD revision is effective for claims processed **on or after October 7, 2013**, for services rendered **on or after June 7, 2013**.
- *CPT®* codes *90653, 90666, 90667, 90668, 90687, 90688*, and *90739* have been removed from the *Drugs and Biologicals* section of the LCD as they are denied via editing developed by the Centers for Medicare & Medicaid Services (CMS) and not based on reasonable and necessary criteria in this LCD. This LCD revision is effective for services rendered **on or after October 7, 2013**.
- A new LCD (Transcranial Magnetic Stimulation for Major Depressive Disorder) was developed and includes *CPT®* codes *90867, 90868*, and *90869* which is currently in a 45-day notice period to become effective October 7, 2013. Therefore, *CPT®* codes *90867, 90868*, and *90869* have been removed from the *Procedures* section of the LCD. This LCD revision is effective for services rendered **on or after October 7, 2013**.
- *CPT®* codes *31660* and *31661* were evaluated and a decision was made to remove these codes from the *Procedures* section of the LCD, This LCD revision is effective for services rendered **on or after October 7, 2013**.
- For all claims submitted with *CPT®* codes *31660* and *31661*, medical record documentation will be requested and reviewed on an individual consideration basis. Of note, when an item or service is removed from the *Noncovered Services LCD*, it does not imply a positive coverage statement and coverage by Medicare.

  Therefore, claims billed for *CPT®* codes *31660* and *31661* (assuming all other requirements of the program are met) would always need to meet the medically reasonable and necessary threshold for coverage in a prepayment or post payment audit of the official record.
- Any time there is a question whether Medicare's medical reasonableness and necessity criteria would be met, we recommend the use of an advance beneficiary notice (ABN) and appending modifier GA to the billed HCPCS codes. Please note that services leading up to or associated with non-covered services are also not covered.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage databases at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting *LCD Attachments* in the "Jump to Section" drop-down menu at the top of the LCD page.

Note: To review active, future, and retired LCDs for jurisdiction 9, please *click here*.

First Coast Service Options Inc provides current and draft local coverage determinations (LCDs), when they exist, for Medicare-covered procedure codes.

Not every procedure code is covered by an LCD. *Click here* **to look up current LCDs**

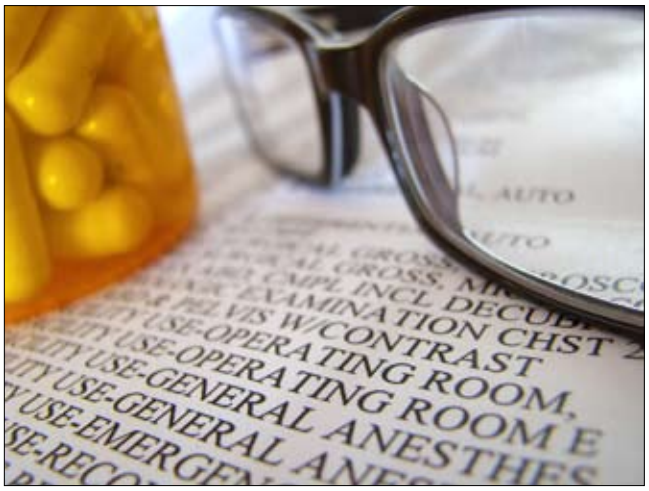
MCD display of ICD-10 local coverage determinations

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare claims administration contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8348 which is issued by the Centers for Medicare & Medicaid Services (CMS) to ensure that *International Classification of Diseases, Tenth Revision* (ICD-10) LCDs and articles are published in the Medicare coverage database (MCD) in a timely manner to allow providers sufficient time to make provider specific billing system changes. Make sure that your billing staff is aware of these changes.



Background

CR 8348 instructs that all ICD-10 LCDs and associated ICD-10 articles will be published on the Medicare coverage database (MCD) no later than April 10, 2014. All other LCDs and articles (i.e., those LCDs and articles that do not contain ICD-10 information, or articles not attached to an LCD) will be published on the MCD no later than September 4, 2014.

Note: All LCDs and articles will receive a new LCD/article ID number. For example, LCD ID 1234 might become LCD ID 4567.

The new LCD/article ID number could have an impact on MACs local systems, such as changing their Medicare summary notice to capture the new LCD/article ID number.

CMS has determined that although new LCD numbers will be assigned to the ICD-10 LCD policies, the policies will not be considered new policies. CMS considers this type of update to be a coding revision that does not change the intent of coverage/non-coverage within an LCD. Therefore, if a MAC only translates ICD-9 codes to the appropriate ICD-10 code, the policy does not need to be vetted through their carrier advisory committee or be sent through the public comment and notice process.

However, if a MAC decides to revise more than just the ICD-10 code(s), they will follow the normal LCD development process outlined in the *Medicare Program Integrity Manual* (Publication 100-08, Chapter 13 (Local Coverage Determinations)) at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf*.

Additional information

The official instruction, CR 8348 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1293OTN.pdf*.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8348
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Implementation Date: April 10, 2014

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Try our E/M interactive worksheet

First Coast Service Options (First Coast) Inc. is proud of its exclusive E/M interactive worksheet, available at *http://medicare.fcso.com/EM/165590.asp*. This resource was developed to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit. This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders.

Add-on HCPCS/*CPT*® codes without primary codes

Note: This article was revised on August 16, 2013, to add a reference *MLN Matters*® article MM8271 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8271.pdf*) to alert providers that Medicare contractors will generate an informational unsolicited response (IUR) or reject claims for an add-on *Current Procedural Terminology*® (*CPT*®) code on an outpatient claim when there is no primary procedure *CPT*® code associated with the add-on code OR when the primary procedure *CPT*® code associated with the add-on code associated is not covered by Medicare. It was previously published in the July 2013 edition of *Medicare A Connection*, Page 21. All other information remains the same.

Provider types affected

This *MLN Matters*® special edition article is intended for providers who submit claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

An add-on code is a Health Care Common Procedure System (HCPCS) code or *CPT*® code that describes a service that, with one exception (see *Background section* below), is always performed in conjunction with another primary service. An add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner on the same date of service.

The Centers for Medicare & Medicaid Services (CMS) has learned from recovery auditor reports that some providers are billing only Add-on HCPCS/*CPT*® codes without their respective primary codes resulting in overpayments.

This *MLN Matters*® special edition article provides an overview of billing for HCPCS/*CPT*® add-on codes, and it is based on CMS manuals and publications including the *Medicare Claims Processing Manual*, (Chapter 12, Sections 30(D) and 30.6.12(I).

Change request (CR) 7501 (Transmittal 2636 dated January 16, 2013) titled "National Correct Coding Initiative (NCCI) Add-On Codes Replacement of Identical Letter, Dated December 19, 1996 with Subject Line, Correct Coding Initiative Add-On (ZZZ) Codes – ACTION."

Background

An add-on code is a HCPCS/*CPT*® code that describes a service that is always performed in conjunction with the primary service. An add-on code is eligible for payment only if it is reported with the appropriate primary procedure performed by the same practitioner.

The *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.12(I) requires a provider to report *CPT*® code *99292* (*Critical care, evaluation and management of the critically ill or critically injured patient*; *each additional 30 minutes* (*List separately in addition to code for primary service)*), without its primary code *CPT*® code *99291* (*Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*). If two or more physicians of the same specialty in a group practice provide critical care services to the same patient on the same date of service.

For the same date of service only one physician of the same specialty in the group practice may report *CPT*® code *99291* with or without *CPT*® code *99292*, and the other physician(s) must report their critical care services with *CPT*® code *99292*. See CR 7501 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2636CP.pdf* for current information regarding add-on codes in addition to the manual section mentioned above.

The following shows an example of this issue:

Example:

- A provider submitted a claim with *CPT*® code *26863* for one unit for date of service May 5, 2010, without billing for the primary *CPT*® code *26862*. Add-on codes billed without their primary codes are considered an overpayment. Overpayment for add-on *CPT*® code *26863* was retracted as a billing error.
- Add-on *CPT*® code *26863* description: *Fuse/Graft added joint – Arthrodesis, interphalangeal joint with or without internal fixation; with autograft, each additional joint*. *List separately in addition to code for primary procedure.*
- Primary *CPT*® code *26862* description: *Fusion/graft of finger – Arthrodesis, interphalangeal joint, without internal fixation; with autograft*. This is a parent *CPT*® code and can be reported with add-on *CPT*® code *26863*.

(continued on next page)

Instruction to use non-alert remittance advice remark codes

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (fiscal Intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME/MACs) and A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 7910 was implemented by Medicare in April 2013. CR 7910 included a business requirement (BR 7910.2) instructing the Medicare shared systems (SSs) and contractors to stop sending non-alert remittance advice remark codes (RARCs) without associated group codes and/or claim adjustment reason codes (CARCs).

It has been reported that this resulted in provider concern and increased provider inquiries. The Centers for Medicare & Medicaid Services (CMS) is working on developing a long term resolution but has decided to continue to send non-alert RARCs without any group code and/or CARC for now.

Additional information

The official instruction, CR 8391 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1285OTN.pdf*.

If you have any questions, please contact your

Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

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Related Change Request (CR) #: CR 8391
Related CR Release Date: August 16, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R12850TN
Implementation Date: October 7, 2013, except January 6, 2014, for DME MACs

Disclaimer - This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Add-on *(continued)*

Additional information

You can find CR 7501 (Transmittal 2636 dated January 16, 2013) titled "National Correct Coding Initiative (NCCI) Add-On Codes Replacement of Identical Letter, Dated December 19, 1996 with Subject Line, Correct Coding Initiative Add-On (ZZZ) Codes – ACTION" at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2636CP.pdf*.

You can review the *Medicare Claims Processing Manual* (Chapter 12, Section 30.6.12(I) Critical Care Services Provided by Physicians in Group Practice(s)) at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

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Related Change Request (CR) #: N/A
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Related CR Transmittal #: N/A
Implementation Date: N/A

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Operating rules for code usage in remittance advice

This article was revised September 4 and September 16, 2013, respectively, to reflect a revised change request (CR) 8182 issued August 30 and add reference to MM8365 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8365.pdf)* for business scenarios, descriptions and updates related to Rule 3. This information was previously published in the May 2013 edition of *Medicare A Connection*, Pages 20-21.

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries, (RHHIs), Medicare administrative contractors (A/B MACs), or durable medical equipment Medicare administrative contractors (DME MACs) for services to Medicare beneficiaries.

What you need to know

CR 8182 instructs Medicare contractors to implement the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set for code usage in electronic funds transfer (EFT) & electronic remittance advice (ERA) by January 1, 2014.

Background

The Health Insurance Portability and Accountability Act (HIPAA) amended Title XI of the Social Security Act by adding Part C (Administrative Simplification), which requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards for certain transactions to enable health information to be exchanged more efficiently; and to achieve greater uniformity in its transmission. (Please refer to: *Public Law* 104-191, Health Insurance Portability and Accountability Act of 1996, *http://aspe.hhs.gov/admnsimp/pl104191.htm#1173*.)

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions and by mandating the adoption of a set of operating rules for each HIPAA transaction.

In December 2011 congressional testimony, the National Committee on Vital and Health Statistics (NCVHS) stated that the transition to electronic data interchange (EDI) from paper has been slow and "disappointing." (You can find a copy of this testimony at *http://www.ncvhs.hhs.gov/*.)

Note: The same rules will also apply to standard paper remittance (SPR), as Medicare reports the same standard codes in both electronic and paper formats of remittance advice.

The EFT & ERA operating rule set includes the following rules:

(Please note that CR 8182 focuses only on rule numbers 3 and 4)

1. Phase III CORE 380 EFT enrollment data rule;

2. Phase III CORE 382 ERA enrollment data rule;

3. Phase III Core 360 uniform use of claim adjustment reason codes and remittance advice remark codes (835) rule;

4. CORE-required code combinations for CORE-defined business scenarios for the phase III core uniform use of claim adjustment reason codes and remittance advice remark codes (835) rule;

5. Phase III CORE 370 EFT & ERA re-association (CCD+/835) Rule; and

6. Phase III CORE 350 health care claim payment/advice (835) infrastructure rule.

HIPAA initially mandated the standard code sets that a health plan may use to explain to providers/suppliers how a claim/line has been adjudicated, and now the ERA/EFT operating rules under the Affordable Care Act are mandating a standard use of those standard codes.

The ERA/EFT operating rules mandate consistent and uniform use of remittance advice (RA) codes (group codes, claim adjustment reason codes (CARC) and remittance advice remark codes (RARC)) to mitigate confusion that may result in:

- Unnecessary manual provider follow-up;
- Faulty electronic secondary billing;
- Inappropriate write-offs of billable charges;
- Incorrect billing of patients for co-pays and deductibles, and/or
- Posting delay.

The CORE Phase III ERA/EFT operating rules define four business scenarios, and specify the maximum set of the standard codes that a health plan may use. This list will be updated and maintained by a CORE task group when the two code committees update the lists and/or when there is need for additional combinations based on business policy change and/or federal/state mandate.

The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for each business scenario is specified in the document: Committee on Operating Rules for Information Exchange (CORE®)-required code combinations for CORE-defined business scenarios for the Phase III CORE 360 uniform use of claim adjustment reason codes and remittance advice

(continued on next page)

Codes *(continued)*

remark codes (835) rule) that is an attachment to CR 8182. This list of code combinations will be updated by CAQH CORE on a regular basis, and for Medicare, the updated list will be a part of the recurring code update CR (published 4 times a year) in the future.

Additionally, you should be aware that Medicare is implementing the code combinations that relate to these four scenarios in October 2013, as follows:

Scenario #1 - Additional information required - missing/invalid/incomplete documentation This scenario refers to situations in which additional documentation is needed from the billing provider or an ERA from a prior payer.

Scenario #2 - Additional information required – missing/invalid/incomplete data from submitted claim This scenario refers to situations in which additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

Scenario #3 - Billed service not covered by health plan - This scenario refers to situations in which the billed service is not covered by the health plan.

Scenario #4 - Benefit for billed service not separately payable - This scenario refers to situations in which the billed service or benefit is not separately payable by the health plan.

Finally, by October 7, 2013, the Medicare remit easy print (MREP) and PC print software will be modified as necessary.

Additional information

The official instruction, CR 8182, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1291OTN.pdf*. You will find a copy of the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule).

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

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Disclaimer - This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Save time and money – resolve reason code 34538

Remittance message: Claim submitted as Medicare primary and a positive working elderly record exists at the common working file (CWF). The contractor ID is equal to '11121'. The claim should be billed to the employer group health plan (EGHP).

What does this really mean? The beneficiary or the spouse was/is working for the date of service(s) and the employer's insurance is primary to Medicare.

Provider action required

- Upon patient registration and prior to submitting the claim, have the beneficiary complete the *Medicare secondary payer (MSP) questionnaire* located in the *Medicare Secondary Payer Internet-only manual* (IOM), Publication 100-05, Chapter 3, Section 20.1.2.
- Confirm the beneficiary's eligibility via direct data entry (DDE), the interactive voice response (IVR) system, or take advantage of the secure provider online tool (SPOT), where you can view claims status, eligibility and benefits, payment information, and comparative billing data in a secure online environment. Please follow this path to learn more about the SPOT as well as how to begin the registration process: *http://medicare.fcso.com/Landing/256747.asp*
- If the information is **invalid**
- The provider or the beneficiary must contact the coordination of benefits contractor (COBC) at 1-800-999-1118 to have the record updated. Once the record is updated, re-file the claim to Medicare for primary payment consideration.
- If the information is **valid**
- File the claim to the primary insurance listed on the beneficiary's records and then to Medicare for secondary payment consideration

Additional resources

- Resolve reason code *U5233*
  Resolve reason code *N5052*
  Resolve reason code *C7010*

Source: *Internet-only manual, Medicare Secondary Payer, Publication 100-05, Chapter 3*

Update to remittance advice remark and claims adjustment reason codes

Provider types affected

This *MLN Matters*® article is intended is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHHI), carriers, durable medical equipment Medicare administrative contractors (DME MAC) and Medicare administrative contractors (A/B MAC) for services to Medicare beneficiaries.

