Medicare A CONNECTION

medicare.fcso.com

FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

August 2014

In this issue

CMS issues hospital inpatient payment regulation

Final rule strengthens tie between payment and quality improvement

The final rule issued August 4, 2014, by the Centers for Medicare & Medicaid Services (CMS) adopts improvements in the quality of care that limit payment for hospital acquired conditions (HACs) and readmissions. The rule, which updates Medicare payment policies and rates for inpatient stays at general acute care and long-term care hospitals (LTCHs) for fiscal year (FY) 2015, builds on the administration's efforts for better hospital patient outcomes and slowing the long-term health care cost growth.

The rule also supports price transparency by reminding hospitals of the Affordable Care Act requirement to post or otherwise make their charges available to patients and the public.

"Today's policies further support our efforts to continue improving the care our Medicare beneficiaries receive while also cutting the growth of Medicare costs," said CMS Administrator Marilyn Tavenner. "This final rule builds on our recent efforts to improve hospital performance while giving hospitals the clarity and resources they need to deliver the best possible patient care."

CMS announced that the payment rate update to general acute care hospitals will be 1.4 percent in FY 2015. The rate update for long term care hospitals will be 0.9 percent. The difference in the update is accounted for by different statutory and regulatory provisions that apply to each system.

The final rule also summarizes ideas received from stakeholders on an alternative payment methodology for short stay inpatient cases that also may be treated on an outpatient basis.

Improving patient care

Hospital Value-based Purchasing (VBP) Program: The hospital VBP, which was established by the Affordable Care Act, adjusts payments to hospitals under the inpatient prospective payment system (IPPS) based on the quality of care they furnish to patients. For FY 2015, as directed by the law, CMS is increasing the applicable percent reduction, the portion of Medicare payments available

See **REGULATION**, Page 3

Contents

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

Publication staff:
Terri Drury
Kathleen Cruz Fuentes
Sofia Lennie
Martin Smith
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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

General Information

REGULATION

From front page

to fund the value-based incentive payments under the program, to 1.5 percent of the base operating diagnosis-related group (DRG) payment amounts to all participating hospitals. CMS estimates that the total amount available for value-based incentive payments in FY 2015 will be approximately $1.4 billion.

Hospital readmissions reduction program: The maximum reduction in payments under the Hospital Readmissions Reduction Program will increase from two to three percent as required by law.

For FY 2015, CMS will assess hospitals' readmissions penalties using five readmissions measures endorsed by the National Quality Forum. CMS estimates that hospital readmissions in Medicare declined by a total of 150,000 from January 2012 through December 2013.

Hospital-acquired condition reduction program: CMS is implementing the Affordable Care Act's Hospital Acquired Condition Reduction Program. Beginning FY 2015, hospitals scoring in the top quartile for the rate of hospital acquired conditions (HACs) (i.e. those with the poorest performance) will have their Medicare inpatient payments reduced by one percent.

This new program builds on the progress in this area achieved through the existing HAC program, which is currently saving approximately $30 million annually by not providing additional Medicare payment for treatment of certain conditions that are reasonably preventable when those conditions are acquired after the beneficiary has been admitted to the hospital for a different condition.

Quality reporting programs: The rule's changes to Medicare quality incentive programs will continue to encourage high quality care while decreasing the time and effort it takes for providers to report the information. It will also align certain reporting requirements in both the electronic health record (EHR) incentive program and the hospital inpatient quality reporting (IQR) program.

The final rule revises measures for the hospital inpatient quality reporting, LTCH quality reporting and PPS-exempt cancer hospital quality reporting programs.

Wage index – updated labor market areas

The law requires that Medicare adjust its inpatient hospital payment for area differences in the cost of labor -- an adjustment known as the wage index. CMS is revising the labor market areas used for the wage index based on the most recent Office of Management and Budget (OMB) core-based statistical area delineations that are based on 2010 census data.

In order to mitigate potential negative payment impacts due to the adoption of the new OMB delineations, CMS is adopting a one-year transition during FY 2015 that would be based on a 50/50 blend of the former wage index and the new wage index. The new wage index will take effect in full in FY 2016. This will be for all hospitals that would experience a decrease in their wage index exclusively due to the implementation of the new OMB delineations, and a three-year transition for the relatively few hospitals currently located in an urban county that would become rural under the new OMB delineations.

