# Medicare A Connection

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A Newsletter for MAC Jurisdiction 9 Providers

December 2013

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## The SPOT does heavy lifting for physical therapy practices

Changes in Medicare coverage policy, while they protect the Medicare trust fund and promote better services for beneficiaries, can sometimes create backaches for medical office practices.

For physical therapy providers, recent policy updates such as therapy caps place providers at risk for thousands of dollars in claims when beneficiaries exceed cap limits.

To help health providers stay current on patient eligibility and other benefit information, First Coast Service Options created the Secure Provider Online Tool (the SPOT).

“For many physical therapist practices in Florida, Medicare is everything. And using the SPOT greatly helps offices streamline their processes, particularly with eligibility and benefit verification,” said Linda Zane, President of the Physical Therapy Provider Network of Florida, a network of more than 150 independent rehabilitation providers in 40 Florida cities.

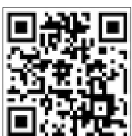
“My experience with SPOT is that it is saving me tons of time and resources. The IVR (interactive voice response system) is labor-intensive and requires a detailed script. Thanks to the SPOT, I no longer need a highly trained Medicare billing manager to handle eligibility look-ups, someone at the front desk can handle this with a simple set of instructions.”

Among the useful tools for physical therapy providers, the SPOT offers subsections which display occupational, physical, and speech therapy cap information. The deductibles/caps section displays the amount of therapy services used by the Medicare beneficiary, allowing providers to determine whether the patient exceeded the respective annual therapy cap.

Zane also likes the ability to review patient eligibility within a few days of a patient’s appointment. Before the SPOT, Zane said eligibility would take place several days prior to a patient visit.

As the owner of an independent physical therapy practice, not having timely access to benefit verification and accurate eligibility information sometimes hit her back pocket.

*(continued on Page 3)*



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**SPOT** *(continued)*

"A patient with a bed sore may need home care to change their wound dressing. When a patient like this comes for physical therapy, they tell us they were not receiving home health care.

Only later, we find out our claim was denied because the patient did not understand their wound care was a home health care episode.

> **"SPOT is amazing because you have given us a tool which the entry level employee can use easily and has a major positive impact on our business"**
>
> *– Linda Zane, President, Physical Therapy Provider Network of Florida*

*Linda Zane, (left) and Dr. Ira Fiebert, co-founded the Physical Therapy Institute in Palm Beach County in 1987.*

"With the SPOT, I can determine if a patient is under a home health plan of care before they arrive at the office," Zane said. "If there is an issue with the timing of claims not appearing on the system, then I can address the issue, if possible, and I'm only at risk for only one physical therapy visit at the most.

Zane said she sees many other benefits to the SPOT. "The SPOT allows me an easy way to keep track of the therapy cap. With the IVR, providers are limited to three inquiries per call. The SPOT gives me time to determine if the patient is about to bump up against the cap. There's no limit to how many inquires you do. If you have a dozen patients who are close to the cap, you can track them almost every day to make sure they haven't bumped over it."

Zane says she promotes usage of the SPOT to her peers as often as possible. "The SPOT is amazing because you have given us a tool which the entry level employee can use easily and has a major positive impact on our business," Zane said.

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

## 2014 update for ALJ and Federal District Court appeals.

The Medicare Prescription Drug, Improvement, and Modernization Act requires an annual reevaluation of the dollar amount in controversy required for an administrative law judge (ALJ) hearing (third level review) or Federal District Court (fifth level) review.

- **ALJ hearing request**: The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2013, is $140. This amount remains at $140 for ALJ hearing requests filed on or after January 1, 2014.
- **Federal District Court review**: The amount that must remain in controversy for Federal District Court review requests filed on or before December 31, 2013, is $1,400. This amount increased to $1,430 for appeals to Federal District Court filed on or after January 1, 2014

## Informational unsolicited response or reject for add-on codes billed without respective primary codes

This *MLN Matters*® article was rescinded November 27, 2013, because change request (CR) 8271 was rescinded. CR 8271 will not be replaced. It was previously published in the August 2013 edition of Medicare A Connection, Pages 33-34.

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# Implementation of provider enrollment provisions in CMS-6028-FC

**Note:** This article was revised December 9, 2013, to provide the application fee amount of $542.00 for 2014. It was previously published in the December 2012 edition of *Medicare A Connection*, Pages 24-26. All other information remains the same.

## Provider types affected

All providers and suppliers submitting enrollment applications to fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare carriers, A/B Medicare administrative contractors (A/B MACs), and the national supplier clearinghouse (NSC) are affected by this article.

## Provider action needed

**Stop – impact to you**

The Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period, entitled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the *Federal Register*.

**Caution – what you need to know**

This rule finalized provisions related to the:

- Establishment of provider enrollment screening categories;
- Submission of application fees as part of the provider enrollment process;
- Suspensions of payment based on credible allegations of fraud; and
- Authority to impose a temporary moratorium on the enrollment of new Medicare providers and suppliers of a particular type (or the establishment of new practice locations of a particular type) in a geographic area.

**Go – what you need to do**

This article is based on change request (CR) 7350, which describes how Medicare contractors will implement the changes related to provider enrollment screening, application fees, and temporary moratoria. (Payment suspensions will be addressed via separate CMS guidance.). Please ensure that your staffs are aware of these new provisions.

## Background

CR 7350 describes how Medicare will implement certain provisions of the final rule CMS-6028-FC. These details are provided in new sections 19 through 19.4 of Chapter 15 in the *Medicare Program Integrity Manual*. Those manual sections are attached to CR 7350 and are summarized as follows:

## Screening processes

Beginning on March 25, 2011, Medicare will place newly-enrolling and existing providers and suppliers in one of three levels of categorical screening: limited, moderate, or high. The risk levels denote the level of the contractor's screening of the provider or supplier when it initially enrolls in Medicare, adds a new practice location, or revalidates its enrollment information.

Chapter 15, Section 19.2.1 of the *Program Integrity Manual* (PIM) provides the complete list of these three screening categories, and the provider types assigned to each category, and a description of the screening processes applicable to the three categories (effective on and after March 25, 2011), and procedures to be used for each category. Once again, that new section of the PIM is attached to CR 7350.

Although fingerprinting and criminal background checks are included in CMS-6028-FC as requirements for providers and suppliers in the "high" category of screening, these requirements will be implemented at a later date and providers and suppliers will be notified well in advance of their implementation.

## Application fees

With the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices, providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application:

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.

This requirement applies to applications that your Medicare contractor receives on or after March 25, 2011.

**Note that a physician, non-physician practitioner,**

*(continued on next page)*

**Enrollment** *(continued)*

**physician group, or non-physician practitioner group that is enrolling as a DMEPOS supplier via the CMS-855S application must pay the required application fee**.

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for January 1, 2013, through December 31, 2013, is $532.00. The fee for January 1, 2014, through December 31, 2014 is $542.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare contractors and the public advance notice of any change in the fee amount for the coming calendar year.

The application fee is non-refundable, except if it was submitted with one of the following:

- A hardship exception request that is subsequently approved;
- An application that was rejected prior to the Medicare contractor's initiation of the screening process; or
- An application that is subsequently denied as a result of the imposition of a temporary moratorium as described in 42 CFR 424.570.

The provider or supplier must pay the application fee electronically by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do and paying their fee via credit card, debit card, or check. Providers and suppliers are strongly encouraged to submit with their application a copy of their receipt of payment. This may enable the contractor to more quickly verify that payment has been made.

## Hardship exception

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper CMS-855 application is submitted, the hardship exception letter must accompany the application.

If the application is submitted via the Internet-based provider enrollment, chain and ownership system (PECOS), the hardship exception letter must accompany the certification statement. Hardship exception letters will not be considered if they were submitted separately from the application or certification statement, as applicable. If your Medicare contractor receives a hardship exception request separately from the application or certification statement, it will: (1) return it to you, and (2) notify you via letter, e-mail, or telephone, that it will not be considered.

Upon receipt of a hardship exception request with the application or certification statement, the contractor will send the request and all documentation accompanying the request to CMS. CMS will determine if the request should be approved. During this review period, the contractor will not begin processing the provider's application. CMS will communicate its decision to the institutional provider and the contractor via letter.

**Important:** In addition, the contractor will not begin to process the provider's application until: (1) the fee has been paid, or (2) the hardship exception request has been approved. Once processing commences, the application will be processed in the order in which it was received.

## Review of hardship exception request

As already stated, the application fee for 2014 is $542. This generally should not represent a significant burden for an adequately capitalized provider or supplier. It is not enough for the provider to simply assert that the imposition of the application fee represents a financial hardship.

The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that may suggest that a hardship exception is appropriate include the following:

a) Considerable bad debt expenses,

b) Significant amount of charity care/financial assistance furnished to patients,

c) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;

d) Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or

e) Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Note that if the provider fails to submit appropriate documentation to support its hardship exception request, the contractor is not required to contact the provider to request it. **Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.**

**Appeal of the denial of hardship exception decision**

*(continued on next page)*

**Enrollment** *(continued)*

If the provider or supplier is dissatisfied with CMS's decision, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination.

The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity.

Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review. To file a reconsideration request, providers and suppliers should follow the procedures outlined in Chapter 15, Section 19 of the *Program Integrity Manual* (PIM), which is attached to CR 7350.

### Temporary moratoria

CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area.

The announcement of a moratorium will be made via the *Federal Register*. For initial and new location applications involving the affected provider and supplier type, the moratorium:

- Will not apply to applications for which an approval or a recommendation for approval has been made as of the effective date of the moratorium, even if the contractor has not yet formally granted Medicare billing privileges. Such applications can continue to be processed to completion.
- Will apply to applications that are pending as of the effective date of the moratorium and for which the contractor has not yet made a final approval/denial decision or recommendation for approval. The contractor will deny such applications and will return the application fee if it was submitted with the application.
- Will apply to initial applications that the contractor receives on or after the effective date of the moratorium, and for as long as the moratorium is in effect. The contractor will deny such applications and will return the application fee if it was submitted with the application.

If a particular moratorium is lifted, all applications pending with the contractor as of the effective date of the moratorium's cessation are no longer subject to the moratorium and may be processed.

However, such applications will be processed in accordance with the "high" level of categorical screening.

In addition, any initial application received from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium, and (b) within 6 months after the applicable moratorium was lifted, the contractor will process the application using the "high" level of categorical screening.

### Additional information

The official instruction, CR 7350, issued to your FI, RHHI, carrier, and A/B MAC regarding this change, may be viewed at *http://www.cms.gov/transmittals/downloads/R371PI.pdf*. Complete details regarding this issue, as defined in the PIM revisions, are attached to CR 7350.

*MLN Matters*® article SE1126, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf*, has further details on the Affordable Care Act-required revalidation of provider enrollment information for all providers and suppliers who enrolled in the Medicare program prior to March 25, 2011.

For more information about the application fee payment process, refer to *MLN Matters*® article SE1130, which is available at *http://www.cms.gov/MLNMattersArticles/downloads/SE1130.pdf*.

A sample letter requesting providers to review, update, and certify their enrollment information is available at *http://www.cms.gov/MedicareProviderSupEnroll/Downloads/SampleRevalidationLetter.pdf*.

If you have any questions, please contact your FI, RHHI, carrier, or A/B MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip*.

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# *Medicare Benefit Policy Manual* – RHC and FQHC Update

## Provider types affected

This *MLN Matters*® article is intended for rural health clinics (RHCs) and federally qualified health centers (FQHCs) submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

## What you need to know

This article is based on change request (CR) 8504, which advises MACs of updates to Chapter 13 of the *Medicare Benefit Policy Manual*. These updates include new information on transitional care management and hospice payment exceptions, and RHC employment. It also provides clarification of existing information. Make sure that your billing staffs are aware of these updates.

## Background

Some of the key revisions/updates of the *Medicare Benefit Policy Manual*, Chapter 13 - rural health clinic (RHC) and federally qualified health center (FQHC) services, are as follows:

RHCs are not paid for services furnished by contracted individuals other than physicians (CFR 42 405.2468(b)(1)). Therefore, non-physician practitioners must be employed by the RHC, as evidenced by a W-2 form from the RHC. If another entity such as a hospital has 100 percent ownership of the RHC, the W-2 form can be from that entity as long as all the non-physician practitioners in the RHC receive their W-2 from this owner.

Transitional care management (TCM) services can also be considered a RHC or FQHC visit. TCM services can be billed as a visit if it is the only medical service provided on that day with a RHC or FQHC practitioner and it meets the TCM billing requirements. If it is furnished on the same day as another visit, only one visit can be billed.

Effective January 1, 2013, RHCs and FQHCs can bill for qualified TCM services furnished by a RHC or FQHC practitioner. TCM services must be furnished within 30 days of the date of the patient's discharge from a hospital (including outpatient observation or partial hospitalization), SNF, or community mental health center (CMHC). communication (direct contact, telephone, or electronic) with the patient or caregiver must commence within two business days of discharge, and a face-to-face visit must occur within 14 days of discharge for moderate complexity decision making (*CPT*® code *99495*), or within seven days of discharge for high complexity decision making (*CPT*® code *99496*).

The TCM visit is billed on the day that the TCM visit takes place, and only one TCM visit may be paid per beneficiary for services furnished during that 30-day post-discharge period. The TCM visit is subject to applicable copayments and deductibles. If the TCM visit occurs on the same day as another billable visit, only one visit may be billed.

Services furnished incident to an RHC or FQHC professional service are included in the per visit payment and are not billed as a separate visit. The costs of covered services provided incident to a billable visit may be included on the RHC or FQHC cost report. Auxiliary services are included as administrative and general costs on the cost report.

Although RHCs and FQHCs are required to furnish certain laboratory services (for RHCs see section 1861(aa)(2)(G) of the Act), and for FQHCs see section 330(b)(1)(A)(i)(II) of the PHS Act), laboratory services are not within the scope of the RHC or FQHC benefit.