What you need to know

Change request (CR) 8422, from which this article is taken, updates the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists, effective October 1, 2013; and also instructs the fiscal intermediary standard system (FISS) and VIPs Medicare system (VMS) maintainers to update Medicare remit easy print (MREP) and PC print. Make sure that your billing staffs are aware of these updates.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions, adopted under HIPAA, using valid standard codes.

Accordingly, Medicare policy states that two standard code sets (claim adjustment reason codes (CARC) and remittance advice remark codes (RARC)) must be used for:

- Transaction 835 (health care claim payment/ advice) and standard paper remittance advice, (along with group code) to report payment adjustments; and Informational RARCs to report appeal rights, and other adjudication related information; and
- Transaction 837 (coordination of benefits (COB)).

Staff at the Centers for Medicare & Medicaid Services (CMS) usually requests changes to the CARC and RARC codes that impact Medicare, in conjunction with a policy change.

If an entity other than CMS initiates a modification for a code that Medicare currently uses, contractors must either use the modified code (or another code), if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

CARC and RARC code sets are regularly updated three times a year. CR 8422 lists only the changes that have been approved since the last code update CR (CR 8281, Transmittal 262686, issued on April 12, 2013), and does not provide a complete list of codes for these two code sets.

Note: In case of any discrepancy in the code text as posted on Washington Publishing Company (WPC) website and as reported in any CR, the WPC version should be implemented.

Changes in CARC list since CR 8281

These are the changes in the CARC database since the last code update CR8281. The full CARC list may be downloaded from the WPC website, available at *http://wpc-edi.com/Reference*.

New Codes – CARC:

Code	Narrative	Effective date
253	Sequestration - reduction in federal spending.	06/02/2013
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	06/02/2013
255	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with group code OA)	06/02/2013
256	Service not payable per managed care contract.	06/02/2013
W5	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with group code CO or OA)	06/02/2013
W6	Referral not authorized by attending physician per regulatory requirement.	06/02/2013
W7	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.	06/02/2013
W8	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.	06/02/2013
W9	Service not paid under jurisdiction allowed outpatient facility fee schedule.	06/02/2013

(continued on next page)

Codes *(continued)*

Modified Codes – CARC:

Code	Modified narrative	Effective date
16	Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT.) This change effective 11/1/2013: Claim/service lacks information or has submission/ billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT.) Note: Refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF), if present.	06/02/2013
18	Exact duplicate claim/service (Use only with group code OA except where state workers' compensation regulations requires CO)	06/02/2013
45	Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement. (Use only with group codes PR or CO depending upon liability)	07/01/2013
136	Failure to follow prior payer's coverage rules. (Use only with group code OA)	07/01/2013
163	Attachment/other documentation referenced on the claim was not received.	06/02/2013
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	06/02/2013
173	Service/equipment was not prescribed by a physician.	07/01/2013
201	Workers' compensation case settled. Patient is responsible for amount of this claim/ service through WC 'Medicare set aside arrangement' or other agreement. (Use only with group code PR)	07/01/2013
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with group code OA)	07/01/2013
221	Claim is under investigation. **Note**: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 insurance policy number segment (Loop 2100 other claim related information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the line level, the payer must send and the provider should refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF). (**Note**: To be used by property & casualty only)	07/01/2013
226	Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient/incomplete. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT.)	07/01/2013
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12x. **Note**: This code can only be used in the 837 transaction to convey coordination of benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with group code PR)	07/01/2013

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Codes *(continued)*

Code	Modified narrative	Effective date
236	This procedure or procedure/ modifier combination is not compatible with another procedure or procedure/ modifier combination provided on the same day according to the national correct coding initiative or workers compensation state regulations/fee schedule requirements.	07/01/2013
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with group code PR)	07/01/2013
242	Services not provided by network/primary care providers **Notes**: This code replaces deactivated code 38	06/02/2013
243	Services not authorized by network/primary care providers. **Notes**: This code replaces deactivated code 38	06/02/2013
250	The attachment/other documentation content received is inconsistent with the expected content.	06/02/2013
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	06/02/2013
252	An attachment/other documentation is required to adjudicate this claim/service. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT).	06/02/2013

Code	Modified narrative	Effective date
W1	Workers' compensation jurisdictional fee schedule adjustment. **Note**: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 class of contract code identification segment (Loop 2100 other claim related Information REF). If adjustment is at the line level, the payer must send and the provider should refer to the 835 healthcare policy identification segment (loop 2110 service payment information REF) if the regulations apply.	06/02/2013
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. **Note**: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 insurance policy number segment (Loop 2100 other claim related information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the line level, the payer must send and the provider should refer to the 835 healthcare policy identification segment (Loop 2110 service payment information REF) if the regulations apply. To be used for workers' compensation only.	06/02/2013

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Codes *(continued)*

Code	Modified narrative	Effective date
Y1	Payment denied based on medical payments coverage (MPC) or personal injury protection (PIP) benefits jurisdictional regulations or payment policies, use only if no other code is applicable. **Note**: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 insurance policy number segment (Loop 2100 other claim related information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the line level, the payer must send and the provider should refer to the 835 healthcare policy identification segment (Loop 2110 service payment information REF) if the regulations apply. To be used for P&C auto only.	06/02/2013
Y2	Payment adjusted based on medical payments coverage (MPC) or personal injury protection (PIP) benefits jurisdictional regulations or payment policies, use only if no other code is applicable. **Note:** If adjustment is at the claim level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 other claim related information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the line level, the payer must send and the provider should refer to the 835 healthcare policy identification segment (Loop 2110 service payment information REF) if the regulations apply. To be used for P&C auto only.	06/02/2013
Y3	Medical payments coverage (MPC) or personal injury protection (PIP) benefits jurisdictional fee schedule adjustment. **Note**: If adjustment is at the claim level, the payer must send and the provider should refer to the 835 class of contract code identification segment (Loop 2100 other claim related information REF). If adjustment is at the line level, the payer must send and the provider should refer to the 835 healthcare policy identification segment (Loop 2110 service payment information REF) if the regulations apply. To be used for P&C Auto only.	06/02/2013

Deactivated Codes (Also included in CR 8281) – CARC

Code	Current narrative	Effective date
125	Submission/billing error(s). At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT.)	11/01/2013

Changes in RARC list since CR 8281

These are the changes in the RARC database since the last code update CR 8281. The full RARC list may be downloaded from the WPC website, available at *http://wpc-edi.com/Reference*.

New Codes– RARC:

Code	Current narrative	Effective date
N574	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/ referring provider.	07/15/2013

(continued on next page)

Codes *(continued)*

Code	Modified narrative	Effective date
N575	Mismatch between the submitted ordering/referring provider name and the ordering/referring provider name stored in our records.	07/15/2013
N576	Services not related to the specific incident/claim/accident/ loss being reported.	07/15/2013
N577	Personal injury protection (pip) coverage.	07/15/2013
N578	Coverages do not apply to this loss.	07/15/2013
N579	Medical payments coverage (MPC).	07/15/2013
N580	Determination based on the provisions of the insurance policy.	07/15/2013
N581	Investigation of coverage eligibility is pending.	07/15/2013
N582	Benefits suspended pending the patient's cooperation.	07/15/2013
N583	Patient was not an occupant of our insured vehicle and therefore, is not an eligible injured person.	07/15/2013
N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	07/15/2013
N585	Benefits are no longer available based on a final injury settlement.	07/15/2013
N586	The injured party does not qualify for benefits.	07/15/2013
N587	Policy benefits have been exhausted.	07/15/2013
N588	The patient has instructed that medical claims/bills are not to be paid.	07/15/2013
N589	Coverage is excluded to any person injured as a result of operating a motor vehicle while in an intoxicated condition or while the ability to operate such a vehicle is impaired by the use of a drug.	07/15/2013
N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.	07/15/2013
N591	Payment based on an independent medical examination (IME) or utilization review (UR).	07/15/2013
N592	Adjusted because this is not the initial prescription oe exceeds the amount allowed for the initial prescription.	07/15/2013
N593	Not covered based on failure to attend a scheduled independent medical exam (IME).	07/15/2013
N594	Records reflect the injured party did not complete an application for benefits for this loss.	07/15/2013
N595	Records reflect the injured party did not complete an assignment of benefits for this loss.	07/15/2013
N596	Records reflect the injured party did not complete a medical authorization for this loss.	07/15/2013
N597	Adjusted based on a medical provider's apportionment of care between related injuries and other unrelated medical conditions/injuries.	07/15/2013
N598	Health care policy coverage is primary.	07/15/2013
N599	Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida no-fault statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon 200 percent of the Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered.	07/15/2013

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Codes *(continued)*

Code	Modified narrative	Effective date
N600	Adjusted based on the applicable fee schedule for the region in which the service was rendered.	07/15/2013
N601	In accordance with *Hawaii Administrative Rules*, Title 16, Chapter 23 Motor Vehicle Insurance Law payment is recommended based on Medicare resource based relative value scale system applicable to Hawaii.	07/15/2013
N602	Adjusted based on the *Redbook* maximum allowance.	07/15/2013
N603	This fee is calculated according to the New Jersey medical fee schedules for automobile personal injury protection and motor bus medical expense insurance coverage.	07/15/2013
N604	In accordance with New York no-fault law, Regulation 68, this base fee was calculated according to the New York Workers' Compensation Board Schedule of Medical Fees, pursuant to Regulation 83 and / or Appendix 17-C of 11 NYCRR.	07/15/2013
N605	This fee was calculated based upon New York all patients refined diagnosis related groups (APR-DRG), pursuant to Regulation 68.	07/15/2013
N606	The Oregon allowed amount for this procedure is based upon the workers compensation fee schedule (OAR 436-009). The allowed amount has been calculated in accordance with Section 4 of ORS 742.524.	07/15/2013
N607	Service provided for non-compensable condition(s).	07/15/2013
N608	The fee schedule amount allowed is calculated at 110 percent of the Medicare fee schedule for this region, specialty and type of service. This fee is calculated in compliance with Act 6.	07/15/2013
N609	80 percent of the providers billed amount is being recommended for payment according to Act 6.	07/15/2013
N610	**Alert**: Payment based on an appropriate level of care.	07/15/2013
N611	Claim in litigation. Contact insurer for more information.	07/15/2013
N612	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.	07/15/2013
N613	**Alert**: Although this was paid, you have billed with an ordering provider that needs to update their enrollment record. Please verify that the ordering provider information you submitted on the claim is accurate and if it is, contact the ordering provider instructing them to update their enrollment record. Unless corrected, a claim with this ordering provider will not be paid in the future.	07/15/2013
N614	**Alert**: Additional information is included in the 835 healthcare policy identification segment (loop 2110 service payment information).	07/15/2013
N615	**Alert**: This enrollee receiving advance payments of the premium tax credit is in the grace period of three consecutive months for non-payment of premium. Under the *Code of Federal Regulations*, Title 45, Part 156.270, a qualified health plan issuer must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.	07/15/2013
N616	**Alert**: This enrollee is in the first month of the advance premium tax credit grace period.	07/15/2013
N617	This enrollee is in the second or third month of the advance premium tax credit grace period.	07/15/2013

(continued on next page)

Codes *(continued)*

Code	Modified narrative	Effective date
N618	**Alert**: This claim will automatically be reprocessed if the enrollee pays their premiums.	07/15/2013
N619	Coverage terminated for non-payment of premium.	07/15/2013
N620	Alert: This procedure code is for quality reporting/ informational purposes only.	07/15/2013
N621	Charges for Jurisdiction required forms, reports, or chart notes are not payable.	07/15/2013
N622	Not covered based on the date of injury/accident.	07/15/2013
N623	Not covered when deemed unscientific/unproven/ outmoded/experimental/ excessive/inappropriate.	07/15/2013
N624	The associated workers' compensation claim has been withdrawn.	07/15/2013
N625	Missing/Incomplete/Invalid workers' compensation claim number.	07/15/2013
N626	New or established patient E/M codes are not payable with chiropractic care codes.	07/15/2013
N627	Service not payable per managed care contract.	07/15/2013
N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	07/15/2013
N629	Reviews/documentation/notes/ summaries/reports/charts not requested.	07/15/2013
N630	Referral not authorized by attending physician.	07/15/2013
N631	Medical fee schedule does not list this code. An allowance was made for a comparable service.	07/15/2013
N632	According to the official medical fee schedule this service has a relative value of zero and therefore no payment is due.	07/15/2013
N633	Additional anesthesia time units are not allowed.	07/15/2013
N634	The allowance is calculated based on anesthesia time units.	07/15/2013
N635	The allowance is calculated based on the anesthesia base units plus time.	07/15/2013
N636	Adjusted because this is reimbursable only once per injury.	07/15/2013
N637	Consultations are not allowed once treatment has been rendered by the same provider.	07/15/2013
N638	Reimbursement has been made according to the home health fee schedule.	07/15/2013
N639	Reimbursement has been made according to the inpatient rehabilitation facilities fee schedule.	07/15/2013
N640	Exceeds number/frequency approved/allowed within time period.	07/15/2013
N641	Reimbursement has been based on the number of body areas rated.	07/15/2013
N642	Adjusted when billed as individual tests instead of as a panel.	07/15/2013
N643	The services billed are considered covered or non-covered (NC) in the applicable state fee schedule.	07/15/2013
N644	Reimbursement has been made according to the bilateral procedure rule.	07/15/2013
N645	Mark-up allowance	07/15/2013
N646	Reimbursement has been adjusted based on the guidelines for an assistant.	07/15/2013
N647	Adjusted based on diagnosis-related group (DRG).	07/15/2013
N648	Adjusted based on stop loss.	07/15/2013
N649	Payment based on invoice.	07/15/2013
N650	This policy was not in effect for this date of loss. No coverage is available.	07/15/2013
N651	No personal injury protection/ medical payments coverage on the policy at the time of the loss.	07/15/2013
N652	The date of service is before the date of loss.	07/15/2013
N653	The date of injury does not match the reported date of loss.	07/15/2013

(continued on next page)

Codes *(continued)*

Code	Modified narrative	Effective date
N654	Adjusted based on achievement of maximum medical improvement (MMI).	07/15/2013
N655	Payment based on provider's geographic region.	07/15/2013
N656	An interest payment is being made because benefits are being paid outside the statutory requirement.	07/15/2013
N657	This should be billed with the appropriate code for these services.	07/15/2013
N658	The billed service(s) are not considered medical expenses.	07/15/2013
N659	This item is exempt from sales tax.	07/15/2013
N660	Sales tax has been included in the reimbursement.	07/15/2013
N661	Documentation does not support that the services rendered were medically necessary.	07/15/2013
N662	**Alert**: Consideration of payment will be made upon receipt of a final bill.	07/15/2013
N663	Adjusted based on an agreed amount.	07/15/2013
N664	Adjusted based on a legal settlement.	07/15/2013
N665	Services by an unlicensed provider are not reimbursable.	07/15/2013
N666	Only one evaluation and management code at this service level is covered during the course of care.	07/15/2013
N667	Missing prescription	07/15/2013
N668	Incomplete/invalid prescription	07/15/2013
N669	Adjusted based on the Medicare fee schedule.	07/15/2013
N670	This service code has been identified as the primary procedure code subject to the Medicare multiple procedure payment reduction (MPPR) rule.	07/15/2013
N671	Payment based on a jurisdiction cost-charge ratio.	07/15/2013
N672	**Alert**: Amount applied to health insurance offset.	07/15/2013
N673	Reimbursement has been calculated based on an outpatient per diem or an outpatient factor and/or fee schedule amount.	07/15/2013
N674	Not covered unless a pre-requisite procedure/service has been provided.	07/15/2013
N675	Additional information is required from the injured party.	07/15/2013
N676	Service does not qualify for payment under the outpatient facility fee schedule.	07/15/2013

Modified Codes – RARC

Code	Current Narrative	Effective Date
N1	**Alert**: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract, plan benefit documents or jurisdiction statutes.	07/15/2013
N7	**Alert**: Processing of this claim/service has included consideration under major medical provisions.	07/15/2013
N10	Payment based on the findings of a review organization/professional consult/manual adjudication/ medical advisor/dental advisor/peer review.	07/15/2013
N441	This missed/cancelled appointment is not covered.	07/15/2013

Deactivated Codes – RARC NONE

Additional information

The official instruction, CR 8422 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2776CP.pdf*.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8422
Related Change Request (CR) #: CR 8422
Related CR Release Date: August 30, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2776CP
Implementation Date: October 7, 2013

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CMS instructs on use of CORE phase III EFT and ERA rules

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, A/B Medicare administrative contractors (MACs), home health & hospice Medicare administrative contractors (HH&H), durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 8365, from which this article is taken, instructs Medicare contractors and shared system maintainers (SSM) to use (effective January 1, 2014) the May 24, 2013 update to the *Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase III*, *CORE 360 Uniform Use of Claim Adjustment Reason Codes* (CARCs) and *Remittance Advice Remark Codes (RARCs) (835) Rule CORE-required Code Combinations* for CORE-defined business scenarios, version 3.0.2.