For more information:

- *Final rule*
- *Fact sheet* - FY 2015 policy and payment changes for inpatient stays in acute-care hospitals and long-term care hospitals
- *Fact sheet* - CMS to improve quality of care during hospital inpatient stays

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/160958.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.

Extension of provider enrollment moratoria for home health agencies and Part B ambulance suppliers

Provider types affected

This *MLN Matters*® article is intended for home health agencies, home health agency sub-units, and Part B ambulance suppliers in parts of Florida, Illinois, Michigan, Texas and New Jersey that provide services to Medicare, Medicaid and CHIP beneficiaries.

Provider action needed

Stop – impact to you

Effective July 30, 2014, the temporary moratoria on new home health agencies, home health agency sub-units, and Part B ambulance suppliers are being extended for an additional 6 months in certain geographic locations.

Caution – what you need to know

During the six-month temporary moratorium, initial provider enrollment applications and change of information applications to add additional practice locations, received from home health agencies, home health agency sub-units and Part B ambulance suppliers in the listed counties will be denied. Application fees that are paid for applications that are denied due to this temporary moratorium will be refunded.

Go – what you need to do

Effective July 30, 2014, home health agencies, home health agency sub-units, and Part B ambulance suppliers should not submit initial enrollment applications or change of information applications to add additional practice locations until the six-month moratoria has expired. CMS will announce in the *Federal Register* when the moratorium has been lifted or if it will be extended.

Background

In accordance with *42 CFR §424.570(c)*, the Centers for Medicare & Medicaid Services (CMS) may impose a moratorium on the enrollment of new Medicare providers and suppliers of a specific type or the establishment of new practice locations in a particular geographic area.

On July 29, 2014, CMS announced, in a *Federal Register* notice (*https://www.federalregister.gov/articles/2014/08/01/2014-18174/extended-temporary-moratoria-onenrollment-of-ambulance-suppliers-and-home-health-agencies-in*), the extension of temporary moratoria on the enrollment of new home health agencies, home health agency sub-units and Part B ambulance suppliers in designated geographic locations.

The moratoria initially became effective on July 30, 2013, and its implementation was announced in the *Federal Register*, which may be accessed at: *https://www.federalregister.gov/articles/2014/02/04/2014-02166/medicare-medicaidand-childrens-health-insurance-programs-announcement-of-new-and-extendedtemporary#page-6475*

Moratoria extension

Effective July 30, 2014, the temporary moratoria on new home health agencies and home health agency sub-units is being extended for an additional six months in the areas stated in Table 1, below.

Table 1: Home health agencies and home health agency sub-units under temporary moratorium

City	Counties
Fort Lauderdale	Broward
Miami	Miami-Dade Monroe
Detroit	Macomb Monroe Oakland Washtenaw Wayne
Dallas	Collin Dallas Denton Ellis Kaufman Rockwall Tarrant
Houston	Brazoria Chambers Fort Bend Galveston Harris Liberty Montgomery Waller
Chicago	Cook DuPage Kane Lake McHenry Will

In addition, the temporary moratorium on new Part B ambulance suppliers is being extended for an additional six months in the areas stated in Table 2, below.

Table 2: Part B ambulance suppliers under six-month temporary moratoria

City	Counties
Houston	Harris Brazoria Chambers Fort Bend Galveston Liberty Montgomery Waller
Philadelphia	Bucks (PA) Delaware (PA) Montgomery (PA) Philadelphia (PA) Burlington (NJ) Camden (NJ) Gloucester (NJ)

Initial provider enrollment applications and change of information applications to add additional practice locations received from home health agencies, home health agency sub-units and Part B ambulance suppliers in the above listed counties will be denied in accordance with *42 CFR §424.570(c)*. Application fees that are paid for applications that are denied due to this temporary moratorium will be refunded.

See **MORATORIA**, next page

Adjustment of some hospital claims for therapy services

Issue

Certain hospital claims for therapy services processed between April 7 and July 28, 2014, may have been paid in error because Medicare claims processing systems did not apply the services to the therapy cap appropriately.