When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead and personnel for these services must be adjusted out of the RHC or FQHC cost report. This does not include venipuncture, which is included in the all-inclusive rate when furnished in the RHC or FQHC by an RHC or FQHC practitioner and as part of an RHC or FQHC visit.

RHCs and FQHCs can treat hospice beneficiaries for medical conditions not related to their terminal illness. However, if a Medicare beneficiary who has elected the hospice benefit receives care from a RHC or FQHC related to his/her terminal illness, the RHC or FQHC cannot be reimbursed for the visit, even if it is a medically necessary, face-to-face visit with a RHC or FQHC provider, since that would result in duplicate payment for services, except under either of the following circumstances:

The RHC or FQHC has a contract with the hospice provider to furnish core hospice services related to the patient's terminal illness and related conditions when extraordinary circumstances exist within the hospice. Extraordinary circumstances are described as "unanticipated periods of high patient loads;

*(continued on next page)*

# Additional updates to Chapter 15 of the *Program Integrity Manual*

## Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health and hospice MACs, for services to Medicare beneficiaries.

## What you need to know

This article is based on change request (CR) 8393, which instructs MACs to implement several recent provider enrollment policy determinations that were incorporated into Chapter 15 of the *Medicare Program Integrity Manual* (PIM). Make sure that your billing staffs are aware of these updates.

## Background

As stated in CR 8393, the provider enrollment application fee for January 1, 2014, through December 31, 2014 is $542.00.

## Additional information

The official instruction, CR 8393 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R492PI.pdf.

See CR 8393 to read other provider enrollment policy determinations that have been incorporated into Chapter 15 of the *PIM*.

The revised Chapter of the *PIM* is attached to CR

8393. 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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**Manual** *(continued)*

staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside the hospice's service area" (42 CFR 418.64);

The RHC or FQHC has a contract with the hospice provider to furnish highly specialized nursing services that are provided by the hospice so infrequently that it would be impractical and prohibitively expensive for the hospice to employ a practitioner to provide these services.

For example, a hospice may infrequently have a pediatric patient, and in those situations, contract with a RHC or FQHC that has a pediatric nurse on staff to furnish hospice services to the patient.

## Additional information

The official instruction, CR 8504 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R173BP.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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# Recalcitrant provider procedures

## Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including durable medical equipment Medicare administrative contractors (DME MACs), for services or items to Medicare beneficiaries.

## What you need to know

The change request (CR) that this article refers to how MACs will address recalcitrant providers and suppliers. The Centers for Medicare & Medicaid Services (CMS) has learned from contractors that some providers are abusing the Medicare program and not changing inappropriate behavior even after contractors provide them extensive education to address these behaviors.

These noncompliant providers who refuse to comply with CMS rules, result in contractors' placing these providers on prepay medical review and causing an administrative burden.

## Background

Over the years, CMS has heard from Medicare contractors that some providers are abusing the Medicare program; and, even after extensive educational efforts, do not change their inappropriate behavior.

**Notes**: In this context:

1. Providers are defined as both providers and suppliers, under their current definitions found in the *Code of Federal Regulations* (CFR) at 42 CFR, Section 400.202); and
2. Recalcitrant providers are defined as those who abuse the Medicare program and do not change their inappropriate behavior even after their Medicare contractors have given them extensive provider education addressing these behaviors.

The behavior of these recalcitrant providers who refuse to comply with CMS requirements has resulted in their being placed on prepay medical review for long periods of time, requiring the extensive use of contractor resources; that (while, indeed, protecting Trust Fund dollars) would be better utilized for other types of more productive oversight activity.

Accordingly, CMS is encouraging contractors to take advantage of current sanctions to address this problem of recalcitrant providers.

The two authorities that may be appropriate to impose such a sanction are 1128A (a)(1)(E) of the Social Security Act (the Act), or 1128(b)(6)of the Act; which you can find at http://www.ssa.gov/OP_Home/ssact/title11/1128.htm. Both of these sanctions are delegated to the Office of the Inspector General (OIG), who will work with CMS to pursue these cases.

CR 8394, from which this article is taken, updates Chapter 4 Section 4.27 of the *Medicare Program Integrity Manual* by adding a section formalizing the process for addressing recalcitrant providers and suppliers.

**Note**: Any provider referred as a potential recalcitrant provider case should be an "outlier," meaning a provider who has been the least receptive to changing and has a significant history of noncompliance. For any case submitted, it is important to remember that different mitigating or aggravating circumstances may need to be applied.

## Additional information

The official instruction, CR 8394 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R495PI.pdf. You will find the updated *Medicare Program Integrity Manual*, Chapter 4 (Benefit Integrity), Section 27 (recalcitrant providers) as an attachment to that CR.

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: MM8394
Related Change Request (CR) #: CR 8394
Related CR Release Date: December 13, 2013
Effective Date: January 15, 2014 - This process is currently in effect and this is a clarification through a manual update.
Related CR Transmittal #: R495PI
Implementation Date: January 15, 2014

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# With *Jimmo v. Sebelius* settlement, CMS clarifies skilled services policy

## Provider types affected

This *MLN Matters*® article is intended for skilled nursing facilities (SNFs); inpatient rehabilitation facilities (IRFs); home health agencies (HHAs); providers and suppliers of therapy services under the outpatient therapy (OPT) benefit– including critical access hospitals (CAHs), hospitals, rehabilitation agencies, SNFs, HHAs, physicians, certain non-physician practitioners, and therapists in private practice– submitting claims to Medicare contractors (Parts A/B Medicare administrative contractors (MACs) and Medicare advantage organizations) for services to Medicare beneficiaries, including physical therapy, occupational therapy, and speech-language pathology services.

## What you need to know

This article is based on change request (CR) 8458, which updates portions of the *Medicare Benefit Policy Manual* (MBPM) to clarify key components of SNF, IRF, HH, and OPT coverage requirements pursuant to the settlement agreement in the case of *Jimmo v. Sebelius*. Nothing in this settlement agreement modifies, contracts, or expands the existing eligibility requirements for Medicare coverage.

In accordance with the *Jimmo v. Sebelius* settlement agreement, the Centers for Medicare & Medicaid Services (CMS) has agreed to issue revised portions of the relevant program manuals used by Medicare contractors, in order to clarify that coverage of skilled nursing and skilled therapy services "…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care."

Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

The following are some significant aspects of the manual clarifications now being issued: • No "Improvement Standard" is to be applied in determining Medicare coverage for maintenance claims in which skilled care is required.

Medicare has long recognized that even in situations where no improvement is expected, skilled care may nevertheless be needed for maintenance purposes (i.e., to prevent or slow a decline in condition). For example, the longstanding SNF level of care regulations, specify that the ". . . restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.

For example, a terminal cancer patient may need . .. skilled services . . . ." [42 CFR 409.32(c)] (This regulation is available at *http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec409-32.pdf* on the Internet.)

While the example included in this provision pertains specifically to skilled nursing services, we also wish to clarify that, the concept of skilled therapy services can similarly involve not only services that are restorative in nature (or "rehabilitative" therapy in the OPT setting) but, if certain standards are met, maintenance therapy as well:

- **Restorative/rehabilitative therapy**. In evaluating a claim for skilled therapy that is restorative/rehabilitative (i.e., whose goal and/or purpose is to reverse, in whole or in part, a previous loss of function), it would be entirely appropriate to consider the beneficiary's potential for improvement from the services. We note that such a consideration must always be made in the IRF setting, where skilled therapy must be reasonably expected to improve the patient's functional capacity or adaptation to impairments in order to be covered.
- **Maintenance therapy**. Even if no improvement is expected, under the SNF, HH, and OPT coverage standards, skilled therapy services are covered when an individualized assessment of the patient's condition demonstrates that skilled care is necessary for the performance of a safe and effective maintenance program to maintain the patient's current condition or prevent or slow further deterioration. Skilled maintenance therapy may be covered when the particular patient's special medical complications or the complexity of the therapy procedures require skilled care.

Accordingly, these revisions to the MBPM clarify that a beneficiary's lack of restoration potential cannot serve as the basis for denying coverage in this context. Rather, such coverage depends upon an individualized assessment of the beneficiary's medical condition and the reasonableness and necessity of the treatment, care, or services in question.

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**Settlement** *(continued)*

Moreover, when the individualized assessment demonstrates that skilled care is, in fact, needed in order to safely and effectively maintain the beneficiary at his or her maximum practicable level of function, such care is covered (assuming all other applicable requirements are met).

Conversely, coverage in this context would not be available in a situation where the beneficiary's maintenance care needs can be addressed safely and effectively through the use of non-skilled personnel.

Medicare has never supported the imposition of an "improvement standard" rule-of-thumb in determining whether skilled care is required to prevent or slow deterioration in a patient's condition.

Thus, such coverage depends not on the beneficiary's restoration potential, but on whether skilled care is required, along with the underlying reasonableness and necessity of the services themselves. The manual revisions now being issued will serve to reflect and articulate this basic principle more clearly.

Therefore, denial notices should contain an accurate summary of the reason for denial, which should be based on the beneficiary's need for skilled care and not be based on lack of improvement for a beneficiary who requires skilled maintenance nursing services or therapy services as part of a maintenance program in the SNF, HH, or OPT settings.

> "Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition." *-MM8458*

In the MBPM (the Manual within which all revisions were made by CR 8458), the revised Chapter 15, Section 220 specifically discusses Part B coverage under the OPT benefit. In that chapter, both rehabilitative and maintenance therapy are addressed.

Rehabilitative therapy includes services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being.

A "maintenance program" (MP) means a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness." No mention of improving the patient's condition is noted within the MP definition.

**Enhanced guidance on appropriate documentation**. Portions of the revised manual provisions now include additional material on the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care.

While the presence of appropriate documentation is not, in and of itself, an element of the definition of a "skilled" service, such documentation serves as the means by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case.

Thus, even though the terms of the *Jimmo* settlement do not include an explicit reference to documentation requirements as such, CMS has nevertheless decided to use this opportunity to introduce additional guidance in this area, both generally and as it relates to particular clinical scenarios. An example of this material appears in a new Section 30.2.2.1 of the MBPM's revised Chapter 8, in the guidelines for SNF coverage under Part A.

We note that this material on documentation does not serve to require the presence of any particular phraseology or verbal formulation as a prerequisite for coverage (although it does identify certain vague phrases like "patient tolerated treatment well," "continue with POC," and "patient remains stable" as being insufficiently explanatory to establish coverage).

Rather, as indicated previously, coverage determinations must consider the entirety of the clinical evidence in the file, and our enhanced guidance on documentation is intended simply to assist providers in their efforts to identify and include the kind of clinical information that can most effectively serve to support a finding that skilled care is needed and received – which, in turn, will help to ensure more accurate and appropriate claims adjudication.

Further, as noted in the discussion of OPT coverage under Part B in Section 220.3.D of the MBPM, Chapter 15, care must be taken to assure that documentation justifies the necessity of the skilled services provided. Justification for treatment would include, for example, objective evidence or a clinically supportable statement of expectation that:

- In the case of rehabilitative therapy, the patient's condition has the potential to improve or is improving in response to therapy; maximum improvement is yet to be attained; and, there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- In the case of maintenance therapy, the skills of a

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# Review of inpatient hospital admissions for the 'two-midnight rule'

First Coast Service Options Inc. (First Coast) has received instructions from the Centers for Medicare & Medicaid Services (CMS) regarding final rule 1599-F; the "two midnight rule."

The instructions include completion of prepayment review probes on all inpatient Part A hospitals.

This claim review includes all acute-care inpatient hospitals, inpatient psychiatric facilities and long-term care hospitals. The instructions exclude inpatient rehabilitation facilities and critical access hospitals.

Hospitals will receive a development letter via the normal claims processing method. All supporting records should be submitted as quickly as possible but within 30 days.

Upon completion of all reviews each facility will receive a summary letter with a claim by claim explanation.

The summary letter will include any additional instructions.

Visit the CMS website at *http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/InpatientHospitalReviews.html* for additional information and guidelines.

## CMS strengthens incentives to improve outcomes for patients with ESRD

**Settlement** *(continued)*

therapist are necessary to maintain, prevent, or slow further deterioration of the patient's functional status, and the services cannot be safely and effectively carried out by the beneficiary personally or with the assistance of non-therapists, including unskilled caregivers.

### Settlement agreement.

The *Jimmo v. Sebelius* settlement agreement itself includes language specifying that **"Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage."**

Rather, the intent is to clarify Medicare's longstanding policy that when skilled services are required in order to provide care that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration.

As such, the revised manual material now being issued does not represent an expansion of coverage, but rather, provides clarifications that are intended to help ensure that claims are adjudicated accurately and appropriately in accordance with the existing policy.

### Additional information

The official instruction, CR 8458 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R176BP.pdf*. All of the revised portions of the *Medicare Benefit Policy Manual* are a part of CR 8458.

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: MM8458
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Related CR Release Date: December 13, 2013
Effective Date: January 7, 2014
Related CR Transmittal #: R176BP
Implementation Date: January 7, 2014

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# Bariatric surgery for treatment of co-morbid conditions related to obesity

## Provider types affected

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

## What you need to know

This article is based on change request (CR) 8484, which informs Medicare contractors that:

- Effective for dates of service on and after September 24, 2013, facility certification will no longer be required for coverage of covered bariatric surgery procedures;
- The Centers for Medicare & Medicaid Services (CMS) has determined that no changes be made to the bariatric surgery procedures that are deemed covered in Section 100.1 of the *National Coverage Determination (NCD) Manual*; and
- CMS is clarifying in the *NCD Manual* that, under the existing policy, the local MACs have the authority to make coverage decisions for any bariatric surgery procedures not specifically identified as covered or non-covered by an NCD.

Be sure that your billing staffs are aware of these updates.