Background

On August 7, 2012, the Department of Health and Human Services (HHS) announced adoption of the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set. (Refer to *http://www.hhs.gov/news/press/2012pres/08/20120807a.html*).

In CR 8182, released May 9, 2013, CMS instructed Medicare contractors to implement this rule set by January 6, 2014. (You can find the associated *MLN Matters*® article, MM8182 "Standardizing the Standard - Operating Rules for Code Usage in Remittance Advice" at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8182.pdf*.)

The EFT & ERA operating rule set includes the following rules:

1. Phase III CORE 380 EFT enrollment data rule;
2. Phase III CORE 382 ERA enrollment data rule;
3. Phase III Core 360 uniform use of claim adjustment reason codes and remittance advice remark codes (835) rule.
4. CORE-required code combinations for CORE-defined business scenarios for the Phase III core uniform use of claim adjustment reason codes and remittance advice remark codes (835) rule
5. Phase III CORE 370 EFT & ERA Re-association (CCD+/835) rule; and
6. Phase III CORE 350 health care claim payment/advice (835) infrastructure rule.

The Health Insurance Portability and Accountability Act (HIPAA) initially mandated the standard code sets that a health plan may use to explain to providers/suppliers how a claim or service has been adjudicated, and now the ERA/EFT operating rules under the Affordable Care Act are mandating consistent and uniform use of remittance advice (RA) codes (group codes, claim adjustment reason codes (CARC) and remittance advice remark codes (RARC)) to mitigate confusion that may result in:

- Unnecessary manual provider follow-up;
- Faulty electronic secondary billing;
- Inappropriate write-offs of billable charges;
- Incorrect billing of patients for co-pays and deductibles, and/or
- Posting delay

Business scenarios

The CORE Phase III ERA/EFT operating rules define four business scenarios and specify the maximum set of the standard code combinations that a health plan may use. This list will be updated and maintained by a CORE task group when the two code committees update the lists and/or when there is need for additional combinations of existing codes based on business policy change and/or federal/state mandate.

CR 8365, from which this article is taken, focuses on rule 3 , and instructs Medicare contractors and shared system maintainers (SSM) to use (to be effective January 1, 2014, and to be implemented by January 6, 2014) the May 24, 2013 updated CORE combination lists in the document: "CAQH Committee on Operating Rules for Information Exchange (CORE) Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule CORE-required Code Combinations for CORE-defined Business Scenarios," version 3.0.2 (which you will find as an attachment to CR 8365).

The following are the CORE-defined claim adjustment/denial business scenarios and descriptions:

Scenario #1: Additional information required - missing/invalid/incomplete documentation

This scenario refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.

Scenario #2: Additional information required – missing/invalid/incomplete data from submitted claim

Refers to situations where additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

Scenario #3: Billed service not covered

Refers to situations where the billed service is not covered by the health plan.

(continued on next page)

RARC *(continued)*

Scenario #4: Benefit for billed service not separately payable

Refers to situations where the billed service or benefit is not separately payable by the health plan.

Medicare is implementing the code combinations per the ERA/EFT operating rules in two releases (July and October 2013) that relate to these four scenarios (per CR 8182), and is adding updates to CORE CODE combinations (per CR 8365), effective January 1, 2014. Finally, Medicare remit easy print (MREP) and PC print, will be updated if needed, January 6, 2014.

Additional information

The official instruction, CR 8365 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1281OTN.pdf*.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8365
Related Change Request (CR) #: CR 8365
Related CR Release Date: August 16, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R1281OTN
Implementation Date: January 6, 2014

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New claim adjustment reason code (CARC) for sequestration cuts

Note: This article was revised on September 5, 2013, to revise the title to be consistent with the change request. This article was previously published on Page 34 in the August 2013 edition of *Medicare A Connection*. All other information is unchanged.

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME/MACs) and A/B Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider action needed

This article, based on change request (CR) 8378, informs Medicare contractors about a new claim adjustment reason code (CARC) when payments are reduced due to sequestration. Make sure that your billing staffs are aware of these changes.

Background

As required by law, President Obama issued a sequestration order on March 1, 2013. As a result, Medicare fee-for-service claims, with dates of service or dates of discharge on or after April 1, 2013, incur a two percent reduction in Medicare payment.

The Centers for Medicare & Medicaid services (CMS) previously assigned CARC 223 (Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created) to explain the adjustment in payment.

Effective June 3, 2013, a new CARC was created and will replace CARC 223 on all applicable claims. The new CARC is as follows:

- 253 – Sequestration - Reduction in Federal Spending

Also, Medicare contractors will not take any action on claims processed prior to implementation of CR 8378.

Additional information

The official instruction, CR 8378 may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2739CP.pdf*.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8378
Related Change Request (CR) #: CR 8378
Related CR Release Date: July 25, 2013
Effective Date: June 3, 2013
Related CR Transmittal #: R2739CP
Implementation Date: January 6, 2014

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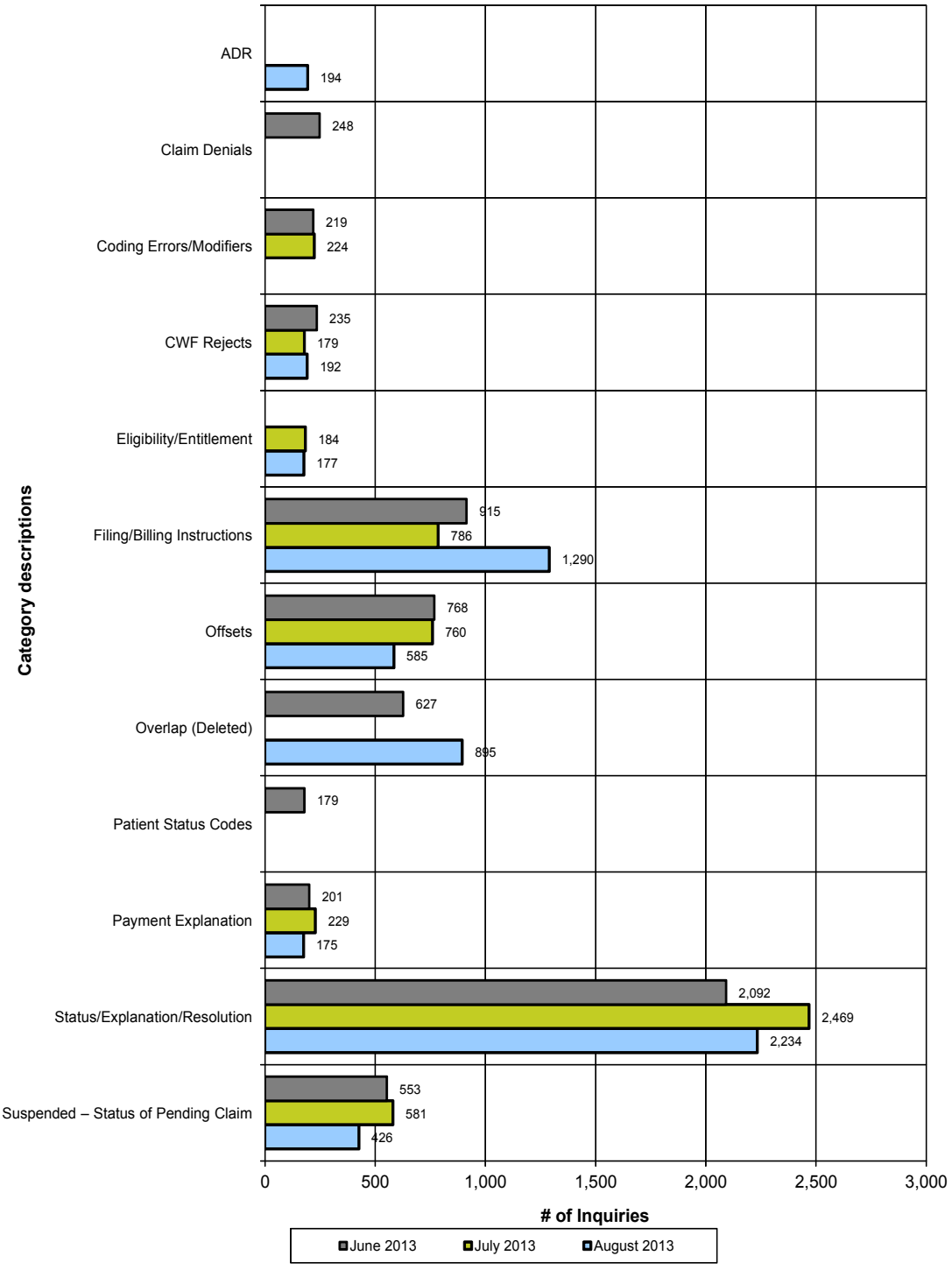
Top inquiries, rejects, and return to provider claims June 2013 through August 2013

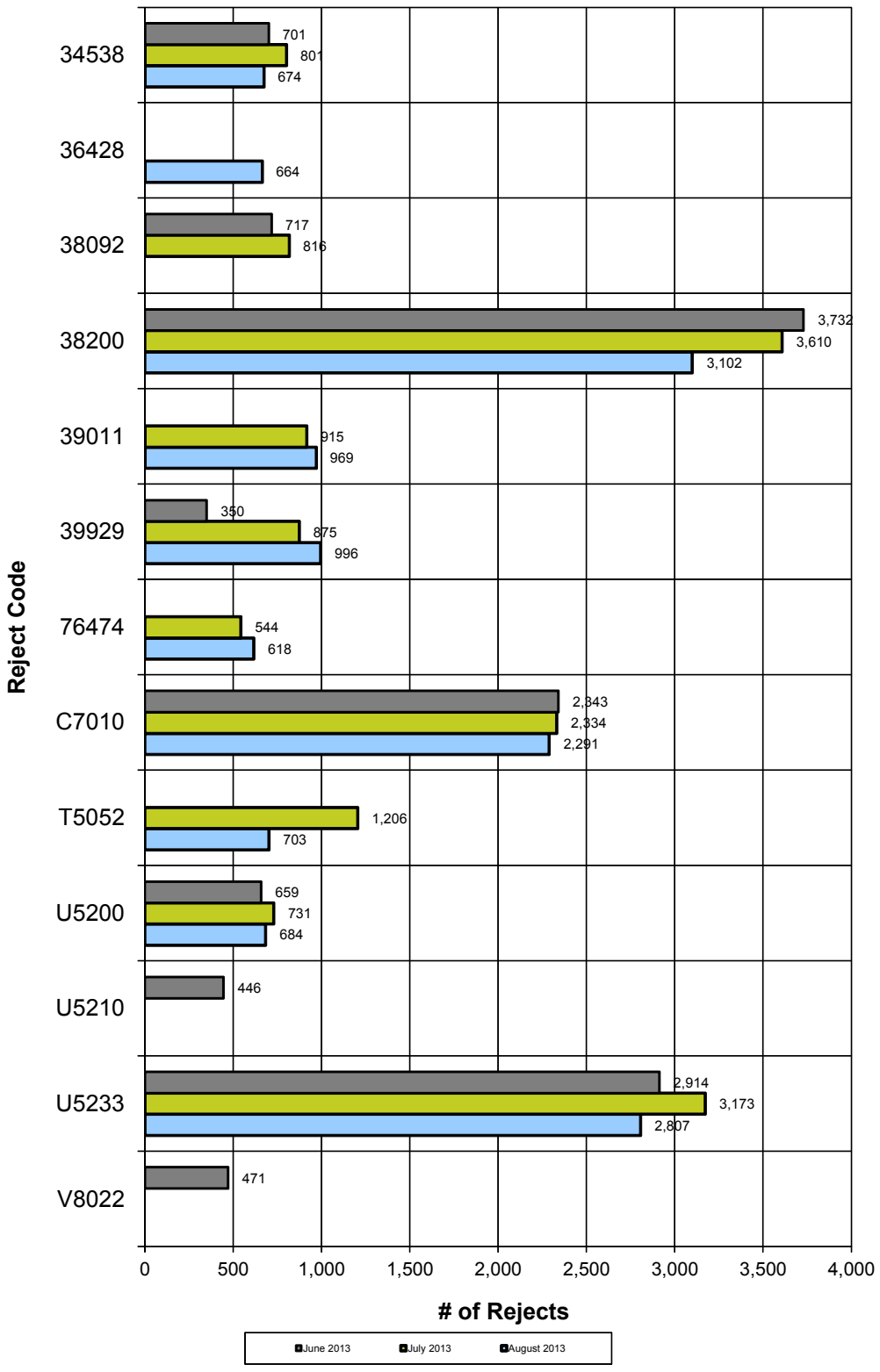
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during June 2013 through August 2013.