Resolution

The claims affected had one or more lines with revenue code 042x, 043x, or 044x with modifier GN, GO, or GP. The system problem was corrected July 28. Affected claims will be adjusted.

Status/date resolved

Open. Claims will be adjusted beginning July 28, 2014. All adjustments will be complete by October 31, 2014.

Provider action

None

Current processing issues

Here is a link to a table of *current processing issues* for both Part A and Part B.

Correction to SNF consolidated billing code lists

Issue

Certain Healthcare Common Procedure Coding System (HCPCS) codes were not included in the 2014 annual update to the skilled nursing facility (SNF) consolidated billing code editing lists.

Resolution

A correction to the coding lists will be implemented in October, 2014. The affected HCPCS codes for practitioner billing are Q2050 and the professional component of G0461 and G0462. The affected code for institutional provider billing is Q2050.

Status/date resolved

Open. October 31, 2014.

Provider action

If you have claims that have been erroneously denied, you should contact your Medicare administrative contractor to have the claims re-opened and re-processed.

Current processing issues

Here is a link to a table of *current processing issues* for both Part A and Part B.

MORATORIA

From previous page

Note: Home health agencies, home health agency sub-units and Part B ambulance suppliers are afforded appeal rights. However, the scope of review will be limited to whether the temporary moratorium applies to the provider or supplier appealing the denial. CMS' basis for imposing a temporary moratorium is not subject to review.

Additional information

For more information regarding CMS' use of temporary moratoriums, please review *MLN Matters*® article MM7350 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf*

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

MLN Matters® Number: SE1425
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

General Coverage

Medicare demonstration allows for prior authorization for certain power mobility devices

Note: *This article was revised August 7, 2014, to add information regarding the addition of 12 states (Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington) to the demonstration. This article was previously published in the September 2012 edition of Medicare A Connection, Page 5-7.*

Provider types affected

This *MLN Matters*® special edition article is intended for Medicare fee-for-service (FFS) suppliers who submit claims to the durable medical equipment Medicare administrative contractors (DME MACs) for power mobility devices (PMDs) in the demonstration states (Arizona, California, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Washington).

Physicians and other practitioners who prescribe these devices for Medicare beneficiaries who reside in the demonstration states may also benefit from this article.

What you need to know

PMDs includes power wheelchairs and power-operated vehicles (POVs) that a beneficiary uses in their home *(42 CFR 410.38(c)*). Power wheelchairs are four-wheeled motorized vehicles that are steered by operating an electronic device or joystick to control direction and turning. POVs are three- or four-wheeled motorized scooters that are operated by a tiller. PMDs are classified as items of durable medical equipment (DME) for Medicare coverage purposes.

Power operated vehicles (POVs or scooters): Under the mobility assistive equipment (MAE) national coverage determination (NCD), POVs may be medically necessary for beneficiaries who cannot effectively perform mobility-related activities of daily living (MRADLs) in the home using a cane, walker, or manually operated wheelchair.

In addition, the beneficiary must demonstrate sufficient strength and postural stability to safely and effectively operate the POV in the home environment. These vehicles are appropriately used in the home environment to improve the ability of chronically-disabled persons to cope with normal domestic, vocational, and social activities.

Power (motorized) wheelchairs: Under the MAE NCD, power wheelchairs may be medically necessary for beneficiaries who cannot effectively perform MRADLs in the home using a cane, walker, manually operated wheelchair, or a POV/scooter. In addition, the beneficiary must demonstrate the ability to safely and effectively operate the power wheelchair. Most beneficiaries who require power wheelchairs are non-ambulatory and have severe weakness of the upper extremities due to a neurological or muscular condition.

This article provides guidance on upcoming changes to billing requirements for PMDs. Please make sure your medical and billing staff is aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to reducing waste, fraud, and abuse in the Medicare fee-for-service program.

CMS is conducting a three-year demonstration to ensure that Medicare only pays for PMDs that are medically necessary under existing coverage guidelines for orders written on or after September 1, 2012. The demonstration was initially implemented in seven States with high rates of Medicare fraud: California, Texas, Florida, Michigan, Illinois, North Carolina, and New York.