## Background

CR 8484 is due to a reconsideration of Section 100.1 of the *NCD Manual* currently titled, Bariatric Surgery for Treatment of Morbid Obesity. On January 24, 2013, CMS initiated a national coverage analysis (NCA) for the reconsideration of the requirement that covered bariatric surgery procedures are only covered when performed in facilities that are certified. CMS also made changes to the NCD which are defined below.

In 2006, CMS established a NCD on Bariatric Surgery for the Treatment of Morbid Obesity (*NCD Manual*, Section 100.1). For Medicare beneficiaries who have a Body Mass Index (BMI) ≥ 35, have at least one co-morbidity related to obesity, and who have been previously unsuccessful with medical treatment for obesity, the following procedures were determined to be reasonable and necessary:

- Open and laparoscopic Roux-en-Y gastric bypass (RYGBP);
- Laparoscopic adjustable gastric banding (LAGB); and
- Open and laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS).

In addition, the NCD stipulates that these bariatric procedures are covered only when performed at facilities that are: (1) Certified by the American College

of Surgeons (ACS) as a Level 1 Bariatric Surgery Center, or (2) Certified by the American Society for Bariatric Surgery (ASBS) as a Bariatric Surgery Center of Excellence (BSCOE) (Program Standards and requirements in effect on February 15, 2006).

The 2006 NCD specifically non-covered open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding because there was a paucity of evidence to support claims of improved health outcomes from those procedures.

This NCA specifically addressed the need for the continuation of the requirement for facility certification by ACS or by the ASBS (currently the American Society for Metabolic and Bariatric Surgeons (ASMBS)).

## CMS policy and manual changes

CMS has determined that the evidence is sufficient to conclude that continuing the requirement for certification for bariatric surgery facilities would not improve health outcomes for Medicare beneficiaries. Therefore, CMS removes this certification requirement, effective with dates of service on or after September 24, 2013.

CMS has determined that no changes need to be made to the bariatric surgery procedures that are deemed covered in Section 100.1 of the *NCD Manual*.

CMS plans to change the title to "Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity", to better reflect the scope of the NCD and to make it clear in the manual that under the existing policy the local MACs have the authority to make coverage decisions for any bariatric surgery procedures not specifically identified as covered or non-covered by an NCD.

In addition, to the proposed decision above, CMS is renumbering and consolidating its manual for Section 100.1. This is an administrative change only to make it easier for the public to read and understand the *NCD*

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**Surgery** *(continued)*

the renumbering and consolidation. The additional NCDs related to bariatric surgery will be consolidated and subsumed into section 100.1 of the *NCD Manual*. These include Sections 40.5, 100.8, 100.11 and 100.14.

### Additional information

The official instruction, CR 8484 issued to your MAC regarding this change via two transmittals. The first is the claims processing transmittal and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2841CP.pdf*.

The second transmittal updates the *NCD Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R158NCD.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: MM8484
Related Change Request (CR) #: CR 8484
Related CR Release Date: December 23, 2013
Effective Date: September 24, 2013
Related CR Transmittal #: R2841CP and R158NCD
Implementation Date: December 17, 2013

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## Revised beneficiary liability and messages associated with denials for claims for services furnished to incarcerated beneficiaries

### Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare administration contractors (MACs), including durable medical equipment Medicare administrative contractors (DME MACs) for services provided to Medicare beneficiaries while they are in federal, state, or local custody.

### Provider action needed

This article is based on change request (CR) 8488 which instructs Medicare claims administration contractors to use an updated claim adjustment reason code (CARC), remittance advice remark code (RARC), and group code when denying claims for services furnished to incarcerated Medicare beneficiaries. 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

According to federal regulations at 42 CFR 411.4, Medicare does not pay for services furnished to a beneficiary who has no legal obligation to pay for the service, and no other person or organization has a legal obligation to provide or pay for the service. Refer to the electronic *Code of Federal Regulations* (e-CFR) at *http://www.ecfr.gov/cgi-bin/textidx?c=ecfr&SID=1270613eb7cae1ed8c62899034b0eca2&rgn=div8&view=text&node=42:2.0.1.2.1 1.1.35.3&idno=42*. This exclusion presumptively applies to individuals who are incarcerated.

Under 42 CFR 411.6, Medicare does not pay for services furnished by a federal provider of services or by a federal agency. Also, under 42 CFR 411.8, Medicare does not pay for services that are paid for directly or indirectly by a governmental entity.

As such, when claims for services furnished to beneficiaries who are incarcerated are submitted to Medicare, the claims are rejected by the common working file (CWF) and denied by the claims processing contractors. Per previously issued instructions (most recently, CR 7678, Transmittal 1054, issued March 7, 2012; see related *MLN Matters*® article at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7678.pdf* ), MACs use the following remittance advice messages and group code when denying such claims:

- **Claim adjustment reason code (CARC): 96** - “Non-covered charges.”
- **Remittance advice remark code (RARC): N103** - “Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in a dederal facility, or while he or she is in state or local custody under a penal authority, unless under state or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the state or local government pursues such debt in the same way and with the same vigor as any other debt.”
- **Group code: PR** - patient responsibility.

CR 8488 revises the remittance advice messages and group code used for denials of claims for services

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**CARC** *(continued)*

furnished to incarcerated beneficiaries. MACs will begin using the following new CARC code when denying claims for services furnished to beneficiaries while they are in federal, state, or local custody:

- **CARC: 258** - Claim/service is not covered when patient is in custody or incarcerated. Appropriate federal, state or local authority may cover this claim/service.

In addition, MACs will begin using the following revised RARC N103 language when denying claims for services furnished to beneficiaries while they are in federal, state, or local custody:

- **RARC: N103** - "Medicare records indicate this patient was a prisoner or in custody of a federal, state, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under state or local law, the individual is personally liable for the cost of his or her health care while in custody and the state or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts."

MACs will begin using the following group code to assign proper liability when denying claims for services furnished to beneficiaries while they are in federal, state, or local custody so that the provider or supplier should seek repayment for the cost of its services provided from the authority that was in custody of the beneficiary on the date of service:

- **Group code**: OA - other adjustment

Other than the above, MACs will continue to use existing remittance advice codes and messages and MSN language already in place when denying claims for services furnished to beneficiaries while they are in federal, state, or local custody.

### Additional information

The official instruction, CR 8488 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1320OTN.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: MM8488
Related Change Request (CR) #: CR 8488
Related CR Release Date: November 22, 2013
Effective Date: February 24, 2014
Related CR Transmittal #: R1320OTN
Implementation Date: February 24, 2014

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## Changes to payment calculations for splints, casts, and intraocular lenses

### Provider types affected

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

### Provider action needed

This article is based on change request (CR) 8523 which informs Medicare contractors about the changes in payment basis for splints, casts, and certain intraocular lenses furnished in 2014. Make sure that your billing staffs are aware of these changes.

### Background

Payment has been made on a reasonable charge basis for splints and casts, and intraocular lenses (IOLs) inserted in a physician's office with the criteria for determining reasonable charges set forth at 42 CFR part 405, subpart E of CMS regulations.

However, Section 1842(s) of the Social Security Act provides the authority for replacing the reasonable charge payment methodology with statewide or other area wide fee schedules to be used for payment for these items. The final rule implementing fee schedules for splints and casts, and IOLs inserted in a physician's office was published December 2, 2013. Effective for dates of service on or after April 1, 2104, payment for splints and casts, and IOLs inserted in a physician's office will be made using national fee schedule amounts, and reasonable charges will no longer be calculated for these items.

For payment of splints and casts furnished from April 1, 2014, through December 31, 2014, regulations at 42 CFR 414.106 require national fee schedules be established based on 2013 reasonable charges updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June 2013.

For subsequent years, the fee schedule amounts will be updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period

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**Payment** *(continued)*

ending with June of the preceding year, reduced by the productivity adjustment as described in section 1886(b)(3)(B)(xi)(II) of the Act. The splints and cast Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the physician fee schedule for the procedure for applying the splint or cast.

For payment of IOLs inserted in a physician's office furnished from April 1, 2014, through December 31, 2014, regulations at 42 CFR 414.108 require national fee schedules be established based on the national average allowed charge for the item from January 1, 2012, through December 31, 2012, updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 24-month period ending with June 2013.

For subsequent years, the fee schedule amounts will be updated by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year, reduced by the productivity adjustment as described in section 1886(b)(3)(B)(xi)(II) of the Act.

The reasonable charge amounts for splints and casts that are effective for dates of service January 1, 2014, through March 31, 2014, are shown in *Attachment A* of CR 8523, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2837CP.pdf*.

MACs will make payment for splints and casts based on the lower of the actual charge or the reasonable charge payment limits established for these codes. Payment will also be made on a reasonable charge basis for IOL codes V2630, V2631, and V2632 that are inserted in a physician's office for dates of service January 1, 2014, through March 31, 2014.

MACs shall use the national fee schedule amounts listed in *Attachment B* of CR 8523 to pay claims for splints and casts, and IOLs inserted in a physician's office for dates of service from April 1, 2014, through December 31, 2014.

Subject to coinsurance and deductibles rules, Medicare payment for these items is to be equal to the lower of the actual charge for the item or the amount determined under the applicable fee schedule payment methodology.

Please note that beginning April 1, 2014, the applicable HCPCS codes and the national fee

schedule amounts for splints and casts, and IOLs inserted in a physician's office will be included in the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule file. For subsequent calendar years, MACs are to pay claims for splints and casts, and IOLs inserted in a physician's office using the national fee schedule amounts available in the DMEPOS fee schedule file.

## Additional information

The official instruction, CR 8523, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2837CP.pdf*.

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: MM8523
Related Change Request (CR) #: CR 8523
Related CR Release Date: December 13, 2013
Effective Date: January 1, 2014, for payment on a reasonable charge basis and April 1, 2014, for payment on a national fee schedule basis
Related CR Transmittal #: R2837CP
Implementation Date: January 6, 2014, for payment on a reasonable charge basis and April 7, 2014, for payment on a national fee schedule basis

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# Transcatheter aortic valve replacement – permanent code

## Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for transcatheter aortic valve replacement (TAVR) services to Medicare beneficiaries.

## Provider action needed

This article is based on change request (CR) 8537 which informs MACs that the Centers for Medicare & Medicaid Services (CMS) is retiring the remaining temporary *Current Procedural Terminology*® (*CPT*®) code *0318T* and replacing it with permanent *CPT*® code *33366*, effective January 1, 2014. Make sure that your billing staffs are aware of these changes.

## Background

Transcatheter aortic valve replacement (TAVR, which is also known as TAVI or transcatheter aortic valve implantation) is a new technology for use in treating aortic stenosis. A bio-prosthetic valve is inserted percutaneously using a catheter and implanted in the orifice of the native aortic valve.

The procedure is performed in a cardiac catheterization lab or a hybrid operating room/cardiac catheterization lab with advanced quality imaging and with the ability to safely accommodate complicated cases that may require conversion to an open surgical procedure.

The interventional cardiologist and cardiac surgeon jointly participate in the intra-operative technical aspects of TAVR. On May 1, 2012, CMS issued a national coverage determination (NCD) covering TAVR under coverage with evidence development (CED). The policy is available at *http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=355*.

CR 8537 is an update to CR 8168, dated January 7, 2013. CR 8168 implemented replacement codes for TAVR claims with dates of service on and after January 1, 2013, and contains more detailed billing instructions for TAVR services.

Specifically, for dates of service on or after January 1, 2014, CMS is retiring the remaining temporary *CPT*® code *0318T* (*Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical approach (e.g., left thoracotomy)*) with permanent *CPT*® code *33366* (*Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (e.g., left thoracotomy)*). This coding change appears in the January 2014 Medicare

physician fee schedule database and integrated outpatient code editor updates. Providers should also note that if a TAVR claim is denied because a place of service (POS) code other than POS code 21 was used, the following messages will also be used:

- **Claim adjustment reason code (CARC) 58**: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

  **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

## Additional information

The official instruction, CR 8537 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2827CP.pdf*.

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: MM8537
Related Change Request (CR) #: CR 8537
Related CR Release Date: November 29, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2827CP
Implementation Date: January 6, 2014

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## New consolidated billing codes for therapy and speech evaluation

### Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

### Provider action needed

This article is based on change request (CR) 8539, which provides the annual update to home health (HH) consolidated billing effective for dates of service on or after April 1, 2014. The new codes were effective January 1, 2014, but were overlooked and a 2014 annual HH consolidated billing update was not published. The following of healthcare common procedure coding system (HCPCS) codes are added to the HH consolidated billing non-routine supply code list:

- A7047 Oral interface used with respiratory suction pump, each
- A6531 Gradient compression stocking, below knee, 30-40 MMHG, each
- A6532 Gradient compression stocking, below knee, 40-50 MMHG, each

Note that A7047 is a new HCPCS code in 2014. Codes A6531 and A6532 are existing codes added due to their similarity to code A6545, which has been subject to HH consolidated billing since 2009. The following HCPCS codes are added to the HH consolidated billing therapy code list:

- *92521 Evaluation of speech fluency (eg, stuttering, cluttering)*
- *92522 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)*
- *92523 Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (eg, receptive and expressive language)*
- *92524 Behavioral and qualitative analysis of voice and resonance*

These four new speech evaluation codes replace code *92506*. Make sure that your billing staffs are aware of these changes.

### Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the home health prospective payment system (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to MACs will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency).

Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year.

The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

### Additional information

The official instruction, CR 8539, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2835CP.pdf*.

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*.

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# Improve your patients' health with the initial preventive physical examination and annual wellness visit

**Note**: This article was re-issued on November 27, 2013.

## Provider types affected

Health care professionals eligible to furnish the initial preventive physical examination (IPPE) or annual wellness visit (AWV).

## What you need to know

Medicare covers the following services for Medicare patients that meet certain eligibility requirements:

- The initial preventive physical examination (IPPE) (also known as the "Welcome to Medicare" Preventive Visit); and the annual wellness visit (AWV).