For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the Inquiries and Denials section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Top inquiries for June-August 2013

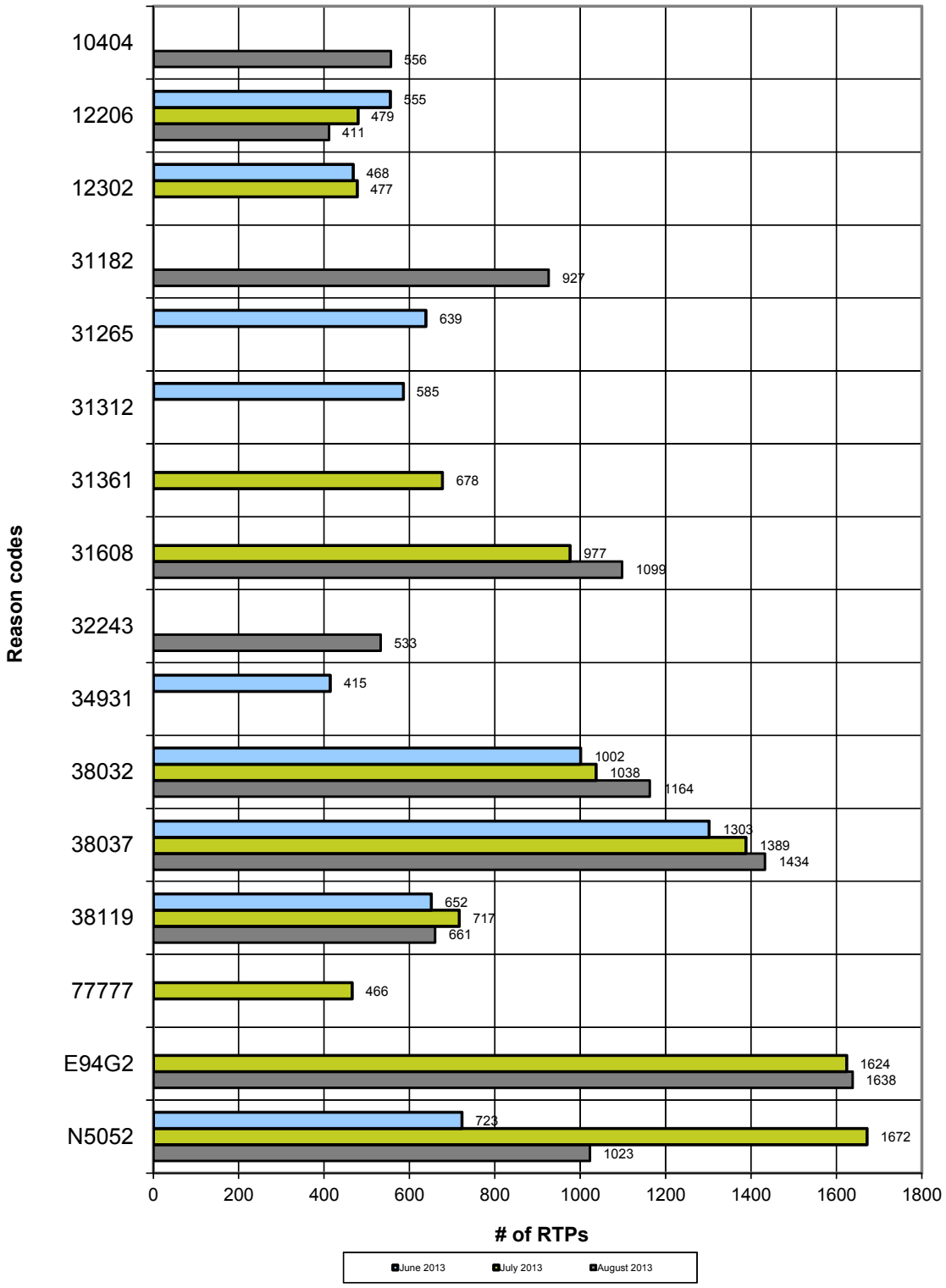


Part A top rejects for June 2013 through August 2013



Part A top return to providers (RTPs) for June 2013 through August 2013

Top RTPs for June-August 2013



October 2013 Medicare physician fee schedule database update

Note: This article was revised September 10, 2013, to reflect the revised change request (CR) 8386. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were revised. This article was previously published in the August 2013 edition of *Medicare A Connection,* Page 43. All other information remains the same.

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services that are paid under the Medicare physician fee schedule database (MPFSDB).

What you need to know

This article is based on CR 8386 and instructs Medicare contractors to download and implement a new MPFSDB, effective October 1, 2013.

Background

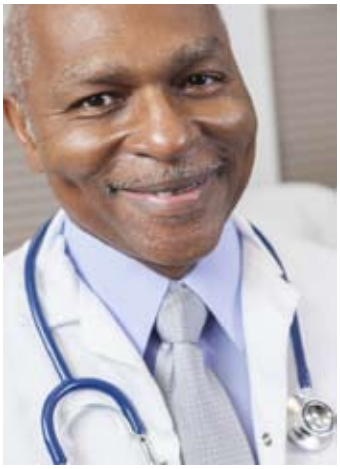
Section 1848(c)(4) of the Social Security Act (see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) authorizes the U.S. Secretary of Health and Human Services (HHS) to establish ancillary policies necessary to implement relative values for physicians' services.

CR 8386, from which this article is taken, announces that the MPFSDB has been updated effective October 1, 2013; and new payment files were issued to your contractor(s) based upon the 2013 Medicare physician fee schedule (MPFS) final rule (published in the *Federal Register* on November 16, 2012); as modified by the American Taxpayer Relief Act of 2012 (applicable January 1, 2013, see *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html*), and the October 1, 2013 updated payment files.

Key changes for the October are as follows:

- Medicare contractors add HCPCS code G9187 (BPCI home visit) to their systems with an effective date of October 1, 2013; and
- The effective date of HCPCS code G0460 (Autologous Platelet-Rich Plasma (PRP)for Chronic Non-Healing Wounds) is adjusted to be August 2, 2012.

For more information and access to the 2013 final rule, see the physician fee schedule webpage available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html*.



The Centers for Medicare & Medicaid Services (CMS) will notify your contractors when the new files are available for retrieval, and CR 8386 instructs them to provide you 30 days' notice before implementing the changes. Further, while they do not have to search their files to either retract payment for claims already paid, or to retroactively pay claims; they will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 8386 issued to your Medicare contractor regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2784CP.pdf*.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8386 Revised
Related Change Request (CR) #: CR 8386
Related CR Release Date: September 10, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2784CP
Implementation Date: October 7, 2013

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New materials available for hospital outpatient PPS proposed rule

The Centers for Medicare & Medicaid Services (CMS) has posted corrected addenda, cost statistics files, an impact file, and an impact table for the 2014 hospital outpatient prospective payment system (OPPS) proposed rule (*CMS-1601-P*).

These *corrected files* are available on the *hospital outpatient PPS* website pages. More information about the proposed rule is available on the *hospital outpatient regulations and notices* Web page.

SOURCE: PERL 201308-09

2014 inpatient and long term care hospital PPS changes

Provider types affected

This *MLN Matters*® article is intended for hospitals that submit claims to Medicare contractors (fiscal intermediaries (FIs) and/or Part A Medicare administrative contractors (Part A MACs) for acute care and long-term care hospital services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8421 which provides fiscal year (FY) 2014 updates to the acute care hospital inpatient prospective payment system (IPPS) and the long-term care hospital (LTCH) prospective payment system (PPS).

All items covered in CR 8421 are effective for hospital discharges occurring on or after October 1, 2013, unless otherwise noted. See the *Background* and *Additional information* sections of this article for further details regarding these changes. Make sure that your billing staffs are aware of these changes.

Background

The policy changes for FY 2014 were displayed in the *Federal Register* August 02, 2013, and published August 19, 2013. You can find the home page for the FY 2014 Hospital Inpatient PPS final rule at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html*.

The IPPS home page centralizes file(s) related to the IPPS final rule, and it contains links to: the final rule (display version or published *Federal Register* version) and all subsequent published correction notices (if applicable); and includes:

- All tables;
- Additional data and analysis files; and
- The impact file.

Files related to the Long Term Care PPS can be found at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html*.

Key points of CR 8421

IPPS updates

MS-DRG grouper and Medicare code editor (MCE) changes

The grouper contractor, 3M Health Information Systems (3M-HIS), developed new MS-DRG Grouper, Version 31.0, software package effective for discharges on or after October 1, 2013. The grouper assigns each case into a MS-DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status).

Please note the national uniform billing committee (NUBC) approved 15 new patient discharge codes (81-95) adapted after existing codes with “a Planned Acute Care Hospital Inpatient Readmission” appended in the title.

A new patient discharge status code 69 was created in order for providers to be able to indicate discharges/transfers to a designated disaster alternative care site. The MCE version 31.0 which is also developed by 3M-HIS, uses the ICD-9-CM codes to validate coding for discharges on or after October 1, 2013.

For discharges occurring on or after October 1, 2013, the fiscal intermediary standard system (FISS) calls the appropriate grouper based on discharge date. Medicare contractors should have received the grouper documentation in early August 2013.

For discharges occurring on or after October 1, 2013, the MCE selects the proper internal tables based on discharge date. Medicare contractors should have received the MCE documentation in early August 2013. Note that the version continues to match the grouper.

Post-acute transfer and special payment policy

There are no changes to the post-acute and special post-acute payment policy or applicable DRGs for FY 2014. Refer to Table 5 in the IPPS Rule for the list of applicable DRGs.

Please note that the new patient status codes (81-95) that refer to “planned readmissions” have been mapped to their non-planned readmission counterparts and are included in the transfer policy.

The new patient status code 69 does not impact the transfer policy.

New technology add-on

The following items are eligible for new-technology add-on payments in FY 2014:

1. DIFICID - Cases involving DIFICID that are eligible for the new technology add-on payment will be

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Inpatient *(continued)*

identified with a ICD-9-CM diagnosis code of 008.45 in combination with NDC code 52015-0080-01 in data element LIN03 of the 837I. The maximum add-on payment for a case involving DIFICID is $868. (For your information the ICD-10-CM diagnosis code is A04.7.)

2. Zenith fenestrated graft - Cases involving the Zenith fenestrated graft that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 39.78. The maximum add-on payment for a case involving the Zenith Fenestrated Graft is $8,171.50.
(The ICD-10-CM procedure codes are: 04U03JZ - Supplement Abdominal Aorta with Synthetic Substitute, Percutaneous Approach; 04U04JZ - Supplement Abdominal Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach; 04V03DZ -Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Approach or 04V04DZ - Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Endoscopic Approach.)

3. Voraxaze - Cases involving Voraxaze that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 00.95. The maximum add-on payment for a case involving the Voraxaze is $45,000. (For your information the ICD-10-CM procedure codes are: 3E033GQ - Introduction of Glucarpidase into Peripheral Vein, Percutaneous Approach or 3E043GQ - Introduction of Glucarpidase into Central Vein, Percutaneous Approach.)

4. New for FY 2014 - Argus- Cases involving the Argus®II System that are eligible for new technology add-on payments will be identified by ICD 9 CM procedure code 14.81. The maximum add-on payment for a case involving the Argus®II System is $72,028.75. (For your information the ICD-10-CM procedure codes are: 08H005Z - Insertion of Epiretinal Visual Prosthesis into Right Eye, Open Approach or 08H105Z - Insertion of Epiretinal Visual Prosthesis into Left Eye, Open Approach.)

5. New for FY 2014 - Kcentra- Cases involving Kcentra that are eligible for new technology add-on payments will be identified by ICD 9 CM procedure code 00.96. The maximum add-on payment for a case of Kcentra™ is $1,587.50. DO NOT MAKE THIS NEW TECH PAYMENT IF ANY OF THE FOLLOWING DIAGNOSIS CODES ARE ON THE CLAIM: 286.0, 286.1, 286.2, 286.3, 286.4, 286.5, 286.7, 286.52, 286.53, 286.59. (For your information the ICD-10-CM procedure codes are: 30280B1 - Transfusion of Nonautologous 4-Factor Prothrombin Complex Concentrate into Vein, Open Approach or 30283B1 - Transfusion of Nonautologous 4-Factor Prothrombin Complex and the ICD-10-CM diagnosis codes are: D66, D67, D68.1, D68.2, D68.0, D68.311, D68.312, D68.318, D68.32 and D68.4.)

6. New for FY 2014 - Zilver- Cases involving the Zilver® PTX® that are eligible for new technology add-on payments will be identified by ICD 9 CM procedure code 00.60. The maximum add-on payment for a case of the Zilver® PTX® is $1,705.25.

(The ICD-10-CM procedure codes are: 047K04Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Open Approach; 047K34Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Approach; 047K44Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach; 047L04Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Open Approach; 047L34Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Approach or 047L44Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach.)

Cost of living adjustment (COLA) update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. These adjustments are listed in a table later in this article.

Section 505 hospital (out-commuting adjustment)

Attachment A of CR 8421 - Section 505, shows the IPPS providers that will be receiving a “special” wage index for FY 2014 (i.e., receive an out-commuting adjustment under section 505 of the MMA).

Treatment of certain providers re-designated under section 1886(d)(8)(B) of the Act

42 CFR 412.64(b)(3)(ii) implements Section 1886(d)(8)(B) of the Social Security Act, which re-designates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as “Lugar counties”.) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are re-designated.

A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered

(continued on next page)

Inpatient *(continued)*

rural for all IPPS purposes. Later in this article is a list of Lugar hospitals that accepted the out-migration adjustment and are therefore rural for all IPPS purposes for FY 2014.

Treatment of certain urban hospitals reclassified as rural hospitals

Under 42 CFR 412.103 An urban hospital that reclassifies as a rural hospital under 412.103 is considered rural for all IPPS purposes. Note that hospitals reclassified as rural under 412.103 are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see 412.320(a)(1)). Please reference Table 9C of FY 2014 Final rule.

Medicare-dependent, small rural hospital (MDH) program expiration

The special payment protections provided to a Medicare dependent small rural hospital (MDH) are not authorized by statute beyond FY 2013. Therefore, beginning in FY 2014, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid based solely on the Federal rate. (We note that, our SCH policy at 42 CFR 412.92(b) allows MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program.)

Hospital specific (HSP) rate update for sole community hospitals (SCHs)

In FY 2013, Medicare contractors updated the hospital specific (HSP) amount for all SCHs to FY 2012 dollars. For FY 2014, the HSP amount will continue to be entered in FY 2012 dollars. pricer will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2013 of 0.9480 and make all updates to the HSP amount for FY 2013 and beyond.

In addition, the HSP logic in pricer has been updated, consistent with the implementation of the statutory changes to the operating DSH payment methodology provided by the provisions of section 3133 of the Affordable Care Act, to include the empirically justified disproportionate share hospital (DSH) payment and the estimated uncompensated care payment in the federal rate payment amount, if applicable, when comparing the HSP rate payment amount to the Federal rate payment amount.

Low-volume hospitals – criteria and payment adjustments for FY 2014

For FYs 2011, 2012, and 2013, the Affordable Care Act, as amended by the American Tax Relief Act, expanded the definition of a low volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Beginning with FY 2014, the low volume hospital definition and payment adjustment will revert to the policies that were in effect prior to the amendments

made by the Affordable Care Act and the American Tax Relief Act. Therefore, as specified under the regulations at 42 CFR 412.101, effective for FY 2014 and subsequent years, in order to qualify as a low-volume hospital, a hospital must be located more than 25 road miles from another “subsection (d) hospital” and have less than 200 total discharges (including both Medicare and non-Medicare discharges) during the fiscal year. For FY 2014 and subsequent years, the low-volume hospital adjustment for all qualifying hospitals is 25 percent.

Your FI/MAC will determine, based on the most recent data available, if the hospital qualifies as a low-volume hospital, so that the hospital will know in advance whether or not it will receive a payment adjustment for the FY. For FY 2014 (and subsequent years), the FI/MAC makes the discharge determination based on the hospital’s number of total discharges, that is, Medicare and non-Medicare discharges. The hospital’s most recently submitted cost report is used to determine if the hospital meets the discharge criterion to receive the low-volume hospital payment adjustment for the current year (see 42 CFR 412.101(b)(2)(i)). To meet the mileage criterion to qualify for the low-volume hospital payment adjustment for FY 2013 (and subsequent years), a hospital must be located more than 25 road miles (as defined at 412.101(a)) from the nearest “subsection (d) hospital” (that is, in general, an IPPS hospital).