Due to the demonstration's early success, the demonstration will be expanded to 12 additional states: Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington.

These 19 states accounted for 71 percent of the total Medicare PMD expenditures in 2011. The expanded demonstration will be effective for orders written on or after October 1, 2014. This demonstration targets a claim type known to be susceptible to fraud and that has had high rates of improper payments.

The demonstration implements a prior authorization request process for PMDs for Medicare beneficiaries residing in the demonstration states. The prior authorization request can be completed by the ordering physician/ practitioner or the DME supplier.

The physician/practitioner or supplier who submits the request is referred to as the "submitter." The DME MAC will review the prior authorization request.

The following HCPCS codes are subject to prior authorization process in the demonstration states:

- Group 1 power operated vehicles (K0800-K0802 and K0812);

See **MOBILITY**, next page

MOBILITY

From previous page

- All standard power wheelchairs (K0813 through K0829);
- All Group 2 complex rehabilitative power wheelchairs (K0835 through K0843);
- All Group 3 complex rehabilitative power wheelchairs without power options (K0848 through K0855);
- Pediatric power wheelchairs (K0890-K0891); and
- Miscellaneous power wheelchairs (K0898).

Note: Group three complex rehabilitative power wheelchairs with power options (K0856 through 0864) are excluded.

The prior authorization process allows submitters to send a prior authorization request for a PMD before the supplier delivers the device to the beneficiary's home. All relevant documentation to support Medicare coverage of the PMD should be submitted to the appropriate DME MAC for an initial decision.

The request package should include the face-to-face encounter documentation, the seven element order, the detailed product description, and whatever additional documentation is necessary to show that coverage requirements have been met.

Physicians/ practitioners can bill G9156 after he/she submits an initial prior authorization request to partially compensate physicians for the additional time spent in submitting the prior authorization request.

Please note, that the prior authorization demonstration does not create new documentation requirements for physician/practitioners or suppliers. It simply allows them to provide the information earlier in the claims process.

After receiving the prior authorization request, the DME MAC will conduct a medical review and communicate the coverage decision to the beneficiary, physician/practitioner and supplier within 10 business days of receiving the request. Under rare, emergency circumstances, Medicare will complete this process within two business days.

Claims with affirmative prior authorization requests will be paid so long as all other Medicare coverage and documentation requirements are met. Claims with a non-affirmative prior authorization decision will not be paid by Medicare.

If a second prior authorization request is resubmitted after a non-affirmative decision on an initial prior authorization request, the DME MAC will conduct a medical review within 20 business days and communicate a coverage decision to the beneficiary, physician/ practitioner, and supplier. Tricare programs and private insurance use similar time frames for prior authorization of non-emergent services.

Suppliers may choose to submit claims without a prior authorization decision. However, the claim will be subject to prepayment review. CMS currently assesses a payment reduction for orders written on or after December 1, 2012, in the initial demonstration states.

CMS will begin to assess a payment reduction for noncompliance with the prior authorization process for any orders written on or after January 1, 2015, in the 12 additional states. If the claim satisfies Medicare's coverage and documentation requirements, it will be paid with a 25 percent reduction in Medicare reimbursement.

The 25 percent reduction will not be applied if the claim is submitted by a contract supplier under the Medicare DMEPOS competitive bidding program and the claim is for a PMD provided to a Medicare beneficiary residing in a competitive bidding area.

Extensive education and outreach to physicians, treating practitioners, suppliers, and Medicare beneficiaries on the requirements of the prior authorization process has been initiated by CMS and will continue after the implementation of the demonstration. Additional information and updates on the demonstration will be posted at *http://go.cms.gov/PADemo*.

Utilizing the prior authorization request process will help CMS improve methods for identifying and prosecuting fraud and prevent improper payments. This will help ensure that Medicare only pays for PMD claims that are medically necessary under existing coverage guidelines. It will also provide valuable data for tackling the continued challenges the Medicare program faces.

Key points

CMS initially conducted this three year demonstration in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas based on the beneficiary's address as reported to the Social Security Administration and recorded in Medicare's common working file (CWF). This demonstration will expand to Arizona, Maryland, Georgia,

See **MOBILITY**, next page

MOBILITY

From previous page

Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington for orders written on or after October 1, 2014. This demonstration involves all four DME MACs.