These preventive benefits allow you to assess your patients' health on an annual basis to help you determine if they have any risk factors and if they are eligible for other preventive services and screenings that Medicare covers.

These preventive benefits are a great way for you to detect illnesses in their earliest stages when treatment works best. The average reimbursement level for the AWV is about $107 and about $150 for the IPPE with no patient deductible or co-pay.

**Note**: Please check the physician fee schedule for the exact amount of reimbursement for your locality and setting. You can view the physician fee schedule by visiting *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html* on the Centers for Medicare & Medicaid Services (CMS) website.

## Initial preventative physical exam ("Welcome to Medicare" Preventive Visit)

Medicare covers an IPPE for all patients who have newly enrolled in Medicare Part B.

- The patient must receive this service within the first 12 months after the effective date of their Medicare Part B coverage.
- The IPPE is a one-time benefit.
- The IPPE consists of the following:
- Review the patient's medical and social history;
- Review potential risk factors for depression and other mood disorders;
- Review functional ability and level of safety;
- Measurement of height, weight, body mass index (BMI), and visual acuity screening.
- End-of-life planning (upon agreement of the individual);

- Education, counseling and referral based on the review of previous five components; and
- Education, counseling and referral for other preventive services, including a brief written plan such as a checklist.

For more information about the IPPE, please see "Quick Reference Information: The ABCs of the IPPE" at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf*.

## The AWV or annual wellness visit

Medicare covers an annual AWV for patients:

- Who are no longer within 12 months of the effective date of their first Part B coverage period; and
- Who have not gotten either an IPPE or AWV within the previous 12 months.

Medicare pays for only one first AWV. Medicare will pay for a subsequent AWV for each patient annually.

**Note**: The elements in first and subsequent AWVs, and the codes to bill them, are different. The first AWV includes the following elements:

- A health risk assessment;
- Establishment of a current list of provider and suppliers;
- Review of medical and family history;
- Measurement of height, weight, BMI, and blood pressure;
- Review of potential risk factors for depression and other mood disorders;
- Review of functional ability and level of safety;
- Detection of any cognitive impairment the patient

*(continued on next page)*

**Health** *(continued)*

may have;

- Establishment of a written screening schedule (such as a checklist);
- Establishment of a list of risk factors; and
- Provision of personalized health advice and referral to appropriate health education or other preventive services.
- Subsequent AWVs include the following elements:
- Review of updated health risk assessment;
- Update medical and family history;
- Update of list of current providers and suppliers;
- Measurement of weight and blood pressure;
- Detection of cognitive impairment the patient may have;
- Update of the written screening schedule (such as a checklist);
- Update of the list of risk factors; and
- Provision of personalized health advice and referral to appropriate health education or other preventive services.

For more information about the AWV, please see:

"Quick Reference Information: The ABCs of the AWV" at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf* or "Providing the Annual Wellness Visit" at: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AnnualWellnessVisit-ICN907786.pdf* .

## Additional information

The *Medicare Learning Network*® has published a variety of additional educational material on Medicare-covered Preventive Services, including:

> "The average reimbursement level for the AWV is about $107 and about $150 for the IPPE with no patient deductible or co-pay." *-SE1338*

- Preventive Services Educational Products: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/education_products_prevserv.pdf*;
- The Preventive Services MLN page: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html*; and
- *MLN Matters*® articles Related to Medicare-Covered Preventive Benefits *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf*.

For general information about Medicare-covered preventive services, visit the CMS Prevention page at *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html*. For information to share with your Medicare patients, please visit *http://www.medicare.gov*.

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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

**Revised LCDs**

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### 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.**

## Revision to LCDs

# Surgical management of morbid obesity – revision to the Part A LCD

### LCD ID number: L33019 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for surgical management of morbid obesity was effective for services rendered **on or after January 29, 2013**.

Since that time, based on the Centers for Medicare & Medicaid Services (CMS) change request (CR) 8484, the LCD has been revised under the "CMS National Coverage Policy" and "Indications and Limitations of Coverage and /or Medical Necessity" sections of the LCD.

The LCD was revised to remove the facility certification requirement for coverage of covered bariatric surgery procedures.

### Effective date

This LCD revision is effective for claims processed **on or after December 17, 2013**, for services rendered **on or after September 24, 2013**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage data base 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**

# Use of claim adjustment reason code 23

## Provider types affected

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

## What you need to know

Change request (CR) 8490, from which this article is taken, modifies Medicare claims processing systems to use Medicare claim adjustment reason codes (CARC) 23 to report impact of prior payers' adjudication on Medicare payment in the case of a secondary claim.

## Background

Effective April 1, 2013, CR 8154 – "Remittance Advice Remark and Claims Adjustment Reason Code, Medicare Remit Easy Print, and PC Print Update" modified CARC 23 (The impact of prior payer(s) adjudication including payments and/or adjustments (Use only with Group Code OA)); to include the instruction that it must be used with Group Code OA (Other Adjustment). The Centers for Medicare & Medicaid Services (CMS) has become aware that the modification to this CARC has resulted in some issues for Medicare. (You can find the *MLN Matters* article associated with CR 8154 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8154.pdf*.)

CR 8297, from which this article is taken, instructs the Medicare's shared system maintainers (SSMs) on how to use CARC 23 to report prior payers' adjudication in the case of a secondary claim.

Medicare beneficiaries may have multiple coverages that occur either before or after Medicare. If (per coordination of benefits) Medicare is the secondary payer, the adjudication process has to take into consideration how previous payers have adjudicated the claim, and report accordingly on the Remittance Advice (RA). The implementation guide for the current electronic remittance advice (ERA) - ASC x12 Transaction 835 version 5010 - has explicit instruction in the *Front Matter*, Section 1.10.2.13 (Secondary Payment Reporting Consideration) to:

"Report the "impact" in the appropriate claim or service level CAS segment with reason code 23 (Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments); and claim adjustment group code OA (Other Adjustment). Code OA is used to identify this as an administrative adjustment.….It is essential that any secondary payer report in the remittance advice only the primary amount that has actually impacted their secondary payment. In many cases, this "impact" is less than the actual primary payment." In these instances, reporting the actual payment would prevent the transaction from balancing.

Medicare does not have to report everything a previous payer has done, because that information is reported by that payer to the provider through the previous payer's remittance advice (RA). In order to generate and send a balanced Medicare RA and coordination of benefits (COB) claim, Medicare should report only the part of previous payers' adjudication that impacts Medicare calculation of payment and adjustments.

Specifically, CR 8279 requires the Medicare SSMs to report:

1. The Medicare allowed amount in the appropriate claim or service level "AMT" segment using qualifier AU (claim level) or B6 (service level) in AMT01 (actual amount qualifier code);
2. Any patient responsibility, remaining after coordination of benefits with the previous payer(s), with group code "PR" (Patient Responsibility) and the appropriate claim adjustment reason code (for example: 1 - Deductible Amount, 2 - Coinsurance Amount); and
3. Any further adjustment, taken by Medicare as a result of previous payer(s) payment and/or adjustment(s), with group code OA and claim adjustment reason code 23.

## Additional information

The official instruction, CR 8297 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1318OTN.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: November 15, 2013
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Related CR Transmittal #: R1318OTN
Implementation Date: April 7, 2014, except July 7, 2014, for suppliers billing DME MACs

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## New influenza virus vaccine code

### Provider types affected

This *MLN Matters*® article is intended for physicians and other providers, including hospitals, home health agencies, and hospices submitting claims to Medicare contractors (carriers, Medicare administrative contractors (A/B MACs), regional home health intermediaries (RHHIs), and home health and hospice Medicare administrative contractors (HH&H MACs) for services to Medicare beneficiaries.

### What you need to know

Change request (CR) 8473, from which this article is taken, provides instructions for updating payment and common working file (CWF) edits to include influenza virus vaccine *Common Procedural Terminology* (*CPT*®) code *90673* (*Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutnin (HA) protein only, preservative and antibiotic free, for intramuscular use*), for claims with dates of service on or after January 1, 2014, that are processed on or after April 1, 2014. CR 8473 also corrects the effective date of code Q2033 from January 1, 2013, to July 1, 2013. You should ensure that your billing staffs are aware of these code changes.

### Background

CR 8473, from which this article is taken, provides that (effective for claims with dates of service on or after January 1, 2014) Medicare will pay for vaccine *CPT*® code *90673* (*Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutnin (HA) protein only, preservative and antibiotic free, for intramuscular use*). All physicians, non-physicians practitioners and suppliers who administer the influenza virus vaccination must take assignment on the claim for the vaccine.

Your Medicare contractor will add influenza virus vaccine *CPT*® code *90673* to existing influenza virus vaccine edits and accept it for claims with dates of service on or after January 1, 2014. Effective for dates of service on and after January 1, 2014, they will:

- Use the Medicare Part B payment limit for influenza virus vaccine *CPT*® code *90673* according to the April 2014 Part B drug pricing file; and
- Pay for vaccine code *90673* as follows:
  1. Hospitals – types of bill (TOB) 12x and 13x, skilled nursing facilities (SNFs) –TOB 22x and 23x, home health agencies (HHAs) – TOB 34x, hospital-based renal dialysis facilities (RDFs) – TOB 72x, and critical access hospitals (CAHs) – TOB 85x based on reasonable cost;
  2. Indian health service (IHS) hospitals – TOB 12x and 13x and IHS CAHs – TOB 85x based on the lower of the actual charge or 95 percent of the average wholesale price (AWP); and comprehensive outpatient rehabilitation facility (CORF) – TOB 75x and independent RDFs – TOB 72x based on the lower of actual charge or 95 percent of the AWP.

**Note**: In all of the above instances, annual Part B deductible and coinsurance do not apply. In addition, (effective for dates of service between January 1, 2014 and March 31, 2014) your Medicare contractor:

- Will use local pricing guidelines to determine payment rates for influenza virus vaccine code *90673*; and
- Until systems changes are implemented, will hold institutional claims containing influenza virus vaccine *CPT*® codes *90673* (with dates of service on or after January 1, 2014) that they receive before April 1, 2014. Once the system changes described in CR 8473 are implemented, these claims will be released for processing.

### Additional information

The official instruction, CR 8473 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2824CP.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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# Phase III CORE 360 CARCs and RARCs rule – implementation

## 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) 8518, from which this article is taken, instructs Medicare contractors to report only the code combinations that are listed in the current version of the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of CARC and RARC Rule. The spreadsheet attached to CR 8518 (which is available also at http://www.caqh.org/CORECodeCombinations.php) shows the change log for CORE code combination version 3.0.3 updates published October 1, 2013.

## Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C – Administrative Simplification – to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently, and to achieve greater uniformity in the transmission of health information.

More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to electronic data interchange (EDI) from paper has been slow and disappointing. 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. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CAQH CORE published code combination version 3.0.3 October 1, 2013. This update is based on July, 2013, CARC and RARC updates as posted at the WPC website. You may review these updates at: http://www.wpc-edi.com/reference for CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php for CAQH CORE defined code combination updates.

## Additional information

The official instruction, CR 8518 issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1316OTN.pdf.

In CR 8365, released August 16, 2013, CMS instructed Medicare contractors to implement this updated rule set by January 6, 2014. You can find the associated *MLN Matters*® article, MM8365 "Implement Operating Rules – Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8365.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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# January 2014 integrated outpatient code editor specifications version 15.0

## Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for outpatient services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services when provided in a home health agency not under the home health prospective payment system or claims for services to a hospice patient for the treatment of a non-terminal illness.

## Provider action needed

This article is based on change request (CR) 8548 which informs the MACs that the I/OCE was updated for January 1, 2014. Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional Information* sections of this article for further details regarding these changes.

## Background

The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis.

The full list of I/OCE specifications is available at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html* on the Centers for Medicare & Medicaid Services (CMS) website. There is a summary of the changes for January 2014 in Appendix M of Attachment A of CR 8548 and that summary is captured in the following key points.

Effective January 1, 2014, (except as noted below) Medicare will:

- Modify extended assessment and management (EAM) composite ambulatory payment classification (APC) assignment criteria (appendix K) by:
  - Deleting composite APCs 8002 and 8003
  - Adding new EAM composite 8009
- Deactivate special logic to make separate payment for certain skin substitute products when billed with specified skin substitute application procedures (appendix N).
- Implement new edit to require that specific skin substitute products (high cost vs. low cost) be submitted with specific skin substitute application procedures (appendix N). Edit 87 is affected.

  **Edit description**: Skin substitute application procedure without appropriate skin substitute product code (return to provider (RTP))

  **Edit criteria**: A list A skin substitute application procedure is submitted without a list A skin substitute product; or a list B skin substitute application procedure is submitted without a list B skin substitute product on the same date of service.
- Change the status indicator (SI) from N to A for any laboratory code (code list) submitted on 14x bill type.
- Deactivate the logic for assignment of payment adjustment flags 7 and 8 with modifiers FB and FC for offset payment reduction.
  - Deactivate payment adjustment flags 7 and 8.
  - Modify edit 75 (Incorrect billing of modifier FB or FC) to apply if modifier FB or FC is submitted on any line/any SI on a claim.
  - Deactivate edit 78 (Nuclear medicine)- Claim lacks required radiolabeled product).
- Deactivate edit 85 (Claim lacks required device code or required procedure code).
- Add code *97610* to the 'Sometimes Therapy' list/logic (Change SI to A if submitted with a therapy revenue code or therapy modifier).
- Implement mid-quarter Food and Drug Administration (FDA) approval coverage for code *90688*. Edit 67 is affected. Effective August 16, 2013.
- Make HCPCS/APC/SI changes as specified by CMS (data change files).
- Implement version 20.0 of the NCCI (as modified for applicable institutional providers). [All edits combined in a single file, in code1/code2 format; mutually exclusive pairs no longer differentiated]. Edits 20 and 40 are affected.
- Add new modifier PM (Post mortem) to the valid modifier list. Edit 22 is affected.