A hospital must notify and provide documentation to its FI/MAC that it meets the mileage criterion. The use of a Web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion for low-volume hospitals, is acceptable. The FI/MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance (in road miles) from the hospital requesting low-volume hospital status, is sufficient to document that it meets the mileage criterion. If not, the FI/MAC will follow up with the

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hospital to obtain additional necessary information to determine whether or not the hospital meets the low-volume hospital mileage criterion. In order to receive the low-volume hospital payment adjustment for FY 2014, a hospital must meet both the discharge and mileage criteria (set forth at 412.101(b)(2)(i)).

For FY 2014, a hospital should make its request for low-volume hospital status in writing to its FI/MAC and provide documentation that it meets the mileage criterion by September 1, 2013, so that the 25 percent low-volume hospital adjustment can be applied to payments for its discharges occurring on or after October 1, 2013 (through September 30, 2014). For requests for low-volume hospital status for FY 2014 received after September 1, 2013, if the hospital meets the criteria to qualify as a low-volume hospital, the FI/MAC will apply the 25 percent low-volume hospital adjustment in determining payments to the hospital's FY 2014 discharges prospectively within 30 days of the date of the FI's/MAC's low-volume hospital status determination.

The 25 percent low-volume hospital payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH (including the uncompensated care payment), IME and outliers. For SCHs, the low-volume hospital payment is based on and in addition to either payment based on the federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Hospital quality initiative

The hospitals that will receive the quality initiative bonus are listed at *http://www.qualitynet.org* on the Internet. This website was expected to be updated by August 19, 2013. Should a provider later be determined to have met the criteria after publication of this list, they will be added. A list of hospitals that will receive the 2.0 percent reduction to the annual payment update for FY 2014 under the hospital inpatient quality reporting (IQR) program are listed in Attachment C of CR 8421- hospitals not receiving annual payment update (APU) – FY 2014.

New hospitals are treated as receiving the quality update.

Hospital value based purchasing

Section 3001 of the Affordable Care Act added Section 1886(o) to the Social Security Act, establishing the hospital value-based purchasing (VBP) program. This program began adjusting base operating DRG payment amounts for discharges from subsection (d) hospitals, beginning in FY 2013. CMS has excluded Maryland hospitals from the Hospital VBP Program for the FY 2014 program year. The regulations that implement this provision are in subpart I of 42 CFR part 412 (412.160 through 412.162).

Under the Hospital VBP Program, CMS reduces base operating DRG payment amounts for subsection (d) hospitals by the applicable percent defined in statute .The applicable percent for payment reductions for FY 2014 is 1.25 percent, and it gradually increases each fiscal year to 2.0 percent in FY 2017. These payment reductions fund value-based incentive payment to hospitals that meet or exceed performance standards on the measures selected for the program. By law, CMS must base value-based incentive payments on hospitals' performance under the Hospital VBP Program, and the total amount available for value-based incentive payments must be equal to the amount of payment reductions, as estimated by the Secretary.

CMS calculates a total performance score (TPS) for each hospital eligible for the Hospital VBP Program. CMS then uses a linear exchange function to convert each hospital's TPS into a value-based incentive payment. Based on that linear exchange function's slope, as well as an individual hospital's TPS, the hospitals' own annual base operating DRG payment amount and the applicable percent reduction to base operating DRG payment amounts, CMS calculates a value-based incentive payment adjustment factor that will be applied to each discharge at a hospital, for a given fiscal year.

In the FY 2013 IPPS/LTCH PPS final rule, CMS established the methodology to calculate the hospital value-based incentive payment adjustment factor, the portion of the IPPS payment that will be used to calculate the value-based incentive payment amount, and review and corrections and appeal processes wherein hospitals can review information used to calculate their TPS and submit requests for corrections to the information before it is made public.

For FY 2014 CMS will implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2014.

Note that the values listed in Table 16A of the IPPS

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final rule are "proxy" values. The proxy values are not used to adjust payments.

The IPPS pricer will display the VBP payment amount in a new output field.

Hospital readmissions reduction program

For FY 2014, the readmissions adjustment factor is the higher of a ratio or 0.98 (-2 percent). The readmission adjustment factor is applied to a hospital's "base operating DRG payment amount", or the wage adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable), to determine the amount reduced from a hospital's IPPS payment due to excess readmissions. Add-on payments for IME, DSH (including the uncompensated care payment), outliers and low-volume hospitals are not adjusted by the readmissions adjustment factor. In addition, for SCHs, the difference between the SCH's operating IPPS payment under the hospital-specific rate and the federal rate is not adjusted by the readmissions adjustment factor.

Hospitals that are not subject to a reduction under the hospital readmissions reduction program in FY 2014 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY 2014, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9800.

The hospital readmissions reduction program adjustment factors for FY 2014 can be found in Table 15 of the FY 2014 IPPS final rule, which is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Tables.html?DLPage=1&DLSort=0&DLSortDir=ascending*.

Note: Although Maryland hospitals are exempt from the payment adjustment under the hospital readmissions reduction program for FY 2014, a readmissions adjustment factor of 1.0000 (that is no adjustment) is shown for Maryland hospitals in Table 15. Hospitals located in Puerto Rico are not subject to the hospital readmissions reduction program and therefore are not listed in Table 15.

The IPPS pricer will display the HRR payment amount in a new output field.

Recalled devices

As a reminder, Section 2202.4 of the *Provider Reimbursement Manual*, Part I states, "charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient." Accordingly, hospital charges with respect to medical devices must be reasonably related to the cost of the medical device. If a hospital receives a replacement medical device for free, the hospital should not be charging the patient or Medicare for that device. The hospital should not be including costs on the cost report or charges on the Medicare claim. If that medical device was received at a discount, the charges should also be appropriately reduced.

Bundled payments for care improvement initiative (BPCI)

Model 1 - CMS is working in partnership with providers to develop models of bundling payments through the bundled payments for care improvement initiative. In Model 1, the episode of care is defined as the acute care hospital stay only. Applicants for this model propose a discount percentage which will be applied to payment for all participating hospitals' diagnosis related groups (DRG) over the lifetime of the initiative. Participating hospitals may gain-share with physicians any internal hospital savings achieved from redesigning care if they can reduce hospital costs for the episode below the discount provided to CMS as part of their agreement. More information may be found at *http://www.innovations.cms.gov/initiatives/Bundled-Payments/index.html*.

For hospitals participating in Model 1 of the BPCI, a standard discount will be taken from all DRG payments made to the hospital. The discount will be phased in over time, with the discount amount updated as frequently as every six months. This adjustment will be made to the base operating DRG, IME, DSH, and outlier payments will be calculated based on the non-discounted base payments. Pricer will display the Model 1 payment amount in a new output field.

Internally, the claims processing system will convert the Model 1 participating indicator '1' to a demo code '61' which will trigger pricer to perform the payment calculation using the discount percentage. Model 1 demonstration code '61' is for internal use only and shall not be entered by providers.

Provider specific file (PSF)

The PSF-required data elements for all provider types which require a PSF can be found in the *Medicare Claims Processing Manual*, Chapter 3, Section 20.2.3.1 and Addendum A. FIs/MAC s will update the Inpatient PSF for each hospital as needed, but they must update all applicable fields for IPPS hospitals effective October 1, 2013, or effective with cost reporting periods that begin on or after October 1, 2013, or upon receipt of an as-filed (tentatively) settled cost report. Pricer requires a PSF record with a 10/1 effective date.

Tables 8a and 8b contain the FY 2014 Statewide average operating and capital cost-to-charge ratios, respectively. To access Tables 8a and 8b are available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html*.

On the left side select FY 2014 IPPS final rule home

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Inpatient *(continued)*

page and then select FY 2014 Final Rule Tables. Per the regulations at 42 CFR 412.84(i)(3), for FY 2014, statewide average CCRs are used in the following instances:

1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR 489.18).
2. Hospitals whose operating CCR is in excess 1.186 or capital CCR is in excess of 0.173 (referred to as the operating CCR ceiling and capital CCR ceiling, respectively).
3. Hospitals for which the FI or MAC is unable to obtain accurate data with which to calculate an operating and/or capital CCR.

Note: Hospitals, FIs and Medicare contractors can request an alternative CCR to the statewide average CCR per the instructions in section 20.1.2 of chapter 3 of the claims processing manual. provider types (PSF data element 9) 14 and 15 are no longer valid beginning in FY 2014 (with the expiration of the MDH program as noted above). FIs/MACs shall determine the appropriate provider type and update the PSF accordingly with an effective date of October 1, 2013.

Medicare disproportionate share hospitals (DSH) program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Starting in FY 2014, hospitals will receive 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured.

Each Medicare DSH hospital will receive a portion of this uncompensated care pool based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital's share of uncompensated care is based on its share of insured low income days, defined as the sum of Medicare SSI days and Medicaid days, relative to all Medicare DSH hospitals' insured low income days.

The Medicare DSH payment will be reduced to 25 percent of the amount they previously would have received under the current statutory formula in pricer. The calculation of the Medicare DSH payment adjustment will remain unchanged and the 75 percent reduction to the DSH payment will be applied in pricer.

For FY 2014, the total uncompensated care payment amount to be paid to Medicare DSH hospitals is $9,033,273,246, as calculated as the product of 75 percent of Medicare DSH (estimated by the CMS' Office of the Actuary) and the change in percent of uninsured individuals at 94.3 percent. The total uncompensated care payment amount to be paid to the Medicare DSH hospitals was finalized in the FY 2014 IPPS final rule.

The uncompensated care payment will be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2014. The estimated per claim amount is determined by dividing the total uncompensated care payment by the average number of claims from the most recent three years of claims data (FY 2010-2012).

The estimated per discharge uncompensated care payment amount will be in a table in pricer and that dollar amount will be added to each claim for FY 2014. The estimated per discharge uncompensated care payment amount will be included in the outlier payment determinations, and will be included as a federal payment in the comparison for sole community hospitals to determine if a claim is paid under the hospital specific rate or federal rate.

The total uncompensated care payment amount finalized in the FY 2014 IPPS final rule will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis. The IPPS pricer will display the uncompensated care payment amount in a new output field.

LTCH PPS FY 2013 update

FY 2014 LTCH PPS rates and factors are located in a table just before the *Additional information* section near the end of this article. The LTCH PPS pricer has been updated with the Version 31.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2013, and on or before September 30, 2014.

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LTCH quality reporting (LTCHQR) program

Section 3004(a) of the Affordable Care Act requires the establishment of the long-term care hospital quality reporting (LTCHQR) program. Beginning in FY 2014, the annual update to a standard Federal rate will be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance with the LTCHQR program for that year.

Provider specific file (PSF)

The PSF-required fields for all provider types which require a PSF can be found in the *Medicare Claims Processing Manual* Chapter 3, Section 20.2.3.1 and Addendum A. FIs/MACs will update the Inpatient PSF for each hospital as needed, and update all applicable fields for LTCHs effective October 1, 2013, or effective with cost reporting periods that begin on or after October 1, 2013, or upon receipt of an as-filed (tentatively) settled cost report.

Table 8c contains the FY 2014 statewide average LTCH total cost-to-charge ratios (CCRs) for urban and rural hospitals used for calculating short-stay and high cost outlier payments. Table 8c is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/LTCHPPS-Regulations-and-Notices-Items/CMS-1599-F.html*.

Per the regulations in 42 CFR 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2014, statewide average CCRs are used in the following instances:

1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR Section 489.18).
2. LTCHs with a total CCR is in excess of 1.305 (referred to as the total CCR ceiling).
3. Any hospital for which data to calculate a CCR is not available.

Note: Hospitals, FIs and Medicare contractors can request an alternative CCR to the statewide average CCR per the instructions in section 150.24 of chapter 3 of the claims processing manual.

Cost of living adjustment (COLA) for LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. The applicable COLAs that are effective for discharges occurring on or after October 1, 2013 established in the FY 2014 IPPS/LTCH PPS final rule, are shown in the tables section later in this article.

Core-based statistical area (CBSA)-based labor market area updates

There are no changes to the core-based statistical area (CBSA)-based labor market area definitions or CBSA codes used under the LTCH PPS for FY 2014. The CBSAs definitions and codes that will continue to be effective October 1, 2013 can be found in Table 12A listed in the addendum of the FY 2014 IPPS/LTCH PPS final rule, which is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html*.

Additional LTCH PPS policy changes for FY 2014 The moratoria on the full implementation of the "25 percent threshold" payment adjustment will expire for LTCH cost reporting periods beginning on or after October 1, 2013. The five year statutory moratorium which expired for cost reporting periods beginning on or after July 1 or October 1, 2012, as applicable, was followed by regulatory moratoria that generally maintained the existing policies for both "July" and "October" LTCHs.

For additional details, see to the discussion in the FY 2014 IPPS/LTCH PPS final rule. In addition, the short-stay outlier (SSO) logic in the pricer was updated to reflect the implementation of the statutory changes to the IPPS operating DSH payment methodology per by the provisions of section 3133 of the Affordable Care Act in the calculation of "an amount comparable to the IPPS per diem amount" under the 4th option in the SSO payment formula.