Competitive bidding would not affect participation in this demonstration. However, if a contract supplier submits a payable claim for a beneficiary with a permanent residence, according to the CWF, in a competitive bidding area, that supplier would receive the single payment amount under the competitive bid contract. In other words, the single payment amount rules for contract suppliers outlined in *42 CFR 414.408* are not affected by this demonstration.

This demonstration will help ensure that no Medicare payments are made for PMDs unless a beneficiary's medical condition warrants the equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's right to receive quality products from accredited suppliers. It will also help protect beneficiaries from unexpected financial liability.

Additional information

The Prior Authorization of Power Mobility Device Section of the CMS web page is at *http://go.cms.gov/PADemo*.

MLN Matters® special edition article SE1112, "Power Mobility Device Face-to-Face Examination Checklist," is available *at http://www.cms.gov/Outreach-and-Education/Medicare-Learning- Network-MLN/MLNMattersArticles/downloads/SE1112.pdf*.

The *Medicare Learning Network*® (*MLN*®) fact sheet, "Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements," is available at *http://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf*.

Please visit *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html* for the latest *MLN*® educational products designed to help Medicare FFS providers understand – and avoid – common billing errors and other improper activities.

You may want to review *MLN Matters*® article MM8056, which is available at *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8056.pdf*.

The article clarifies that only one G9156 code (for preauthorization incentive payment) may be billed, per beneficiary, per PMD even if the physician or treating practitioner must resubmit the prior authorization request.

MLN Matters® Number: SE1231 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Intravenous immune globulin demonstration program

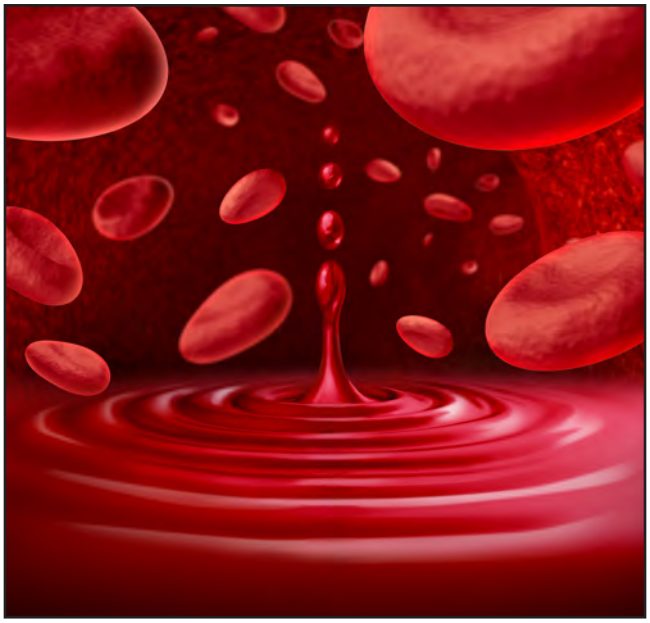
Provider types affected

This *MLN Matters*® article is intended for suppliers submitting claims to durable medical equipment Medicare administrative contractors (DME MACs) for intravenous immune globulin (IVIG) drugs and services to Medicare beneficiaries who are participants in the IVIG demonstration.

Suppliers do not need to apply to participate in the demonstration as long as they meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of demonstration covered services.

Provider action needed

In this article, the Centers for Medicare & Medicaid Services (CMS) alerts providers to a three year demonstration to evaluate the benefits of providing payment for items and services needed for the in-home administration of IVIG for the treatment of primary immune deficiency disease (PIDD). CMS has designed the IVIG demonstration to pay a bundled payment for items and services needed for the in-home administration of intravenous immune globulin for the treatment of PIDD. The demonstration will begin paying for services as of 10/01/2014, and will continue for three years, as long as funding remains available.