*(continued on next page)*

**Outpatient** *(continued)*

- Update procedure/sex conflict edit list. Edit 8 is affected.
- Update procedure/device & device/procedure edit requirements. Edits 71 and 77 are affected.
- Update the add-on/primary procedure pair edit requirements for partial hospitalization program (PHP) claims (G0463 added as a primary code when reported with psychiatric add-on codes) - edit 84.
    - Revise SI descriptions as follows:

      S = Procedure or service, not discounted when multiple

      T = Procedure or service, multiple reduction applies
- Update appendix F, G, K, N.
- Add new flags & code lists to data files (HCPCS map) and user manuals (app B) for edit 87.
- Remove code lists from user manuals (app B, C) for deactivated edit (78) & modifier FB/FC logic.

## Additional information

The official instruction, CR 8548 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2838CP.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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## New timeline proposed for achieving Stage 3 EHR meaningful use

The Centers for Medicare & Medicaid Services (CMS) recently proposed a new timeline for the implementation of Stage 3 meaningful use for the Medicare electronic health record (EHR) incentive programs.

"Meaningful use" is the extent to which a provider uses electronic records in the conduct of their clinical practice such as issuing prescriptions or ordering medical tests, tracking patient health status, or submitting clinical quality measures through electronic systems. The revised timeframe will involve:

- Providers in their first year of Stage 1 for the Medicare EHR incentive program in 2014, must begin 90 days of Stage 1 of meaningful use no later than July 1, 2014, and submit attestation by October 1, 2014, in order to avoid the 2015 payment adjustment.
- Providers who have completed one year of Stage 1 of meaningful use must demonstrate a second year of Stage 1 of meaningful use in 2014 for a three-month reporting period fixed to the quarter for Medicare. These providers will need to demonstrate Stage 2 of meaningful use for two years (2015 and 2016), and will begin Stage 3 of meaningful use in 2017.
- Providers who have completed two or more years of Stage 1 of meaningful use still need to demonstrate Stage 2 of meaningful use in 2014 for a three-month reporting period fixed to the quarter for Medicare. These providers will demonstrate

Stage 2 of meaningful use for three years (2014, 2015, and 2016), and begin Stage 3 of meaningful use in 2017.

These changes will allow CMS to focus efforts on the successful implementation of the enhanced patient engagement, interoperability and health information exchange requirements in Stage 2; and to use information gathered from Stage 2 participation to inform policy decisions for Stage 3. According to CMS, the new timeline would allow ample time for developers to create and distribute certified EHR technology before Stage 3 begins. For more information on EHR incentives, visit the *Medicare EHR Web page* on the CMS website.

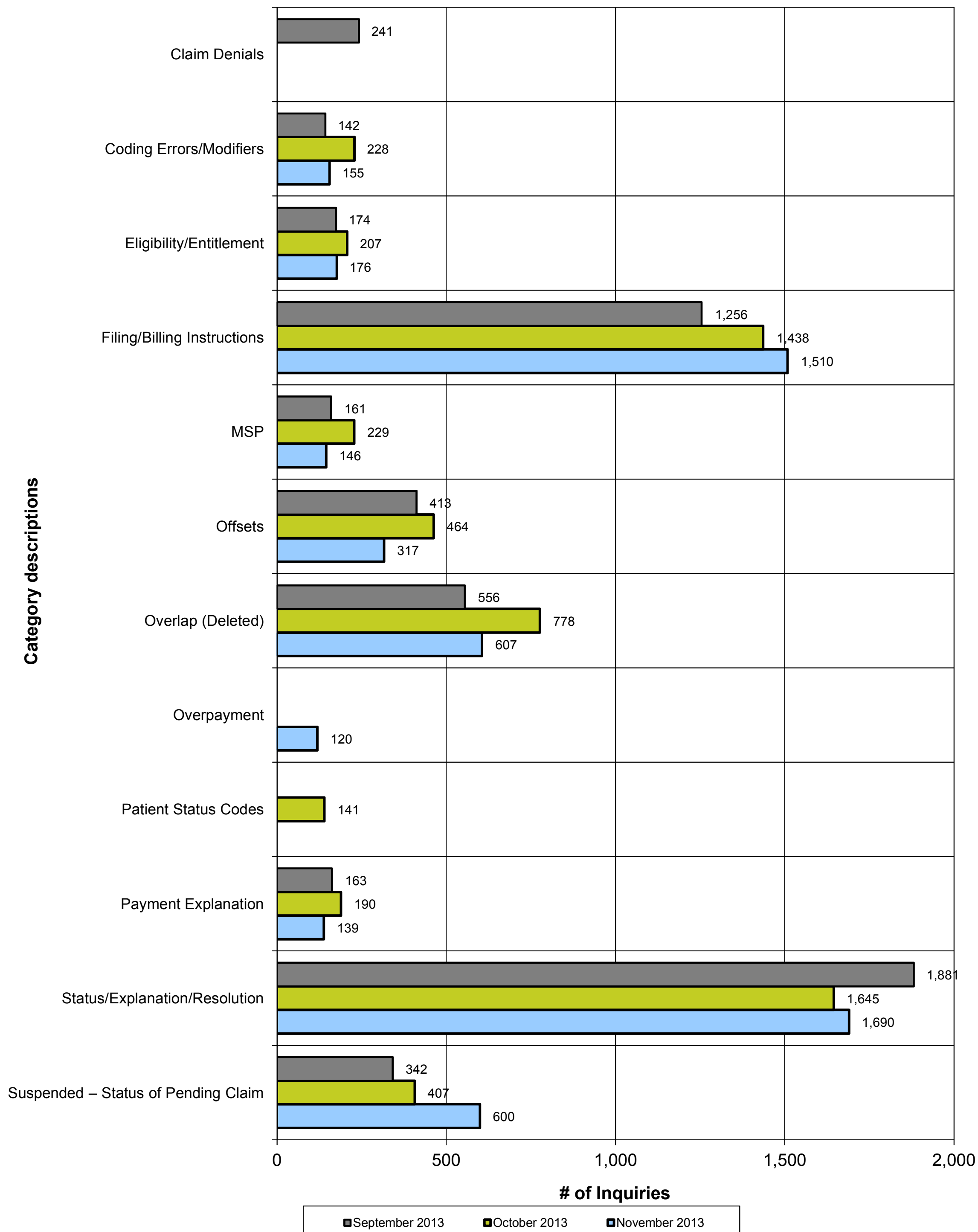
*Information contained within this article was previously released in an edition of the weekly "CMS MLN Connects ™ Provider e-News."*

## Top inquiries, rejects, and return to provider claims September 2013 through November 2013

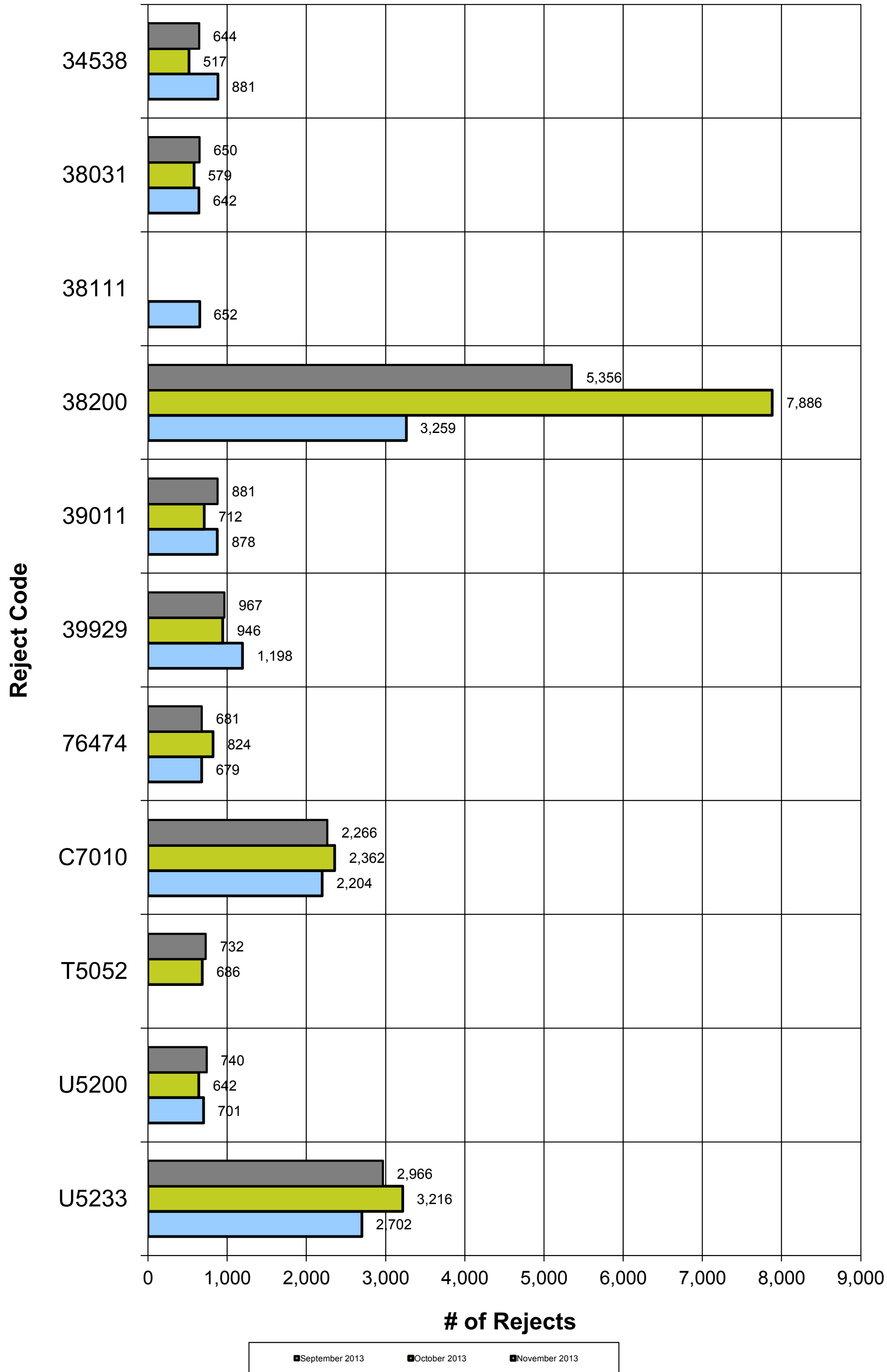
The following charts provide the most frequent inquiries and reason codes for rejected and returned to provider (RTP) claims submitted to First Coast Service Options Inc. (First Coast), by providers in Florida, Puerto Rico, and the U.S. Virgin Islands during September 2013 through November 2013.

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.*

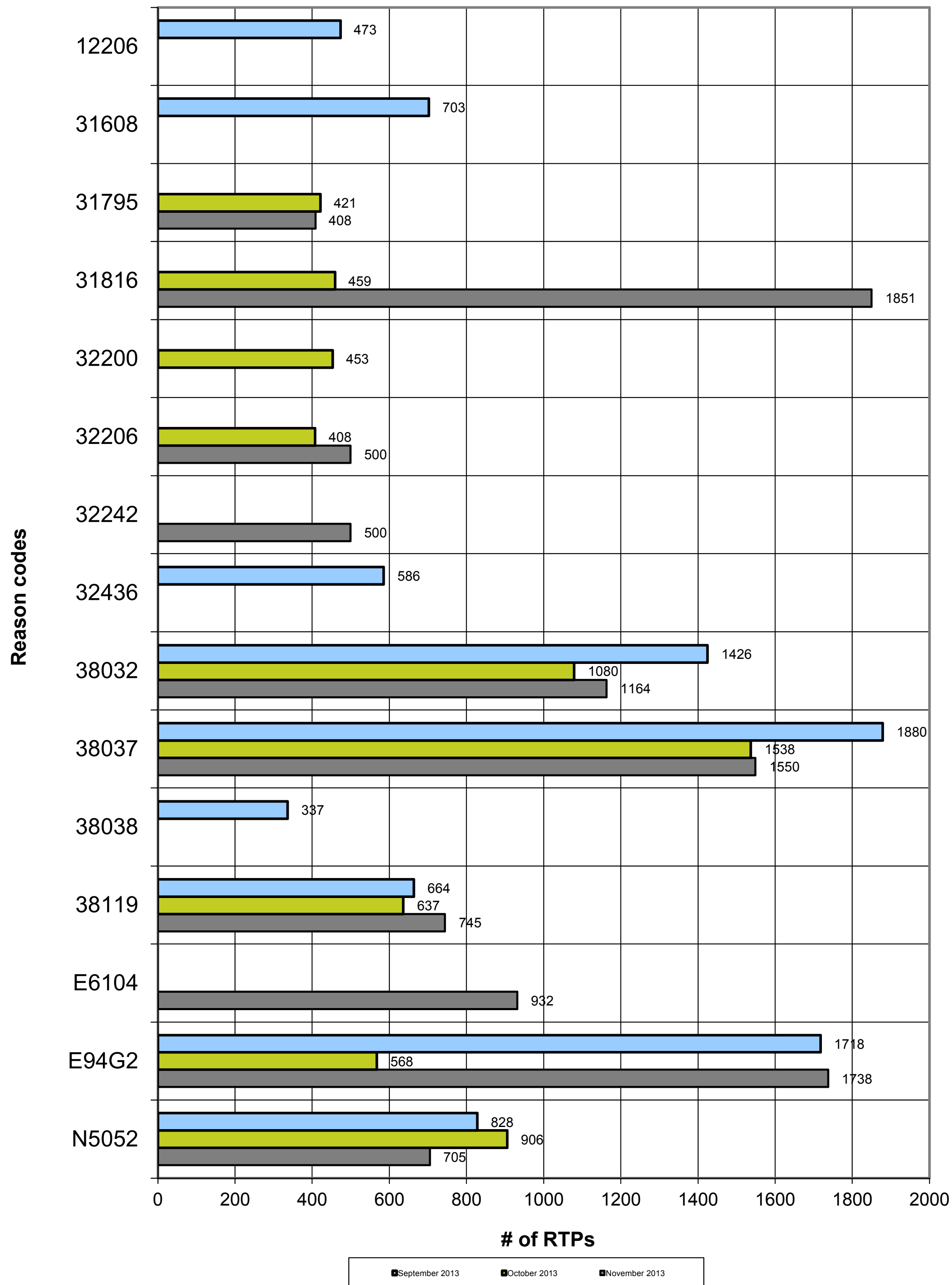
### Top inquiries for September-November 2013



## Part A top rejects for September 2013 through November 2013



## Part A top return to providers (RTPs) for September 2013 through November 2013



# 2014 ESRD policy and payment rate changes finalized

## CMS strengthens incentives to improve outcomes for patients with ESRD

On November 22, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that updates Medicare policies and payment rates for 2014 for dialysis facilities paid under the end-stage renal disease (ESRD) prospective payment system (PPS).