Tables from CR 8421

FY 2014 IPPS rates and factors	
Standardized amount applicable percentage increase	1.017 if IQR = '1' in PSF or 0.997 if IQR = '0' or Blank in PSF
Hospital specific applicable percentage increase	1.017 if IQR = '1' in PSF or 0.997 if IQR = '0' or Blank in PSF
Common fixed loss cost outlier threshold	$21,748.00
Federal capital rate	$429.31
Puerto Rico capital rate	$209.82
Outlier offset-operating national	0.948995
Outlier offset-operating Puerto Rico	0.943455
SCH budget neutrality factor	0.997989
SCH documentation and coding adjustment factor	0.9480
Adjustment to offset the cost of the policy on admission and medical review criteria for hospital inpatient services under Medicare Part A	0.998

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Operating rates

Rates with full market basket and wage index > 1	Rate
National labor share	$3,737.71
National non-labor share	$1,632.57
PR national labor share	$3,737.71
PR national non-labor share	$1,632.57
Puerto Rico specific labor share	$1,608.90
Puerto Rico specific non-labor share	$936.82

Rates with full market basket and wage index < or = 1	Rate
National labor share	$3,329.57
National non-labor share	$2,040.71
PR national labor share	$3,329.57
PR national non-labor share	$2,040.71
Puerto Rico specific labor share	$1,578.35
Puerto Rico specific non-labor share	$967.37

Rates with reduced market basket and wage index > 1	Rate
National labor share	$3,664.21
National non-labor share	$1,600.46
PR national labor share	$3,737.71
PR national non-labor share	$1,632.57
Puerto Rico specific labor share	$1,608.90
Puerto Rico specific non-labor share	$936.82

Rates with reduced market basket and wage index < or = 1	Rate
National and PR national labor share	$3,264.10
National/PR national non-labor share	$2,000.57
PR national labor share	$3,329.57
PR national non labor share	$2,040.71
Puerto Rico specific labor share	$1,578.35
Puerto Rico specific non-labor share	$967.37

FY 2014 cost-of-living adjustment factors: Alaska and Hawaii hospitals

Area	Cost of living adjustment factor
Alaska:	City of Anchorage and 80-kilometer (50-mile) radius by road
1.23	City of Fairbanks and 80-kilometer (50-mile) radius by road
1.23	City of Juneau and 80-kilometer (50-mile)
1.23	Rest of Alaska
1.25	Hawaii:
City and County of Honolulu	1.25
County of Hawaii	1.19
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Hospitals waiving lugar redesignation for the out-migration adjustment

Medicare CCN	Provider name
070021	Windham Comm Mem Hosp & Hatch Hosp
250117	Highland Community Hospital
390031	Schuylkill Medical Center - East Norwegian Street
390150	Southwest Regional Medical Center
390201	Pocono Medical Center

Hospital-Specific (HSP) rate update for sole community hospitals (SCHs)

Hospital specific applicable percentage increase	1.017 if IQR = '1' in PSF or 0.997 if IQR = '0' or Blank in PSF
SCH budget neutrality factor	0.997989
SCH documentation and coding adjustment factor	0.9480
Adjustment to offset the cost of the policy on admission and medical review criteria for hospital inpatient services under Medicare Part A	.998

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FY 2014 LTCH PPS rates and factors	
Federal rate for discharges from 10/1/13 through 09/30/14	New beginning in FY 2014, rate based on successful reporting of quality data. •Full update (quality indicator on PSF = 1): $40,607.31 •Reduced update (quality indicator on PSF = 0 or blank): $ 39,808.74
Labor Share	62.537 percent
Non Labor Share	37.463 percent
High Cost Outlier Fixed-Loss Amount	$13,314

Additional information

The official instruction, CR 8421 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2778CP.pdf*.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8421
Related Change Request (CR) #: CR 8421
Related CR Release Date: August 30, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2778CP
Implementation Date: October 7, 2013

Influenza vaccine payment allowances for 2013-2014 seasons

Provider types affected

This *MLN Matters*® article is intended for physicians and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), and Part A/B Medicare administrative contractors (A/B MACs)) for influenza vaccines provided to Medicare beneficiaries.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8433 to update payment allowances, effective August 1, 2013, for seasonal influenza virus vaccines when payment is based on 95 percent of the average wholesale price (AWP). Be sure your billing staffs are aware of this update.

Background

CR 8433 provides payment allowances for the following seasonal influenza virus vaccine codes when payment is based on 95 percent of the AWP, except when furnished in a hospital outpatient department, a rural health clinic, or a federally qualified health center for which payment is based on reasonable cost:

- *Current Procedural Terminology* (*CPT*®) codes *90654*, *90655*, *90656*, *90657*, *90660*, *90661*, *90662*, *90672*, *90673*, *90685*, *90686*, *90687*, and *90688*; and
- Healthcare Common Procedure Coding System (HCPCS) codes Q2033, Q2035, Q2036, Q2037, and Q2038.

The updated allowance rates are effective for dates of service (DOS) as follows (except when provided in a hospital outpatient department, RHC, or FQHC):

- *CPT*® *90655* is $17.243 (DOS 8/1/2013-7/31/2014)
- *CPT*® *90656* is $12.398 (DOS 8/1/2013-7/31/2014)
- *CPT*® *90657* is $6.022 (DOS 8/1/2013-7/31/2014)
- *CPT*® *90661* is pending (DOS 8/1/2013-7/31/2014)
- *CPT*® *90685* is $23.228 (DOS 8/1/2013-7/31/2014)
- *CPT*® *90686* is $19.409 (DOS 8/1/2013-7/31/2014)
- *CPT*® *90687* is pending (DOS pending-7/31/2014)
- *CPT*® *90688* is pending (DOS pending-7/31/2014)
- HCPCS Q2035 (Afluria®) is $11.543 (DOS 8/1/2013-7/31/2014)
- HCPCS Q2036 (Flulaval®) is $8.579 (DOS 8/1/2013-7/31/2014)
- HCPCS Q2037 (Fluvirin®) is $14.963 (DOS 8/1/2013-7/31/2014)
- HCPCS Q2038 (Fluzone®) is $12.044 (DOS 8/1/2013-7/31/2014)

Effective August 1, 2013, HCPCS Q2039 (Flu Vaccine Adult - Not Otherwise Classified) payment allowance

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Flu *(continued)*

is to be determined by the local claims processing contractor.

As the information becomes available, CMS will post payment limits for influenza vaccines that are approved after the release date of this CR (including *CPT®* codes *90687* & *90688*) on the CMS Seasonal Influenza Vaccines Pricing webpage at *http://cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*.

Payment for the following may be made if your MAC determines its use is medically reasonable and necessary for the beneficiary:

- *CPT® 90654* payment allowance is $18.918 for DOS of 8/1/2013-7/31/2014.
- *CPT® 90662* payment allowance is $31.823 for DOS of 8/1/2013-7/31/2014.
- *CPT® 90672* payment allowance is $24.596 for DOS of 8/1/2013-7/31/2014.
- *CPT® 90673* payment allowance is pending for DOS of 1/1/2014-7/31/2014.
- HCPCS Q2033 (Flublok®) Payment allowance is pending for DOS of 8/1/2013-7/31/2014.

Please note that the payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the quarterly average sales price (ASP) drug pricing files. Further, you should be aware that annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Finally, MACs will not search their files either to retract payment for claims already paid or to retroactively pay claims; however, they will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 8433 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2786CP.pdf*.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: MM8433
Related Change Request (CR) #: CR 8433
Related CR Release Date: September 13, 2013
Effective Date: August 1, 2013
Related CR Transmittal #: R2786CP
Implementation Date: No later than October 25, 2013

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Proper entry of clinical trial number helps avoid delays on TAVR claims

On May 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) that outlines coverage for transcatheter aortic valve replacement (TAVR) under coverage with evidence development (CED).

Change request 8255 was issued requiring that claims for TAVR carry an approved eight-digit clinical trial registry number for the following:

- Professional claims processed on or after July 1, 2013
- Hospital claims for inpatient hospital discharges on or after July 1, 2013

Note: Claims submitted without the clinical trial registry number will be returned.

Reminders

Electronic claims: Only the eight-digit numeric portion of the approved clinical trial registry number is entered in the electronic 837P in Loop 2300 REF01 (REF01=P4).

Paper claims: The eight-digit registry number is preceded by a “CT” prefix in Field 19 of CMS-1500 claims.

Source: Change request 8255

2014 PPS update and pricer changes for inpatient rehabilitation facilities

Provider types affected

This *MLN Matters*® article is intended for inpatient rehabilitation facility (IRF) providers submitting claims to Medicare contractors (fiscal intermediaries (FIs) and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8326 which informs Medicare contractors about the release of new IRF PPS pricer software and the changes that software implements that will modify payment rates for IRF PPS claims. Make sure that your billing staffs are aware of these changes.

Background

On August 7, 2001, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register*, a final rule that established the PPS for IRFs, as authorized under Section 1886(j) of the Social Security Act (the Act). In that final rule, CMS set forth per discharge federal rates for federal fiscal year (FY) 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002.

Annual updates to the IRF PPS rates are required by Section 1886(j)(3)(C) of the Act. The FY 2014 IRF PPS final rule issued July 31, 2013, sets forth the prospective payment rates applicable for IRFs for FY 2014. A new IRF pricer software package will be released to CMS contractors prior to October 1, 2013, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2013, through September 30, 2014.

In addition, Section 1886 (j)(7)(A)(i) of the Act requires application of a 2 percent reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. FY 2014 is to be the first year that the mandated reduction will be applied for IRFs that failed to comply with the data submission requirements during the data collection period October 1, 2012, through December 31, 2012.

Thus, in compliance with 1886(j)(7)(A)(i) of the Act, CMS will apply a 2 percentage point reduction to the applicable FY 2014 market basket increase factor in calculating an adjusted FY 2014 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements.

Application of the 2 percent reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Also, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

The adjusted FY 2014 standard payment conversion factor that will be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the period from October 1, 2012, through December 2012 will be $14,555.

Key points of CR 8326

For IRF PPS FY 2014 (October 1, 2013 – September 30, 2014)

- The standard federal rate is $14,846.
- The adjusted standard federal rate is $14,555 (for IRFs that failed to meet the quality reporting requirements).
- The fixed loss amount is $9,272.
- The labor-related share is 0.69494.
- The non-labor related share is 0.30506.
- Urban national average cost-to-charge ratio (CCR) is 0.516.
- Rural national average CCR is 0.643.
- The low income patient (LIP) adjustment is 0.3177.
- The teaching adjustment is 1.0163.
- The rural adjustment is 1.149.

Additional information

The official instruction, CR 8326, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2769CP.pdf*.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

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Related CR Release Date: August 16, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2769CP
Implementation Date: October 7, 2013

January 2014 ASP update and revisions to prior quarterly pricing files

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME/MACs) and Medicare administrative contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8448 which instructs Medicare contractors to download and implement the January 2014 average sales price (ASP) drug pricing files; and, if released by the Centers for Medicare & Medicaid Services (CMS), the October 2013, July 2013, April 2013, and January 2013 drug pricing files for Medicare Part B drugs.

Medicare will use the January 2014 ASP and not other classified (NOC) drug pricing files to:

- Determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2014, with dates of service January 1, 2014, through March 31, 2014; and
- Update the drug payment limits for claims for infusion drugs furnished through a covered item of DME processed or reprocessed on or after January 1, 2014, with dates of service on or after January 1, 2014.

You should make sure that your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA) Section 303(c) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost, or prospective payment, basis.

The average sales price (ASP) methodology is based on quarterly data that manufacturers submit to the Centers for Medicare & Medicaid Services (CMS); who will quarterly supply Medicare contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs.

Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual*, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient Pricer), located at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf*.

The following table shows how the quarterly payment files will be applied:

Files	Effective dates of service
January 2014 ASP and ASP NOC	January 1, 2014, through March 31, 2014
October 2013 ASP and ASP NOC	October 1, 2013, through December 31, 2013
July 2013 ASP and ASP NOC	July 1, 2013, through September 30, 2013
April 2013 ASP and ASP NOC	April 1, 2013, through June 30, 2013
January 2013 ASP and ASP NOC	January 1, 2013, through March 31, 2013

Please note that:

1) The ASP and NOC drug pricing files will contain the applicable payment allowance limits (i.e., 106 percent ASP, 106 percent wholesale acquisition cost (WAC), or 95 percent actual wholesale price (AWP)); and as a result, your Medicare contractor will not make any additional payment calculations;

2) For any drug or biological not listed in the ASP or NOC drug pricing files, your contractor will determine the payment allowance limits in accordance with the policy described in the *Medicare Claims Processing Manual*, Chapter 17 (drugs and biologicals), Section 20.1.3 (Exceptions to average sales price (ASP) payment methodology); which you can find at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf*; and,

3) Your MAC will seek payment allowances from a local carrier for drugs and biologicals that are not on the ASP file. Be aware that your MAC will not search and adjust claims that have already been processed unless you bring them to their attention.

Additional information

The official instruction, CR 8448, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2780CP.pdf*.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

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2014 inpatient psychiatric facilities PPS fiscal year update

Provider types affected

This *MLN Matters*® article is intended for providers who submit claims to Medicare contractors (fiscal intermediaries (FIs), and/or Part A Medicare administrative contractors (A MACs)) for services provided to Medicare beneficiaries and are paid under the inpatient psychiatric facilities prospective payment system (IPF PPS).

Provider action needed

This article is based on change request (CR) 8395 which identifies changes that are required as part of the annual inpatient psychiatric facility prospective payment system (IPF PPS) update from the fiscal year (FY) 2014 IPF PPS update notice, published August 1, 2013. These changes are applicable to IPF discharges occurring during the fiscal year October 1, 2013, through September 30, 2014. Make sure that your billing staff is are aware of these IPF PPS changes for FY 2014.

Background

The Centers for Medicare & Medicaid Services (CMS) published a final rule in the *Federal Register*, November 15, 2004, that established the prospective payment system (PPS) for inpatient psychiatric facilities (IPF) under the Medicare program in accordance with provisions of the Medicare, Medicaid and SCHIP Balance Budget Refinement Act of 1999 (BBRA; Section 124 of Public Law 106-113).

Payments to IPFs under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (i.e., bad debts, and graduate medical education). CMS is required to make updates to this prospective payment system annually.

CR 8395 identifies changes that are required as part of the annual IPF PPS update from the IPF PPS fiscal year (FY) 2014 final rule. These changes are applicable to IPF discharges occurring October 1, 2013, through September 30, 2014.

Inpatient psychiatric facilities quality reporting program (IPFQR)

Section 1886(s)(4) of the Social Security Act requires the establishment of a quality data reporting program for the IPF PPS beginning in rate year (RY) 2014. CMS finalized new requirements for quality reporting for IPFs in the "Hospital inpatient prospective payment system for acute care hospitals and the long term care hospital prospective payment system and fiscal year 2013 rates" final rule (August 31, 2012) (77 FR 53258, 53644 through 53360).

Section 1886(s)(4)(A)(i) of the Act requires that, for RY 2014 and each subsequent rate year, the Secretary of Health and Human Services shall reduce any annual update to a standard federal rate for discharges occurring during the rate year by 2.0 percentage points for any IPF that does not comply with the quality data submission requirements with respect to an applicable year. Therefore, CMS is applying a 2.0 percentage point reduction to the federal per diem base rate and the ECT base rate as follows:

1. For IPFs that fail to submit quality reporting data under the IPFQR program, CMS is applying a 0 percent annual update (that is 2.0 percent reduced by 2 percentage points in accordance with section 1886(s)(4)(A)(ii) of the Act) and the wage index budget neutrality factor of 1.0010 to the FY 2013 federal per diem base rate of $698.51, yielding a federal per diem base rate of $699.21 for FY 2014.
2. Similarly, CMS is applying the 0 percent annual update and the 1.0010 wage index budget neutrality factor to the FY 2013 ECT base rate of $300.72, yielding an ECT base rate of $301.02 for FY 2014.

Market basket update

For FY 2014, CMS used the FY 2008-based rehabilitation, psychiatric and long term care (RPL) market basket to update the IPF PPS payment rates (that is the federal per diem and electroconvulsive therapy (ECT) base rates).

The Social Security Act (Section 1886(s)(2)(A)(ii); see *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm*), requires the application of an "other adjustment" that reduces any update to the IPF PPS base rate by percentages specified in the Social Security Act (Section 1886(s)(3)) for RY beginning in 2010 through the RY beginning in 2019. For the RY beginning in 2013 (that is, FY 2014), the Social Security Act (Section 1886(s)(3)(B)) requires the reduction to be 0.1 percentage point. CMS is implementing that provision in this FY 2014 notice.

In addition, the Social Security Act (Section 1886(s)(2)(A)(i)) requires the application of the productivity adjustment described in the Social Security Act (Section 1886(b)(3)(B)(xi)(II)) to the IPF PPS for the RY beginning in 2012 (that is, a RY that coincides with a FY), and each subsequent RY. For the RY beginning in 2013 (that is FY 2014), the reduction is 0.5 percentage point. CMS is implementing that provision in this FY 2014 notice.

Specifically, CMS reduced the update to the IPF PPS base rate for FY 2014 by applying the adjusted market basket update of 2.0 percent (which includes the RPL market basket increase of 2.6 percent, an Affordable Care Act required 0.1 percent reduction to the market basket update, and an Affordable Care Act required productivity adjustment reduction of 0.5 percent) and

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Psychiatric *(continued)*

the wage index budget neutrality factor of 1.0010 to the FY 2013 federal per diem base rate of $698.51 yields a federal per diem base rate of $713.19 for FY 2014.

Similarly, applying the adjusted market basket update of 2.0 percent and the wage index budget neutrality factor of 1.0010 to the FY 2013 ECT rate of $300.72 yields an ECT rate of $307.04 for FY 2014.

Pricer updates

- The federal per diem base rate is $713.19.
- The federal per diem base rate is $699.21 (when applying the 2 percentage point reduction.)
- The fixed dollar loss threshold amount is $10,245.
- The IPF PPS will use the FY 2013 unadjusted pre-floor, pre-reclassified hospital wage index.
- The labor-related share is 69.494 percent.
- The non-labor related share is 30.506 percent.
- The ECT rate is $307.04.
- The ECT rate is $301.02 (when applying the 2 percentage point reduction.)

Cost to charge ratios for the IPF prospective payment system FY 2014

Cost to charge ratio	Median	Ceiling
Urban	0.4770	1.7066
Rural	0.6220	1.8644

CMS is applying the national median cost-to-charge ratios (CCRs) to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, CMS is using these national ratios until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
- The IPFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the fiscal intermediary obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

Pre-floor, pre-reclassified hospital wage index

CMS is using the updated wage index and the wage index budget neutrality factor of 1.0010.

COLA adjustment for the IPF PPS FY 2014

The Office of Personal Management (OPM) began transitioning from cost of living adjustment (COLA) factors to a locality payment rate in FY 2010. The 2009 COLA factors were frozen in order to allow this transition. In order to provide a full COLA for Alaska and Hawaii, CMS is adopting the FY 2009 COLA rates obtained from the OPM website. These are the same rates that were in effect for RY 2010, RY 2011, RY 2012, and RY 2013. The COLAs for Alaska and Hawaii are shown in the following tables:

Alaska	Cost of living adjustment factor
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25

Hawaii	Cost of Living Adjustment Factor
City and county of Honolulu	1.25
County of Hawaii	1.18
County of Kauai	1.25
County of Maui and county of Kalawao	1.25

Additional information

The official instruction, CR 8395, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2768CP.pdf*.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

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Hospital OPPS October 2013 update

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Medicare contractors (fiscal intermediaries (FIs), Part A Medicare administrative contractors (A MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS).

Provider action needed

This article is based on change request (CR) 8428 which describes changes to the OPPS to be implemented in the October 2013 update. Be sure your billing staff is aware of these changes.

Background

CR 8428 describes changes to and billing instructions for various payment policies implemented in the October 2013 OPPS update. The October 2013 integrated outpatient code editor (I/OCE) and OPPS pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 8428.

Note that the October 2013 revisions to I/OCE data files, instructions, and specifications are provided in the October I/OCE CR 8419, "October 2013 Integrated Outpatient Code Editor (I/OCE) Specifications Version 14.3." A related *MLN Matters*® article is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8419.pdf*. The key changes in the October update to the hospital OPPS are:

Changes to device edits for October 2013

The most current list of device edits is available under "Device, Radiolabeled Product, and Procedure Edits" at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/*. Failure to pass these edits will result in the claim being returned to the provider.

New device pass-through categories

The Social Security Act (Section 1833(t)(6)(B); see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. The Social Security Act (Section 1833(t)(6)(B)(ii)(IV)) requires that CMS create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices. CMS is establishing one new device pass-through category as of October 1, 2013, as shown in the following table:

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	Device offset from payment
C1841	10-01-13	H	1841	Retinal prosth int/ ext comp	Retinal prosthesis, includes all internal and external components	$0

a. Device offset from payment

The Social Security Act (Section 1833(t)(6)(D)(ii)) requires CMS to deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the device (70 FR 68627-8; see 2005 *Federal Register*, Vol. 70, pages 68627-8 at *http://www.gpoaccess.gov/fr/retrieve.html*). CMS is unable to identify a portion of the APC payment amount associated with the cost of C1841 (Retinal prosthesis, includes all internal and external components) in APC 0672, Level III, posterior segment eye procedures. The device offset from payment represents a deduction from pass-through payments for devices associated with the device in category C1841, and CMS believes there are none. Therefore, CMS is establishing an offset amount for C1841 of $0 and will not make any offset deduction from pass-through payment.

Billing for drugs, biologicals, and radiopharmaceuticals

a. Drugs and biologicals with payments based on average sales price (ASP) effective October 1, 2013

In 2013 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the October 2013 release of the OPPS pricer. The updated payment rates, effective October 1, 2013, will be included in the October 2013 update of the OPPS Addendum A and Addendum B, which will be posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

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OPPS *(continued)*

b. **Drugs and biologicals with OPPS pass-through status effective October 1, 2013**

Two drugs and biologicals have been granted OPPS pass-through status effective October 1, 2013. These items, along with their descriptors and APC assignments, are identified in the following table:

HCPCS code	Long descriptor	APC	Status indicator effective 10/1/13
C1204	Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries	1463	G
C9132	Prothrombin complex concentrate (human), Kcentra, per i.u. of Factor IX activity	9132	G

c. Fluzone (Influenza virus vaccine)

Current Procedural Terminology® *(CPT*®) code *90685* was effective January 1, 2013; however, the flu vaccine associated with this code was not approved by the Food and Drug Administration (FDA) until recently. Specifically, Fluzone (Influenza virus vaccine) was approved by the FDA June 7, 2013. Because of this recent FDA approval, CMS is revising the status indicator for *CPT*® code *90685* from "E" (Not paid by Medicare) to "L" (Influenza Vaccine; Pneumococcal Pneumonia Vaccine) effective June 7, 2013.

d. Revised status indicator for HCPCS Codes Q4135 and Q4136 effective October 1, 2013

Effective October 1, 2013, the status indicators (SIs) for HCPCS code Q4135 (Mediskin, per square centimeter) and HCPCS code Q4136 (Ez-derm, per square centimeter) will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (paid under OPPS; separate APC payment). For the remainder of 2013, HCPCS code Q4135 and HCPCS code Q4136 will be separately paid and the prices for these codes will be updated on a quarterly basis.

e. Updated payment rate for HCPCS code J1566 effective July 1, 2013, through September 30, 2013

The payment rate for J1566 was incorrect in the July 2013 OPPS pricer. Providers that had claims containing J1566 and a date of service on July 1, 2013, through September 30, 2013, and that were incorrectly paid may request their MAC to adjust the claims. The corrected payment rate is listed in the following table:

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J1566	K	2731	Immune globulin, powder	$30.66	$6.13

Coverage determinations

The fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Fiscal intermediaries (FIs)/Medicare administrative contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional information

The official instruction, CR 8428 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2775CP.pdf*.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

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Temporary instructions for implementation of final rule 1599-F for Part A to Part B billing of denied hospital inpatient claims

Provider types affected

This *MLN Matters*® special edition article is intended for hospitals submitting claims to Medicare contractors (fiscal intermediaries (FIs and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

What you need to know

This article conveys temporary instructions for the implementation of that portion of final rule 1599-FI that relates to billing for Part B services that were provided during a hospital inpatient stay, for which Medicare denied payment. Make sure billing staff are aware of these instructions.

Background

For admissions on or after October 1, 2013

Hospitals are required to maintain documentation to support the services billed on a Part B inpatient claim for services rendered during the inpatient stay.

A hospital may also be paid for Part B inpatient services if it determines under Medicare's utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, and the beneficiary has already been discharged from the hospital (commonly referred to as hospital self-audit).

If the hospital already submitted a claim to Medicare for payment under Part A, the hospital would be required to cancel its Part A claim prior to submitting a claim for payment of Part B inpatient services. Any coinsurance or deductible collected for the Part A claim must be refunded.

Whether or not the hospital had submitted a claim to Part A for payment, Medicare requires the hospital to submit a Part A claim indicating that the provider is liable under section 1879 of the Act for the cost of the Part A services. The hospital would indicate provider liability period on the Part A claim by including the occurrence span code "M1" and the inpatient admission dates of service. The hospital could then submit an inpatient claim for payment under Part B on a type of bill (TOB) 12x for inpatient services that would have been reasonable and necessary

For Part B inpatient services furnished by the hospital that are not paid under the outpatient prospective payment system (OPPS), but rather under some other Part B payment mechanism, Part B inpatient payment would be made pursuant to the Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients.

if the beneficiary had been treated as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.

All hospitals billing Part A services are eligible to bill the Part B inpatient services, including short term acute care hospitals paid under the inpatient prospective payment system (IPPS), hospitals paid under the OPPS, long term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs) and IPF hospital units, inpatient rehabilitation facilities (IRFs) and IRF hospital units, critical access hospitals (CAHs), children's hospitals, cancer hospitals, and Maryland waiver hospitals. Hospitals paid under the OPPS would continue billing the OPPS for Part B inpatient services. Hospitals that are excluded from payment under the OPPS in 42 CFR 419.20(b) would be eligible to bill Part B inpatient services under their non-OPPS Part B payment methodologies.

Beneficiaries are liable for their usual Part B financial liability. For example, beneficiaries would be liable for Part B copayments for each hospital Part B inpatient service and for the full cost of drugs that are usually self-administered. Timely filing restrictions will apply for Part B inpatient services. Claims that are filed beyond 12 months from the date of service will be rejected as untimely and will not be paid.

CMS notes, when beneficiaries treated as hospital inpatients, are either not entitled to Part A at all, or are entitled to Part A but have exhausted their Part A benefits, hospitals may only bill for the limited set of Part B inpatient services specified in the *Medicare Benefit Policy Manual* (Chapter 6, Section 10), which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf.*

Hospitals may continue to bill Part B for outpatient services provided to the beneficiary prior to the point of inpatient admission in the three calendar day (or one calendar day for a non-IPPS hospital) payment window prior to the admission, including those services that require an outpatient status (see the *Medicare Benefit*

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Temporary *(continued)*

Policy Manual, Chapter 4, Section 10.12, at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c02.pdf*). These services should be billed on a 131 Part B outpatient TOB and must be filed timely (within 12 months of date of service) in order to be paid.

Services provided prior to the point of inpatient admission are outpatient services and may not be included on the 121 Part B inpatient claim; services provided after the point of admission are inpatient services and may not be included on the 131 Part B outpatient claim. Two complementary claims are therefore necessary if some services are provided before admission and others are provided after admission. In placing services on the appropriate claim, hospitals should use the same billing and coding rules used for assigning dates of service to services that cross midnight, using the start of the service to determine correct claim placement unless other specific instructions are provided, and ensuring that services are not double billed.

If inpatient only services, such as procedures on the inpatient only list, were delivered prior to the point of admission, they cannot be paid because they were provided as outpatient services; they may not be reported on the 121 Part B inpatient claim because they were provided prior to the point of admission. If outpatient only services, such as outpatient observation, were continued after the point of admission, the post admission services cannot be paid because they were provided as inpatient services; the time may not be included on the 131 Part B outpatient claim because it was provided after the point of admission.

Appeals

If a hospital chooses to submit a Part B claim for payment following the denial of an inpatient admission on a Part A claim, the hospital cannot also maintain its request for payment for the same services on the Part A claim (including an appeal of the Part A claim). In this situation, before the hospital submits a Part B claim, it must ensure that there is no pending appeal request on the Part A claim. In addition, if a beneficiary files an appeal of a Part A inpatient admission denial, a hospital cannot submit a Part B claim in order to extinguish a beneficiary's appeal rights.

Therefore, the hospital's submission of a Part B claim does not affect a beneficiary's pending appeal or right to appeal the Part A claim. If a beneficiary has a pending Part A appeal for an inpatient admission denial, any claims re-billed under Part B by the hospital will be denied as duplicates by the Medicare contractor.

Once a Part B claim is filed, there are no further appeal rights available with respect to the Part A claim. However, the hospital and beneficiary have appeal rights with respect to an initial determination made on the Part B claim under existing policies set forth at 42 CFR Part 405, Subpart I.

Billing tips

For "self-audit" claims, providers shall submit a Part A provider liable claim. The inpatient claim must indicate the following information on the UB-04 claim form when billed to Medicare:

- Type of bill (TOB) 110 in form locator (FL) 4.
- Non-covered days.
- The services from admission through discharge.
- The appropriate patient status.
- Occurrence span code "M1" and dates of service.
- Non-covered charges for all services rendered.
- All diagnosis codes.
- All procedures codes.

After the inpatient claim has processed and a remittance advice (RA) has been issued, a Part B inpatient claim (TOB 12x) can be submitted.

For Part A Inpatient admissions denied as not reasonable and necessary, providers shall submit a qualifying Part B inpatient claim (TOB 12x) with:

1. A treatment authorization code of A/B Rebilling submitted by a provider.

Note: Providers billing an 837I shall place the appropriate prior authorization code above into Loop 2300 REF02 (REF01 = G1) as follows:

REF*G1*A/B Rebilling~

2. A condition code "W2" attesting that this is a rebilling and no appeal is in process; and
3. The original, denied inpatient claim (CCN/DCN/ICN) number

Note: Providers billing an 837I shall place DCN in the Billing Notes loop 2300/NTE in the format:

NTE*ADD*ABREBILL12345678901234~

For DDE or paper claims, providers shall place the word "ABREBILL" plus the denied inpatient DCN/CCN/ICN shall be added to the remarks field (form locator #80) on the claim using the following format: "ABREBILL12345678901234".

Note: The numeric string above (12345678901234) is meant to represent original claim DCN/ICN numbers from the inpatient denial.

Inpatient Part B hospital services

Inpatient Part B services include services which are not strictly provided in an outpatient setting. Examples of services that are strictly provided in an outpatient setting include services such as diabetes self-

(continued on next page)

Temporary *(continued)*

management training (DSMT), clinic visits, emergency department, and observation services (this is not a complete listing). Inpatient routine services in a hospital generally are those services included by the provider in a daily service charge, sometimes referred to as the "room and board" charge.

Routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made. Examples of routine nursing services that are captured in the room and board rate include patients that receive from the floor nurse IV infusions and injections, blood administration, and nebulizer treatments. These services are not separately billable Inpatient Part B services.

Medicare pays for medically necessary services under inpatient Part B for the non-physician medical and other health services listed in the *Medicare Benefit Policy Manual*, Chapter 6, Section 10.1. The revenue codes listed in the table below are a guide for providers to use when a service is non-covered at the revenue code level. Some revenue codes allow many services, some of which are covered and some of which are non-covered by Medicare inpatient Part B for inpatients.

When a revenue code can be sometimes covered, sometime not covered, providers should use the HCPCS to determine if the service is covered (i.e., revenue code 0942 is not listed below. However, when DSMT services are billed with this revenue code, the DSMT service remains non-covered under Medicare inpatient Part B).

Revenue codes not covered under inpatient Part B medical necessity denials					
010x	011x	012x	013x	014x	015x
016x	017x	018x	019x	020x	021x
022x	023x	024x	029x	0390	0391
0399	045x	050x	051x	052x	054x
055x	056x	057x	058x	059x	060x
0630	0631	0632	0633	0637	064x
065x	066x	067x	068x	072x	0762
078x	082x	083x	084x	085x	088x
089x	0905	0906	0907	0912	0913
093x	0941	0943	0944	0945	0946
0947	0948	095x	096x*	097x*	098x*
099x	100x	210x	310x		

*Only used by critical access hospitals (CAH) that bill both the technical and professional services components.