CMS received extensive public comment on the proposed rule, issued in July. CMS carefully reviewed the comments and has decided to implement a three to four-year transition for the drug utilization adjustment to the base rate mandated by Congress as part of the American Taxpayer Relief Act, and overall payments for 2014 will see a 0 percent change.

The rule also finalized a 50 percent increase to the home dialysis training add-on payment adjustment that is made for both peritoneal dialysis and home hemodialysis training treatments.

While the ESRD PPS, implemented in 2011, was effective for renal dialysis services furnished on or after January 1, 2011, the statute provided for a four-year transition period during which the ESRD facilities were paid a blended payment with a portion of payments based on the composite rate methodology and a portion based on the new PPS rate.

In 2014, the final year of the four-year transition period, all ESRD facilities will be paid 100 percent of the ESRD PPS rate for renal dialysis services furnished on or after January 1, 2014.

The final rule will also strengthen the ESRD Quality Incentive Program (QIP), which creates incentives for dialysis facilities to improve the quality of care and patient outcomes for beneficiaries diagnosed with ESRD. For the ESRD QIP payment year (PY) 2016 program (which will rely on measures of dialysis facility performance during 2014), CMS is finalizing 11 measures addressing infections, anemia management, dialysis adequacy, vascular access, mineral metabolism management, and patient experience of care. CMS is also finalizing the method by which performance scores will be calculated by weighting clinical measures at 75 percent of the total performance score and weighting the reporting measures at 25 percent. The ESRD QIP will reduce payments to ESRD facilities that do not meet or exceed certain performance standards.

Both the ESRD PPS and the ESRD QIP were mandated by the Medicare Improvements for Patients and Providers Act of 2008. The ESRD PPS is intended to improve efficiency and reduce incentives to use more items and services than needed for appropriate care, while the ESRD QIP is intended to promote improvement in the quality of care provided to Medicare beneficiaries with ESRD.

Additionally, the final rule includes several provisions related to Medicare policies on durable medical equipment (DME). CMS is finalizing clarification of the three-year minimum lifetime requirement for DME and the distinction between routinely purchased and capped rental DME.

The rule also finalizes the implementation of budget-neutral fee schedules for splints and casts, and intraocular lenses inserted in a physician's office as well as a few technical amendments and corrections to existing regulations related to payment for durable medical equipment, prosthetics, and orthotics items and services.

Full text of this excerpted *CMS press release* (issued November 22).

*Final rule*

*ESRD center*

SOURCE: *PERL 201311-07*

### Your feedback matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our Website highlights page at *http://medicare.fcso.com/Feedback/201743.asp* . You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's Web team.

# 2014 inpatient and long term care hospital PPS changes

**Note**: This article was revised November 25, 2013, to reflect changes made to CR 8421, November 19, 2013. In the article, the total uncompensated care amount is revised and the year in the last sentence of the second paragraph in the *Low Volume* section is revised.

Also, the CR release date, transmittal number, and the Web address for accessing the CR are changed. This article was previously published in the September 2013 edition of *Medicare A Connection*, Pages 38-46. All other information remains the same.

## 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 2, 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 identified with a ICD-9-CM diagnosis code of 008.45 in combination with NDC code 52015-0080-01 in data

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**Hospital** *(continued)*

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.

(For your information 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.

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.

(For your information 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 IPPS**

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 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.

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**Hospital** *(continued)*

**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 2014 (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 hospital to obtain additional necessary information to determine whether or not the hospital meets the low-

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**Hospital** *(continued)*

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-

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**Hospital** *(continued)*

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 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**

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 Bundled payments for care improvement initiative (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.

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**Hospital** *(continued)*

**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 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**

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 $9,044,632,555.68, 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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**Hospital** *(continued)*

**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 *Medicare Claims Processing Manual*.

**Cost of living adjustment update for LTCH PPS**

The LTCH PPS incorporates a cost of living adjustment (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-based labor market area**

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, 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 |

*(continued on next page)*

**Hospital** *(continued)*

## 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 and 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**: | |
| Anchorage and 80-kilometer (km) (50-mile) radius by road | 1.23 |
| Fairbanks and 80-km (50-mile) radius by road | 1.23 |
| Juneau and 80-km (50-mile) | 1.23 |
| **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 |

## 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 |

*(continued on next page)*

**Hospital** *(continued)*

## 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/R2819CP.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 8421
Related CR Release Date: November 19, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2819CP
Implementation Date: October 7, 2013

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# Pay increase for rural health clinics and federally qualified health centers

## Provider types affected

This *MLN Matters*® article is intended for RHCs and FQHCs submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

## What you need to know

This article is based on change request (CR) 8469, which provides instructions to Medicare contractors for the calendar year 2014 payment rate increases for RHC and FQHC services. Make sure that your billing staffs are aware of these changes.

## Background

CR 8469 provides instructions for the calendar year 2014 payment rate increases for RHC and FQHC services that can be found in *Medicare Claims Processing Manual*, Chapter 9, Section 20. RHCs: The RHC upper payment limit per visit is increased from 79.17 to 79.80 effective January 1, 2014, through December 31, 2014 (i.e., 2014). The 2014 rate reflects a 0.8 percent increase over the 2013 payment limit in accordance with the rate of increase in the Medicare Economic Index (MEI) as authorized by section 1833(f) of the Social Security Act.

FQHCs: The FQHC upper payment limit per visit for urban FQHCs is increased from 128.00 to 129.02 effective January 1, 2014, through December 31, 2014 (i.e., 2014), and the maximum Medicare payment limit per visit for rural FQHCs is increased from 110.78 to 111.67 effective January 1, 2014, through December 31, 2014 (i.e. 2014). The 2014 FQHC rates reflect a 0.8 percent increase over the 2013 rates in accordance with the rate of increase in the MEI.

This effective date of January 1, 2014, is necessary in order to update RHC and FQHC payment rates in accordance with section 1833(f) of the Social Security Act. To avoid unnecessary administrative burden, MACs will not retroactively adjust individual RHC/FQHC bills paid at previous upper payment limits. The MAC does, however, retain the discretion to make adjustments to the interim payment rate or a lump sum

adjustment to total payments already made to take into account any excess or deficiency in payments to date.

## Additional information

The official instruction, CR 8469 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2834CP.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: MM8469
Related Change Request (CR) #: CR 8469
Related CR Release Date: December 11, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2834CP
Implementation Date: January 6, 2014

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# 2014 changes in the end-stage renal disease prospective payment system

## Provider types affected

This *MLN Matters*® article is intended for end stage renal disease (ESRD) facilities submitting claims to Medicare administration contractors (MACs) for ESRD services provided to Medicare beneficiaries.

## Provider action needed

This article is based on change request (CR) 8472 which implements the fourth year of the ESRD prospective payment system (PPS) four-year transition period and the 2014 rate updates for the ESRD PPS. See the *Background* and *Additional information* sections of this article for further details regarding these changes, and make sure that your billing staffs are aware of these changes for 2014.

## Background

In accordance with the Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b)), the Centers for Medicare & Medicaid Services (CMS) implemented the end stage renal disease (ESRD) bundled prospective payment system (PPS) effective January 1, 2011. You can review MIPPA (Section 153(b)) at *http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf*.

The 2014 implements the fourth year of the transition where all ESRD facilities will be paid 100 percent of the ESRD PPS payment amount. Accordingly, a blended rate of the basic case-mix composite rate payment system and the ESRD PPS will no longer be provided, and there will no longer be a transition budget neutrality adjustment factor applied to the payment. Therefore, it is no longer necessary to update the basic case-mix adjusted composite rate payment system.

MIPPA, Section 153(b), was amended by the Affordable Care Act (Section 3401(h); see *http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf*), and stated that for 2012 (and each subsequent year), the Secretary of Health and Human Services will reduce the ESRD bundled (ESRDB) market basket increase factor by a productivity adjustment described in the Social Security Act (Section 1886(b)(3)(B)(xi)(II); see *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm*).

The ESRDB market basket increase factor minus the productivity adjustment will update the ESRD PPS base rate.

The Social Security Act (Section 1881(b)(14)(I), as added by the American Taxpayer Relief Act of 2012 (ATRA; Section 632(a); see *http://www.gpo.gov/fdsys/pkg/BILLS-112hr8eas/pdf/BILLS-112hr8eas.pdf*), requires that, for services furnished on or after January 1, 2014, CMS will make reductions to the single payment for renal dialysis services to reflect the CMS estimate of the change in the utilization of

ESRD-related drugs and biologicals (excluding oral-only ESRD-related drugs) by comparing per patient utilization data from 2007 with such data from 2012.

## 2014 rate updates

For 2014, CMS will make the following updates to the 2013 ESRD PPS base rate:

1. The ESRDB market basket minus a productivity adjustment of 2.8 which results in $247.09 ($240.36 x 1.028 = $247.09).
2. The wage index budget neutrality adjustment factor of 1.000454 which results in $247.20 ($247.09 x 1.000454 = $247.20).
3. The home dialysis training add-on budget neutrality adjustment factor of 0.999912 which results in $247.28 ($247.20 x 0.999912 = $247.18).
4. After the application of the ESRDB market basket, the wage index budget neutrality adjustment factor, and the home dialysis training add-on budget neutrality factor, the ESRD PPS base rate will be reduced by the drug utilization adjustment amount of $8.16. Therefore, the ESRD PPS base rate for 2014 is $239.02 ($247.18 - $8.16 = $239.02).

For 2014, CMS will make the following updates to the wage index:

1. The wage index adjustment will be updated to reflect the latest available wage data.
2. The wage index floor will be reduced from 0.50 to 0.45.

## Transition budget neutrality adjustment

Beginning 2014, there will no longer be a transition budget-neutrality adjustment.

## Home dialysis training add-on payment

The home dialysis training add-on payment will increase from $33.44 to $50.16.

*(continued on next page)*

**ESRD** *(continued)*

## Outlier policy changes

For 2014, CMS will make the following updates to the average outlier service Medicare allowable payment (MAP) amount per treatment:

1. For adult patients, the adjusted average outlier service MAP amount per treatment is $50.25.
2. For pediatric patients, average outlier service MAP amount per treatment is $40.49.

For 2014, CMS will make the following updates to the fixed dollar loss amount that is added to the predicted MAP to determine the outlier threshold:

1. The fixed dollar loss amount is $98.67 for adult patients.

2. The fixed dollar loss amount is $54.01 for pediatric patients.

For 2014, CMS will make the following changes to the list of outlier services:

1. The ESRD-related Part D drugs which are based on the most recent prices retrieved from the Medicare prescription drug plan finder will be updated to reflect the most recent mean unit cost. The list of ESRD-related Part D drugs will also be updated to reflect the most recent list of ESRD-related Part D drugs that are eligible for outlier payment. (See attachment A of CR 8472, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2839CP.pdf*.)

2. The mean dispensing fee of the national drug codes (NDC) qualifying for outlier consideration is revised to $1.42 per NDC per month for claims with dates of service on or after January 1, 2014.

CR 8472 also revises the *Medicare Claims Processing Manual*, (Chapter 8 (Section 20.1 (Calculation of the Basic Case-Mix Adjusted Composite Rate and the ESRD Prospective Payment System Rate); Section 50.8 (Training and Retraining); and Section 60.2.1.2 (Facilities Billing for ESRD Drugs and Biologicals Equivalent to Injectable Drugs)). The manual revisions are attached to CR 8472.

## Additional information

The official instruction, CR 8472 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R177BP.pdf* and *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2839CP.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: MM8472 Revised
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Implementation Date: January 6, 2014

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# CMS updates EFT authorization agreement: CMS 588

The Office of Management and Budget recently approved changes to the *CMS 588*, Electronic Funds Transfer (EFT) Authorization Agreement. The revised CMS 588 is available on the *CMS Forms List*.

Medicare administrative contractors (MACs) will continue to accept the 05/10 version of the CMS 588 through December 31, 2013.

After December 31, 2013, the MACs will return any newly submitted 05/10 versions of the CMS 588 applications with a letter explaining the CMS 588 application has been updated and the provider/supplier must submit a current version (09/13) of the CMS 588 application.

Full text of this excerpted *CMS press release* (issued November 22).

Source: *PERL 201312-03*

**Learn the secrets to billing Medicare correctly**

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Improve Your Billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time. You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

# 2014 home health prospective payment system update

## Provider types affected

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

## What you need to know

This article is based on change request (CR) 8515, which informs MACs about the changes and updates to the 60-day national episode rates, the national per-visit amounts, low-utilization payment adjustment (LUPA) add-on amounts, and the non-routine medical supply payment amounts under the home health prospective payment system (HH PPS) for 2014. Make sure that your billing staffs are aware of these changes.

## Background

Section 3131(a) of the Affordable Care Act mandates that, starting in 2014, the Secretary of Health and Human Services (HHS) must apply an adjustment to the national, standardized 60-day episode payment rate and other amounts applicable under section 1895(b)(3)(A)(i)(III) of the Act to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. In addition, section 3131(a) of the Affordable Care Act mandates that this rebasing must be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the amount (or amounts), as of the date of enactment, applicable under section 1895(b)(3)(A)(i)(III) of the Act, and be fully implemented by 2017.

Also, Section 3131(c) of the Affordable Care Act amended section 421(a) of the Medicare Modernization Act (MMA), which was amended by section 5201(b) of the Deficit Reduction Act (DRA). The amended section 421(a) of the MMA provides an increase of 3 percent of the payment amount otherwise made under section 1895 of the Act for home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2016. The statute waives budget neutrality related to this provision, as the statute specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under Section 1895 of the Act applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

The home health (HH) market basket update for 2014 is 2.3 percent. home health agencies (HHAs) that do not report the required quality data will receive a 2 percent reduction to the HH market basket update of 2.3 percent (0.3 percent) for 2014.

**Note**: All of the information provided below contains references to tables. These tables can be found in the attachment contained in CR 8515, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2820CP.pdf*.

## National, standardized 60-day episode payment

As described in the 2014 final rule, to determine the 2014 national, standardized 60-day episode payment rate, Centers for Medicare & Medicaid Services (CMS) starts with the 2013 estimated average payment per episode ($2,952.03). CMS removes the 2.5 percent for outlier payments that was put back in the rates. Then CMS applies a standardization factor of 1.0026 to ensure budget neutrality in episode payments using the 2014 wage index. CMS then applies an $80.95 reduction (which is 3.5 percent of the 2010 national, standardized 60-day episode rate of $2,312.94). Lastly, the national, standardized 60-day episode payment rate is updated by the 2014 HH market basket update of 2.3 percent for HHAs that submit the required quality data and by 0.3 percent for HHAs that do not submit quality data. The updated 2014 national standardized 60-day episode payment rate for HHAs that submit the required quality data is shown in Table 1 (see attachment) and for HHAs that do not submit the required quality data are shown in Table 4. These payments are further adjusted by the individual episode's case-mix weight and wage index.

## National per-visit rates

To calculate the 2014 national per-visit payment rates, CMS starts with the 2013 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0006 to ensure budget neutrality for LUPA per-visit payments after applying the 2014 wage index, and then applies the maximum rebasing adjustments to the 2013 outlier adjusted per-visit rates. The per-visit rates for each discipline are then updated by the 2014 HH market basket update of 2.3 percent for HHAs that submit the required quality data and by 0.3 percent for HHAs that do not submit quality data. The 2014 national per-visit rates per discipline for HHAs that submit the required quality data are shown in Table 3 and for HHAs that do not submit the required quality data are shown in Table 4 of CR 8515.

## Low-utilization payment adjustment add-on payments

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. Beginning in 2014, CMS will calculate the payment for the first visit in a LUPA episode by multiplying the per-visit rate by a LUPA add-on factor specific to the type of visit (skilled nursing, physical therapy, or speech-language pathology). The 2014 LUPA add-on adjustment factors are displayed in Table 5.

*(continued on next page)*

**Home health** *(continued)*

### Non-Routine Supply Payments

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by the NRS conversion factor. To determine the 2014 NRS conversion factor, CMS starts with the 2013 NRS conversion factor ($53.97) and apply a 2.82 percent rebasing adjustment calculated in the 2014 final rule (1-0.0282 = 0.9718). CMS then updates the conversion factor by the HH market basket update of 2.3 percent for HHAs that submit the required quality data and by 0.3 percent for HHAs that do not submit quality data. CMS does not apply a standardization factor as the NRS payment amount calculated from the conversion factor is not wage or case-mix adjusted when the final claim payment amount is computed.

The NRS conversion factor for 2014 payments for HHAs that submit the required quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b. The NRS conversion factor for 2014 payments for HHAs that do not submit quality data is shown in Table 7a and the payment amounts for the various NRS severity levels are shown in Table 7b. As stipulated in section 3131(c) of the Affordable Care Act, the 3 percent rural add-on is applied to the national standardized 60-day episode rate, national per-visit payment rates, LUPA add-on payments, and the NRS conversion factor when home health services are provided in rural (non-CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2016. Refer to Tables 8 through 10b for the 2014 rural payment rates.

### Additional information

The official instruction, CR 8515 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2820CP.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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## Medicare finalizes home health payments for 2014

### Changes promote lower costs for beneficiaries and taxpayers

On November 22, CMS issued the final CY 2014 home health care payment rule. The final policies in this rule better align Medicare payments with home health agencies' costs providing care, while lowering costs to taxpayers and the 3.5 million Medicare beneficiaries who receive home health services nationwide.

The 2014 final rule reduces Medicare payments under the home health prospective payment system (HH PPS) by 1.05 percent.

This amount reflects the combined effects of an increase in the home health payment update percentage of 2.3 percent, offset by a decrease of 2.7 percent -- the result of rebasing the adjustments required by the Affordable Care Act – and a 0.6 percent decrease due to a refinement of the HH PPS grouper.

As required by the Affordable Care Act, CMS must begin phasing in rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates and the NRS conversion factor to reflect changes since the inception of the HH PPS, such as change in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors.

Prior to the Affordable Care Act, rates were based on analyses of home health agency cost and service utilization data available in 2000, when the HH PPS originally was implemented.

The final rule adds two new quality measures, which will require HHAs to report unnecessary hospital readmission rates and preventable trips to the emergency room. These measures support critical reforms laid out in the Affordable Care Act. The final rule reduces the number of home-health quality measures reported by home health agencies.

Full text of this excerpted *CMS press release* (issued November 22).

*Final rule*

*CMS home health PPS Web page*

SOURCE: *PERL 201311-07*

# 2014 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

## Provider types affected

This *MLN Matters*® article is intended for clinical diagnostic laboratories who submit claims to Medicare claims administration contractors (carriers, fiscal intermediaries (FIs), and/or A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries.

## Provider action needed

This article is based on change request (CR) 8517 which provides instructions for the 2014 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Be sure that your billing staff is aware of these updates.

## Background

## Update to Fees

In accordance with the Social Security Act (Section 1833(h)(2)(A)(i)), as amended by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Section 628), and further amended by the Affordable Care Act (Section 3401), the annual update to the local clinical laboratory fees for 2014 is (-0.75) percent. The annual update to local clinical laboratory fees for 2014 reflects an additional multi-factor productivity adjustment and a (-1.75) percentage point reduction as described by the Affordable Care Act. The annual update to payments made on a reasonable charge basis for all other laboratory services for 2014 is 1.80 percent (See 42 CFR 405.509(b)(1) at update to fees *http://www.ecfr.gov/cgi-bin/textidx?SID=40538fb2e20d60fb4d4de0ab33d0ca22&node=42:2.0.1.2.5&rgn=div5#42:2.0.1.2.5.5.25.10* on the Internet).

The Social Security Act Section 1833(a)(1)(D); (see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*) provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA).

For a cervical or vaginal smear test (pap smear), the Social Security Act (Section 1833(h)(7)) requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge. The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

## National minimum payment amounts

For a cervical or vaginal smear test (pap smear), the Social Security Act (Section 1833(h)(7)) requires payment to be the lesser of the local fee or the NLA,

but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The 2014 national minimum payment amount is $14.42 ($14.53 plus (-0.75) percent update for 2014). The affected codes for the national minimum payment amount are: *88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175*, G0123, G0143, G0144, G0145, G0147, G0148, and P3000.

## National limitation amounts (maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with the Social Security Act (Section 1833(h)(4)(B)(viii)).

The 2014 clinical laboratory fee schedule data file will be retrieved electronically through Centers for Medicare & Medicaid Services (CMS) mainframe telecommunications system. Carriers will retrieve the data file on or after November 19, 2013. Intermediaries will retrieve the data file on or after November 19, 2013. Internet access to the 2014 clinical laboratory fee schedule data file will be available after November 19, 2013, at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html* on the CMS website.

Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, will use the Internet to retrieve the 2014 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

## Data file format

For each test code, if your system retains only the pricing amount, load the data from the field named "60% Pricing Amt." For each test code, if your system

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**Lab** *(continued)*

has been developed to retain the local fee and the NLA, you may load the data from the fields named "60% Local Fee Amt" and "60% Natl Limit Amt" to determine payment. For test codes for cervical or vaginal smears (pap smears), you should load the data from the field named "60% Pricing Amt" which reflects the lower of the local fee or the NLA, but not less than the national minimum payment amount. Fiscal Intermediaries should use the field "62% Pricing Amt" for payment to qualified laboratories of sole community hospitals.

## Public comments

On July 10, 2013, CMS hosted a public meeting to solicit input on the payment relationship between 2013 codes and new 2014 *Current Procedural Terminology*® (*CPT*®) codes. Notice of the meeting was published in the *Federal Register* on May 24, 2013 (see *http://www.federalregister.gov/articles/2013/05/24/2013-12225/medicare-program-public-meeting-in-calendar-year-2013-for-new-clinical-laboratory-test-payment* ), and on the CMS website approximately June 1, 2013.

Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations on the website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*. Additional written comments from the public were accepted until October 30, 2013. CMS has posted a summary of the public comments and the rationale for the final payment determinations.

## Pricing information

The 2014 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes *36415*, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Social Security Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for 2014, CMS will issue a separate instruction on the clinical laboratory travel fees.

The 2014 clinical laboratory fee schedule also includes codes that have a "QW" modifier to both identify codes and determine payment for tests performed by a laboratory having only a certificate of waiver under the clinical laboratory improvement amendments (CLIA).

Similar to prior years, the 2014 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or

the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

## Mapping information

- Existing code *82777* is priced at the same rate as code *84244*.
- New code *80155* is priced at the same rate as code *80198*.
- New code *80159* is priced at the same rate as code *80154*.
- New code *80169* is priced at the same rate as code *80195*.
- New code *80171* is priced at the same rate as code *80157*.
- New code *80175* is priced at the same rate as code *80157*.
- New code *80177* is priced at the same rate as code *80157*.
- New code *80180* is priced at the same rate as code *80158*.
- New code *80183* is priced at the same rate as code *80157*.
- New code *80199* is priced at the same rate as code *82542*.
- New code *80203* is priced at the same rate as code *80157*.
- New code *81161* is to be gap filled.
- New code *81287* is to be gap filled.
- New code *87661* is priced at the same rate as code *87511*.

## Laboratory costs subject to reasonable charge payment in 2014

For outpatients, the following codes are paid under a

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**Lab** *(continued)*

reasonable charge basis (See the Social Security Act (Section 1842(b)(3)) at http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the Internet). In accordance with 42 CFR 405.502 through 42 CFR 405.508 (see http://www.ecfr.gov/cgi-bin/text-idx?SID=ab7bf0a61515aca26cefc0f2e7dae3b9&c=ecfr&tpl=/ecfrbrowse/Title42/42cfrv2_02.tpl), the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update.

The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1) (see http://www.ecfr.gov/cgi-bin/text-idx?SID=40538fb2e20d60fb4d4de0ab33d0ca22&node=42:2.0.1.2.5&rgn=div5#42:2.0.1.2.5.5.25.10 ). The inflation-indexed update for 2013 is 1.7 percent.

Manual instructions for determining the reasonable charge payment can be found in Publication 100-4, *Medicare Claims Processing Manual*, Chapter 23, Section 80 through 80.8 (see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf ). If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When services described by the healthcare common procedure coding system (HCPCS) in the following list are performed for independent dialysis facility patients, Publication 100-04, *Medicare Claims Processing Manual*, Chapter 8, Section 60.3 (see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf) instructs that the reasonable charge basis applies.

However, when these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

## Blood products

Blood products codes are: P9010, P9011, P9012, P9016, P9017, P9019, P9020, P9021, P9022, P9023, P9031, P9032, P9033, P9034, P9035, P9036, P9037, P9038, P9039, P9040, P9044, P9050, P9051, P9052, P9053, P9054, P9055, P9056, P9057, P9058, P9059, and P9060.

Also, payment for the following codes (including transfusion medicine, and reproductive medicine procedures, listed below) should be applied to the blood deductible as instructed in the *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 3, Section 20.5 through 20.5.4: P9010, P9016, P9021, P9022, P9038, P9039, P9040, P9051, P9054, P9056, P9057, and P9058.

**Note**: Biologic products not paid on a cost or prospective payment basis are paid based on the Social Security Act (Section 1842(o)). The payment limits based on the Social Security Act (Section 1842(o)), including the payment limits for codes P9041, P9043, P9045, P9046, P9047, and P9048, should be obtained from the Medicare Part B drug pricing files.

## Transfusion medicine

Transfusion medicine codes are: *86850, 86860, 86870, 86880, 86885, 86886, 86890, 86891, 86900, 86901, 86903, 86904, 86905, 86906, 86920, 86921, 86922, 86923, 86927, 86930, 86931, 86932, 86945, 86950, 86960, 86965, 86970, 86971, 86972, 86975, 86976, 86977, 86978*, and *86985*.

## Reproductive medicine procedures

Reproductive medicine procedures codes are: *89250, 89251, 89253, 89254, 89255, 89257, 89258, 89259, 89260, 89261, 89264, 89268, 89272, 89280, 89281, 89290, 89291, 89335, 89342, 89343, 89344, 89346, 89352, 89353, 89354*, and *89356*.

MACs will not search their files to either retract payment or retroactively pay claims processed prior to implementation of CR 8517; however, they will adjust such claims that you bring to their attention.

## Additional information

The official instruction, CR 8517 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2823CP.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 DMEPOS fee schedule update

### Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare administrative contractors (MACs) for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

### What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8531 to advise providers of the 2014 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. Make sure your staffs are aware of these updates.

### Background and key points of CR 8531

The DMEPOS fee schedules are updated on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

Payment on a fee schedule basis is required for DME, prosthetic devices, orthotics, prosthetics, and surgical dressings by Section 1834 (a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for parenteral and enteral nutrition (PEN) and splints, casts, and certain intraocular lenses.