Providers are reminded to include the full range of ICD-9 diagnosis codes that support medical necessity for all services being billed on the Inpatient Part B claim (12x) and Outpatient Part B claim (13x). Also, providers should be aware of local coverage determinations (LCD's) that may apply to both bill types.

Implantable prosthetic devices

When a hospital that is not paid under the OPPS furnishes an implantable prosthetic device that meets the criteria for coverage in *Medicare Benefit Policy Manual*, Chapter 6, Section 10, to an inpatient who has coverage under Part B, payment for the implantable prosthetic device is made under the payment mechanism that applies to other hospital outpatient services (e.g., reasonable cost, all inclusive rate, waiver).

When a hospital that is paid under the OPPS furnishes an implantable prosthetic device to an inpatient who has coverage under Part B due to Part A medical necessity denial, the hospital should report the HCPCS that describes the device as outlined under OPPS rules. The OPPS hospital should not report HCPCS code, C9899, Implanted Prosthetic Device, Payable Only for Inpatients who do not have inpatient coverage, when the Part A claim has been medically denied. The OPPS hospital should only report HCPCS code, C9899, Implanted Prosthetic Device, Payable only for inpatients who do not have inpatient coverage, due to no Part A coverage or Part A benefits exhausted.

Additional information

If you have any questions, please contact your MAC at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: SE1333
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Disclaimer - This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Additional reporting requirements concerning physician ownership and investment in hospitals

Provider types affected

This *MLN Matters*® article is intended for hospitals that have physician ownership or investment interests, and seek to avail themselves of the whole hospital or rural provider exception to the physician self-referral law. In this article, we refer to hospitals with physician owners or investors as "physician-owned hospitals."

What you need to know

Under Section 1877 of the Social Security Act (the Act), also known as the physician self-referral law, a physician may not refer a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or an immediate family member of the physician) has a financial relationship, unless an exception applies, and the entity may not present or cause to be presented a claim to Medicare (or bill another individual, entity, or third party payer) for those referred services.

The Centers for Medicare & Medicaid Services (CMS) issues this article to address the additional reporting requirements imposed by Section 6001 of the Affordable Care Act on physician-owned hospitals seeking to available themselves of the whole hospital or rural provider exception to the physician self-referral law. This article does not address other additional requirements imposed by Section 6001 of the Affordable Care Act.

Background

Two exceptions to the physician self-referral law for ownership or investment interests are the whole hospital and rural provider exceptions. Section 1877(i)(1)(C)(i) of the Act requires physician-owned hospitals submit to CMS an annual report containing ownership and investment information to qualify for either exception.

This reporting requirement is implemented in the physician self-referral regulations at 42 CFR 411.362(b)(3)(i). (This regulation is available at *http://www.gpo.gov/fdsys/search/pagedetails.action?granuleId=CFR-2011-title42-vol2-sec411-362&packageId=CFR-2011-title42-vol2*.)

Physician-owned hospitals that report ownership and investment information by following the instructions set forth in the Medicare enrollment application form CMS-855A (CMS-855A) for reporting physician-owned hospital ownership and investment information satisfy the above reporting requirement. Please note that this reporting requirement is not mandatory for Medicare enrollment and does not ensure Medicare enrollment.

Physician-owned hospitals seeking to avail themselves of the whole hospital or rural provider exception must report ownership and investment information following the above process by December 1, 2013. Physician-owned hospitals that submitted this information on or after December 1, 2012, consistent with the above process, will be considered to have met the December 1, 2013 deadline.

Hospitals must either update their information or verify that the relevant ownership and investment information in the Medicare provider enrollment, chain, and ownership system is correct on an annual basis to continue to meet the reporting requirement.

We remind hospitals that information submitted under this process may be published on the CMS website pursuant to Section 1877(i)(2) of the Act. If a hospital reports ownership or investment information under this process but is not seeking to use the whole hospital or rural provider exception, the hospital may request that CMS not publish or remove its information from the website by emailing *POHExceptions@cms.hhs.gov*.

Additional information

For more information about provisions affecting physician-owned hospitals under the physician self-referral law, visit the Physician Self-Referral Physician-Owned Hospitals Web page at *http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Physician_Owned_Hospitals.html*.

For information about Medicare enrollment, visit the Medicare Provider-Supplier Enrollment page at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*.

MLN Matters® Number: SE1332
Related Change Request (CR) #: n/a
Related CR Release Date: n/a
Effective Date: n/a
Related CR Transmittal n/a
Implementation Date: n/a

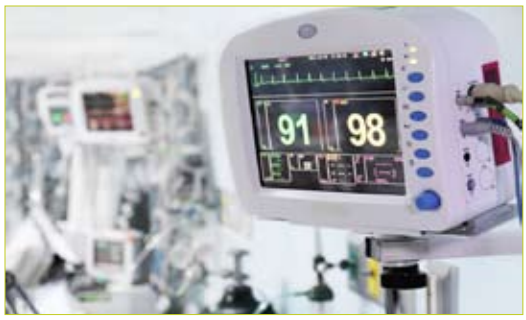
Benefit reassignment to critical access hospitals, health centers

Provider types affected

This *MLN Matters*® article is intended for critical access hospitals (CAHs), federally qualified health centers (FQHCs), and rural health clinics (RHCs) submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 8387, which clarifies that individual physicians and non-physician practitioners can reassign benefits directly to a Part A CAH, FQHC, or RHC through their Form CMS-855A enrollment. CAHs, FQHCs, and RHCs are no longer required to submit a separate Form CMS-855B in order to receive reassigned benefits.



Background

The Centers for Medicare & Medicaid Services (CMS) previously released guidance regarding reassignments to Part A entities in CR 7864, "Revision of the *Medicare Program Integrity Manual* (PIM), Chapter 15, Section 15.5.20, consistent with 42 *Code of Federal Regulations* (CFR), Section 424.80(b)(1) and (b)(2) and the *Medicare Claims Processing Manual*, Chapter 1, Sections 30.2.1(D) and (E) and 30.2.6 and 30.2.7."

Medicare may pay: (1) a physician or other supplier's employer if the supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services; or (2) an entity (i.e., a person, group, or facility) that is enrolled in the Medicare program for services furnished by a physician or other supplier under a contractual arrangement with that entity. CR 7864 allowed for reassignments to occur to all Part A entities via the CMS-855B Medicare enrollment application.

CR 8387 clarifies that all Part A entities may obtain reassignments via Part B, except for CAHs, FQHCs, and RHCs. These three Part A entities may only obtain reassignments through the Medicare Part A CMS 855A enrollment process.

Physicians and non-physician practitioners have the option to reassign their benefits to a CAH, FQHC or an RHC. This is not required. However, if the physician or non-physician practitioner wants to participate in the Medicare electronic health records (EHR) incentive program as an eligible professional (EP) and wishes to have their EHR payments sent to a CAH, FQHC, or RHC, a reassignment to that entity needs to be established with Medicare.

The entity receiving the reassigned benefits must enroll with the Part A Medicare administrative contractor (MAC) via a Form CMS-855A, and the physician or non-physician practitioner reassigning benefits must enroll with the Part B MAC via a Form CMS-855I and Form CMS-855R.

If the physician or non-physician practitioner is currently enrolled with the Part B MAC via a Form CMS-855I and wishes to solely establish a new reassignment to a CAH, FQHC or RHC, only a Form CMS-855R is required.

The Part A CAH, FQHC, and RHC, may only receive reassigned benefits, assuming that the requirements for a reassignment exception are met and that the re-assignee meets all enrollment requirements.

Note that Medicare will verify that the national provider identifier (NPI) reported for physicians in the rendering or attending physician fields on CAH Method II claims for payment, matches physician enrollment data in Medicare's files.

Additional information

The official instruction, CR 8387, issued to your Medicare contractor regarding this clarification, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R483PI.pdf*.

The official instruction, CR 7864, regarding this revision may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R445PI.pdf*.

MLN Matters® article 7864, "Revision to Chapter 15 (Section 15.5.20) of the *Medicare Program Integrity Manual* (PIM) Revision to the *Medicare Program Integrity Manual*" is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7864.pdf*.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html.*

MLN Matters® Number: MM8387
Related Change Request (CR) #: CR 8387
Related CR Release Date: August 16, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R483PI
Implementation Date: January 6, 2014

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Educational Events

Provider outreach and educational events – October 2013

"How can we say it better" First Coast Service Options' seeks your feedback

When: Tuesday, October 29
Time: 11:30 a.m. -1:00 p.m. ET – Delivery language: English
Type of Event: Webcast

Two easy ways to register

1. **Online** – Visit *www.fcsouniversity.com*, logon to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**. First-time user?** Set up an account by completing "Request a New Account" online. Providers with no national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.
2. **Fax** – Providers without Internet access may request a fax registration form through our Registration Hotline at 904-791-8103. Class materials will be faxed to you the day of the event.

Please note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking the *Education* section of our website, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit *medicare.fcso.com*, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to our live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. Our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Explore our catalog of online courses and learn more at *www.fcsouniversity.com*.

Other Educational Resources

CMS MLN Connects™ Provider eNews

The Centers for Medicare & Medicaid Services (CMS) MLN Connects™ Provider eNews is an official *Medicare Learning Network®* (*MLN*) – branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the e-News to their membership as appropriate.

To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels, CMS conducted a pilot that ended September 30, 2012; however, CMS has extended it until further notice. The following are links to the latest e-News:

- CMS MLN Connects™ Provider eNews: August 22, 2013, – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-22-eNews.pdf*
- CMS MLN Connects™ Provider eNews: August 29, 2013 – *https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-08-29-eNews.pdf*
- CMS MLN Connects™ Provider eNews: September 5, 2013– *https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-09-05-enews.pdf*
- CMS MLN Connects™ Provider eNews: September 12, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-09-12-Enews.pdf*
- CMS MLN Connects™ Provider eNews: September 19, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-09-19-enews.pdf*

Source: CMS PERL 201308-08, 201308-08, 201309-01, 201309-02, 201309-03

Addresses

First Coast Service Options

American Diabetes Association certificates
Medicare Provider Enrollment – ADA
P. O. Box 2078
Jacksonville, FL 32231-0048

Claims/correspondence
Florida:
Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

U.S. Virgin Islands:
First Coast Service Options Inc.
P. O. Box 45071
Jacksonville, FL 32232-5071

Electronic claim filing
Direct Data Entry
P. O. Box 44071
Jacksonville, FL 32231-4071

Fraud and abuse
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests
(relative to cost reports and audits)

Provider Audit and Reimbursement (PARD)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268

Local coverage determinations
Medical Policy and Procedures – 19T
P.O. Box 2078
Jacksonville, FL 32231-0048

Medicare secondary payer (MSP)
General information, conditional payment
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Hospital protocols, admission questionnaires, audits
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

MSPRC DPP debt recovery, automobile accident cases, settlements/lawsuits, liabilities
Auto/Liability – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

Overpayment collections
Repayment plans, cost reports, receipts and acceptances, tentative settlement determinations, provider statistical and reimbursement reports, cost report settlement, interim rate determinations, TEFRA target limit and SNF routine cost limit exceptions

Provider Audit and Reimbursement
P. O. Box 45268
Jacksonville, FL 32232-5268

Post-pay medical review
First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

Provider enrollment
CMS-855 Applications
P. O. Box 44021
Jacksonville, FL 32231-4021

Redetermination
Florida:
Medicare Part A Redetermination and Appeals
P. O. Box 45053
Jacksonville, FL 32232-5053

U.S. Virgin Islands:
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Special delivery mail and courier services
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

Durable medical equipment regional carrier (DMERC)
DME, orthotic and prosthetic device, take-home supply, and oral anti-cancer drug claims

CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Railroad Medicare
Palmetto Government Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

Regional home health and hospice intermediary
Palmetto Government Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Phone numbers

Customer service/IVR
Providers:
888-664-4112
Speech and hearing impaired
877-660-1759

Beneficiaries:
800-MEDICARE (800-633-4227)
Speech and hearing impaired
800-754-7820

Credit balance report
Debt recovery
904-791-6281
Fax
904-361-0359

Electronic data interchange
888-670-0940

Option 1 – Transaction support

Option 2 – PC-ACE support

Option 3 – Direct data entry (DDE)

Option 4 – Enrollment support

Option 5 – 5010 testing

Option 6 – Automated response line

Provider audit and reimbursement
904-791-8430

Provider education and outreach
Seminar registration hotline
904-791-8103
Seminar registration fax
904-361-0407

Provider enrollment
877-602-8816

Websites

First Coast Service Options Inc. (Florida and U.S. Virgin Islands Medicare contractor)
medicare.fcso.com

Centers for Medicare & Medicaid Services
Providers:
www.cms.gov

Beneficiaries:
www.medicare.gov

Puerto Rico Contact Information

Addresses

Claims

Additional documentation
General mailing
Congressmen mailing
First Coast Service Options Inc.
P.O. Box 45003
Jacksonville, FL 32232-5003

Redeterminations

Redeterminations on overpayments
First Coast Service Options Inc.
P.O. Box 45028
Jacksonville, FL 32232-5028

Debt recovery (except for MSP)

First Coast Service Options Inc.
P.O. Box 45096
Jacksonville, FL 32232-5096

Post-payment medical exams

First Coast Service Options Inc.
P.O. Box 44159
Jacksonville, FL 32231-4159

Freedom of Information Act (FOIA*) related requests

First Coast Service Options Inc.
Attn: FOIA PARD 16T
P.O. Box 45268
Jacksonville, FL 32232-5268

Medicare fraud and abuse

First Coast Service Options Inc.
P.O. Box 45087
Jacksonville, FL 32232-5087

Provider enrollment

First Coast Service Options Inc.
Provider Enrollment
Post Office Box 44021
Jacksonville, FL 32231-4021

Electronic Data Interchange (EDI*)

First Coast Service Options Inc.
Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

MSPRC DPP debt collection – Part A

First Coast Service Options Inc.
P.O. Box 44179
Jacksonville, FL 32231-4179

Credit balance
First Coast Service Options Inc.
P.O. Box 45011
Jacksonville, FL 32232-5011

Audit and reimbursement department

Reporte de costo, auditoría, apelación de reporte de costo, porcentaje tentativo, rama de PS &R
First Coast Service Options Inc.
P.O. Box 45268
Jacksonville, FL 32231-0048

Overnight mail and other special handling postal services

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Other Medicare carriers and intermediaries

Durable Medical Equipment Regional Carrier (DMERC)
CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Regional Home Health & Hospice Intermediary
Palmetto Goverment Benefit Administrators
Medicare Part A
P.O. Box 100238
Columbia, SC 29202-3238

Railroad Medicare
Palmetto Goverment Benefit Administrators
P. O. Box 10066
Augusta, GA 30999-0001

Phone Numbers

Providers

Customer service – free of charge
Monday to Friday
8:00 a.m. to 4:00 p.m.
1-877-908-8433

For the hearing and speech impaired (TDD)
1-888-216-8261

Interactive voice response (IVR)
1-877-602-8816

Beneficiary

Customer service – free of charge
1-800-MEDICARE
1-800-633-4227

For the hearing and speech impaired (TDD)
1-800-754-7820

Electronic Data Interchange

1-888-875-9779

Educational Events Enrollment

1-904-791-8103

Fax number
1-904-361-0407

Audit And Reimbursement Department

Fax number
1-904-361-0407

Websites

Providers

First Coast – MAC J9
medicare.fcso.com

medicareespanol.fcso.com

Centers for Medicare & Medicaid Services
www.cms.gov

Beneficiary

Centers for Medicare & Medicaid Services
www.medicare.gov