#### Fee schedule files

The DMEPOS fee schedule file will also be available for providers and suppliers, as well as state Medicaid agencies, managed care organizations, and other interested parties at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/*.

#### Healthcare Common Procedure Coding System (HCPCS) codes added/deleted

The following new codes are effective January 1, 2014:

- A7047 in the inexpensive/routinely purchased (IN) payment category
- E0766 in the frequently serviced (FS) payment category
- E1352

The following new codes are in the prosthetics and orthotics (PO) payment category: L5969, L8679, L0455, L0457, L0467, L0469, L0641-L0643, L0648-L0651, L1812, L1833, L1848, L3678, L3809, L3916, L3918, L3924, L3930, L4361, L4387, and L4397.

The following codes are deleted as of January 1, 2014: A4611, A4612, A4613, E0457, E0459, L0430, L8685, L8686, L8687, and L8688.

For gap-filling purposes, the 2013 deflation factors by payment category are listed in the following table:

| Factor | Category |
|---|---|
| 0.469 | Oxygen |
| 0.472 | Capped rental |
| 0.473 | Prosthetics and orthotics |
| 0.600 | Surgical dressings |
| 0.653 | Parental and enteral nutrition |

#### Specific coding and pricing issues

As part of this update, fee schedules for the following codes will be added to the DMEPOS fee schedule file effective January 1, 2014:

- A4387 Ostomy Pouch, Closed, With Barrier Attached, With Built-In Convexity, (I Piece), Each
- L3031 Foot, Insert/Plate, Removable, Addition to Lower Extremity Orthotic, High Strength, Lightweight Material, All Hybrid Lamination/Prepreg Composite, Each

CMS is adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes,A5512 or A5513.

To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of 2004. For 2014, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the 2012. The fee schedule amounts for shoe modification codes A5503

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**DMEPOS** *(continued)*

through A5507 are being revised to reflect this change, effective January 1, 2014.

## Off-the-shelf orthotics

Section 1847(a)(2)(C) of the Act mandates implementation of competitive bidding programs throughout the United States for awarding contracts for furnishing off-the-shelf (OTS) orthotics which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual.

Regulations at 42 CFR 414.402 define the term "minimal self-adjustment" to mean an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist,an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc, or by the Board for Orthotist/Prosthetist Certificationor an individual who has specialized training.

As shown in the following table, 22 new codes are added to the HCPCS for OTS orthotics. In addition, as part of the review to determine which HCPCS codes for prefabricated orthotics describe OTS orthotics, it was determined that HCPCS codes for prefabricated orthotics describe items that are furnished OTS and items that require expertise in customizing the orthotic to fit the individual patient.

Therefore, it was necessary to explode these codes into two sets of codes. One set is the existing codes revised, effective January 1, 2014, to only describe devices customized to fit a specific patient by an individual with expertise and a second set of new codes describing the OTS items.

Also, as shown in the table that follows for 2014, the fee schedule amounts for existing codes will be applied to the corresponding new codes added for the items furnished OTS.

The cross walking of fee schedule amounts for a single code that is exploded into two codes for distinct complete items is in accordance with the instructions found in the *Medicare Claims Processing Manual*, Chapter 23, Section 60.3.1, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

**Prefabricated orthotic codes split into two codes, effective January 1, 2014**

| Fee from existing code | Crosswalk to new OTF and revised custom-fitted orthotic codes |
|---|---|
| L0454 | L0455 and L0454 |
| L0456 | L0457 and L0456 |
| L0466 | L0467 and L0466 |
| L0468 | L0469 and L0468 |
| L0626 | L0641 and L0626 |
| L0627 | L0642 and L0627 |
| L0630 | L0643 and L0630 |
| L0631 | L0648 and L0631 |
| L0633 | L0649 and L0633 |
| L0637 | L0650 and L0637 |
| L0639 | L0651 and L0639 |
| L1810 | L1812 and L1810 |
| L1832 | L1833 and L1832 |
| L1847 | L1848 and L1847 |
| L3807 | L3809 and L3807 |
| L3915 | L3916 and L3915 |
| L3917 | L3918 and L3917 |
| L3923 | L3924 and L3923 |
| L3929 | L3930 and L3929 |
| L4360 | L4361 and L4360 |
| L4386 | L4387 and L4386 |
| L4396 | L4397 and L4396 |

Further information on the development of new OTS orthotic codes can be found at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html*.

### Neurostimulator devices

HCPCS codes, L8685, L8686, L8687, and L8688 are not included on the 2014 DMEPOS fee schedule file. They were removed from the file to reflect the change in the coverage indicators for these codes to invalid for Medicare ("I") effective January 1, 2014. However, code L8679 (Implantable neurostimulator, pulse generator, any type) is added to the HCPCS and DMEPOS fee schedule file, effective January 1, 2014, for billing Medicare claims previously submitted under L8685, L8686, L8687, and L8688.

The fee schedule amounts for code L8679 are based on the established Medicare fee schedule amounts for all types of pulse generators under the previous HCPCS code E0756 (Implantable neurostimulator pulse generator), which was discontinued effective December 31, 2005. The payment amount is based on the explosion of code E0756 into four codes for different types of neurostimulator pulse generator systems which were not materially utilized in the Medicare program. As such, payment for code L8679 will revert back to the fee schedule amounts previously established for code E0756.

### Diabetic testing supplies

The fee schedule amounts for non-mail order diabetic

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**DMEPOS** *(continued)*

testing supplies, without KL modifier, for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for 2014. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the single payment amounts for mail order diabetic testing supplies (DTS) established in implementing the national mail order competitive bidding program (CBP) under Section 1847 of the Act.

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years as CBP contracts are re-competed. The national CBP for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016. The program instructions reviewing these changes are transmittal 2709, change request (CR) 8325, dated May 17, 2013, and transmittal 2661, CR 8204, dated February 22, 2013. You may review the following *MLN Matters®* articles for these CRs:

**MM8204**

*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf*

**MM8325**

*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf*

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing bid limits for future rounds of competitive bidding programs.

The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for multi-factor productivity (MFP), which results in update of 1.0 percent for 2014. The single payment amount public use file for the national mail order competitive bidding program is available *http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts*.

### 2014 fee schedule update factor

For 2014, the update factor of 1.0 percent is applied to the applicable 2013 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2014 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2013, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP).

The MFP adjustment is 0.8 percent and the CPI-U percentage increase is 1.8 percent. Thus, the 1.8 percentage increase in the CPI-U is reduced by the 0.8 percentage increase in the MFP resulting in a net increase of 1.0 percent for the update factor.

### 2014 update to the labor payment rates

The 2014 fees for HCPCS labor payment codes K0739, L4205, and L7520 are increased 1.8 percent effective for claims with dates of service from January 1, 2014, through December 31, 2014 and those rates are as follows:

| State | K0739 | L4205 | L7520 |
|---|---|---|---|
| AK | $27.40 | $31.22 | $36.73 |
| AL | $14.55 | $21.68 | $29.43 |
| AR | $14.55 | $21.68 | $29.43 |
| AZ | $17.99 | $21.66 | $36.21 |
| CA | $22.32 | $35.59 | $41.48 |
| CO | $14.55 | $21.68 | $29.43 |
| CT | $24.30 | $22.16 | $29.43 |
| DC | $14.55 | $21.66 | $29.43 |
| DE | $26.79 | $21.66 | $29.43 |
| FL | $14.55 | $21.68 | $29.43 |
| GA | $14.55 | $21.68 | $29.43 |
| HI | $17.99 | $31.22 | $36.73 |
| IA | $14.55 | $21.66 | $35.23 |
| ID | $14.55 | $21.66 | $29.43 |
| IL | $14.55 | $21.66 | $29.43 |
| IN | $14.55 | $21.66 | $29.43 |
| KS | $14.55 | $21.66 | $36.73 |
| KY | $14.55 | $27.76 | $37.64 |
| LA | $14.55 | $21.68 | $29.43 |
| MA | $24.30 | $21.66 | $29.43 |
| MD | $14.55 | $21.66 | $29.43 |
| ME | $24.30 | $21.66 | $29.43 |
| MI | $14.55 | $21.66 | $29.43 |
| MN | $14.55 | $21.66 | $29.43 |
| MO | $14.55 | $21.66 | $29.43 |
| MS | $14.55 | $21.68 | $29.43 |
| MT | $14.55 | $21.66 | $36.73 |
| NC | $14.55 | $21.68 | $29.43 |
| ND | $18.13 | $31.16 | $36.73 |
| NE | $14.55 | $21.66 | $41.04 |
| NH | $15.62 | $21.66 | $29.43 |
| NM | $14.55 | $21.68 | $29.43 |
| NV | $23.18 | $21.66 | $29.43 |
| NY | $26.79 | $21.68 | $29.43 |
| OH | $14.55 | $21.66 | $29.43 |
| OK | $14.55 | $21.68 | $29.43 |
| OR | $14.55 | $21.66 | $42.32 |

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**DMEPOS** *(continued)*

| State | K0739 | L4205 | L7520 |
|---|---|---|---|
| PA | $15.62 | $22.30 | $29.43 |
| PR | $14.55 | $21.66 | $29.43 |
| RI | $17.34 | $22.32 | $29.43 |
| SC | $14.55 | $21.68 | $29.43 |
| SD | $16.26 | $21.66 | $39.35 |
| TN | $14.55 | $21.68 | $29.43 |
| TX | $14.55 | $21.68 | $29.43 |
| UT | $14.59 | $21.66 | $45.83 |
| VA | $14.55 | $21.66 | $29.43 |
| VI | $14.55 | $21.68 | $29.43 |
| VT | $15.62 | $21.66 | $29.43 |
| WA | $23.18 | $31.77 | $37.74 |
| WI | $14.55 | $21.66 | $29.43 |
| WV | $14.55 | $21.66 | $29.43 |
| WY | $20.28 | $28.89 | $41.04 |

### 2014 national monthly payment amounts for stationary oxygen equipment

CR 8531 implements the 2014 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service on or after January 1, 2014. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for oxygen generating portable equipment (OGPE). The updated 2014 monthly payment amount of $178.24 includes the 1.0 percent update factor for the 2014 DMEPOS fee schedule.

Please note that when updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

### 2014 maintenance and servicing payment amount for certain oxygen equipment

CR 8531 also updates the 2014 payment amount for maintenance and servicing for certain oxygen equipment. You can read more about payment for claims for maintenance and servicing for oxygen equipment in *MLN Matters*® articles,MM6792 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf* and MM6990 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf*.

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every six

months beginning six months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the MS modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any six-month period.

Per 42 CFR 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2013 maintenance and servicing fee is adjusted by the 1 percent MFP-adjusted covered item update factor to yield a 2014 maintenance and servicing fee of $68.73 for oxygen concentrators and transfilling equipment.

## Additional information

The official instruction, CR 8531, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2836CP.pdf*.

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: MM8531
Related Change Request (CR) #: CR 8531
Related CR Release Date: December 13, 2013
Effective Date: January 1, 2014
Related CR Transmittal #: R2836CP
Implementation January 6, 2014

*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.*

## Educational Events

# Provider outreach and educational events – January - February 2014

### Medicare “Ask-the-Contractor” teleconference (ACT): 935 recoupment process

**When:** Tuesday, January 28
**Time:** 10 a.m. -11:30 a.m. ET – Delivery language: English
**Type of Event:** Webcast

### EDI presents an overview of PC-ACE Pro32TM, Medicare’s free billing software

**When:** Monday, February 17
**Time:** 11:30 a.m. -1:30 p.m. ET – Delivery language: English
**Type of Event:** Face-to-face
**Location**: The Florida Hotel & Conference Center, 1500 San Lake Road, Orlando, FL 32809

### 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*.

## 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: November 27, 2013, – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-11-27-eNews-PDF.pdf*
- CMS MLN Connects™ Provider eNews: December 5, 2013 – *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-12-05-Enews.pdf*
- CMS MLN Connects™ Provider eNews: December 12, 2013– *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-12-12-Enews.pdf*
- CMS MLN Connects™ Provider eNews: December 19, 2013– *https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-12-19-Enews.pdf*

**Source**: CMS PERL 201311-08, 201312-01, 201312-03, 201312-04

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## Medicare Speaks 2014 Orlando

**February 18-19, 2014**
The Florida Hotel & Conference Center
1500 Sand Lake Road, Orlando, FL 32809

Learn what's trending now in Medicare. Join First Coast Service Options (First Coast) for our new educational event, Medicare Speaks 2014, in Orlando, FL on February 18-19. The event features 20 classes focused on reducing documentation and claim errors, minimizing payment delays and promoting Centers for Medicare & Medicaid Services (CMS) initiatives such as the physician quality reporting system (PQRS) program. First Coast is also offering a bonus seminar on February 17 on PC-ACE Pro32™, Medicare's free billing software.

Participants will benefit from data-driven content based on the latest Medicare changes that you need to know to bill Medicare the right way, the first time. Best of all, providers can interact with their peers as well as Medicare experts from First Coast.

### Highlights

- 20 Part A and B classes chosen by your peers – *view agenda*
- Participation from First Coast's medical director and leaders from Medical Review, Provider Enrollment, Customer Service and Provider Outreach and Education departments
- Bonus seminar on February 17 regarding PC-ACE Pro32™
- Participants can select 4 classes per day, or tailor the schedule to meet your needs
- Medicare experts available to answer your questions at "Ask the Contractor" tables
- Continuing education credits offered

For additional information regarding the event, including logistics and registration, view our Medicare Speaks 2013 Orlando brochure.

*Register now*

Note: If you do not have a training account, please *click here* to learn how to create one.

## 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*

## Contact CMS

The Region 4 office of the Centers for Medicare & Medicaid Services is located in Atlanta. The feedback email address is: *ROATLFM@CMS.HHS.GOV*

## 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*