Background

Depending on the circumstances, traditional fee-for-service (FFS) Medicare covers some, or all, components of home infusion services. By special statutory provision, Medicare Part B covers IVIG for persons with PIDD who wish to receive the drug at home. Medicare does not separately pay for any services or supplies to administer the drug if the person is not homebound and is otherwise receiving services under a Medicare home health episode of care. As a result, many beneficiaries have chosen to receive the drug at their doctor's office, in an outpatient hospital setting, or to self-administer the drug subcutaneously. Beneficiaries may also alternate between settings or drug formulations, if necessary, to accommodate travel or other personal situations.

IVIG demonstration

The "Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012" authorized the demonstration under Part B of Title XVIII of the Social Security Act. The demonstration is limited to no more than 4,000 beneficiaries, and the $45 million budget covers benefit costs, as well as administrative expenses for implementation and evaluation. Participation is voluntary and may be terminated by the beneficiary at any time.

Under this demonstration, Medicare will issue under Part B a bundled payment for all items and services that are necessary to administer IVIG in the home to enrolled beneficiaries who are not otherwise homebound and receiving home health care benefits.

In processing all services and supplies needed for the administration of IVIG, CMS is not making any changes to existing coverage determinations to receive the IVIG drug in the home or for services and supplies that are otherwise not covered under the traditional FFS Medicare Part B benefit.

The demonstration only applies to situations where the beneficiary requires IVIG for the treatment of PIDD, or is currently receiving subcutaneous immune globulin to treat PIDD and wishes to switch to IVIG. This demonstration does not apply if the immune globulin is intended to be administered subcutaneously. Only those beneficiaries with PIDD who are eligible to receive IVIG under the current Medicare benefit (have Part B, and have traditional FFS Medicare) will be eligible to enroll in the demonstration and have the services paid under the new demonstration.

This demonstration will not change how subcutaneous administration of immune globulin (SCIG) is covered and paid for under the traditional Medicare FFS program. In addition, nothing in this demonstration will impact how IVIG is paid by Medicare for beneficiaries who are covered under a home health episode of care.

Beneficiaries participating in the demonstration shall not be restricted in any way from receiving Medicare covered IVIG, and non-demonstration Medicare covered related services from different providers at different times, should they so choose. For example, a beneficiary receiving services under the demonstration at home may choose to switch and receive them at a doctor's office or outpatient department at any time. The beneficiary may switch back to receiving services under the demonstration as long as they are otherwise still eligible, and funding remains available.

See **IMMUNE**, next page

IMMUNE

From previous page

Beneficiaries under hospice shall not be excluded from this demonstration, and their demonstration claims shall be processed in the same manner as other Medicare (non-demonstration) claims for hospice patients.

Beneficiaries covered under a home health episode of care may apply to participate in the demonstration but will not be eligible to have services paid for under the demonstration until after the home health episode of care has ended. Similarly, beneficiaries who are participating in the demonstration and subsequently become eligible to receive services under a home health episode of care will not be eligible to have services paid for under the demonstration for the period of time they are covered under such episodes.

Providers/suppliers billing for the services and supplies covered under the demonstration must meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of services related to home infusion of IVIG.

Beneficiary eligibility

In order to pay for the new demonstration covered services, the following requirements must be met:

1. The beneficiary must be enrolled in the demonstration (on the eligibility file provided by NHIC, Corp., the implementation support contractor);
2. The beneficiary must be eligible to have the IVIG drug paid for at home (have a diagnosis of PIDD) under the traditional FFS Medicare benefit;
3. The beneficiary must be enrolled in Medicare Part B and not be enrolled in a Medicare Advantage plan (i.e. have traditional FFS Medicare coverage);
4. The beneficiary must not be covered on the date of service in a home health episode (In such circumstances, the services are covered under the home health episode payment.);
5. The place of service must be the beneficiary's home or a setting that is "home like."

Billing details

A new "Q" code has been established for services, supplies, and accessories used in the home under the Medicare Intravenous Immune Globulin (IVIG) Demonstration:

- Q2052 – (Long description) - Services, supplies, and accessories used in the home under Medicare Intravenous immune globulin (IVIG) demonstration.
- Q2052- (Short description) - IVIG demo, services/ supplies.

The code is for use with the IVIG demo only and the jurisdiction for this code is DME MAC.

The new demonstration service code (Q2052) must be billed as a separate claim line on the same claim and for the same date of service as the IVIG drug itself.

Specialty pharmacies will bill for the IVIG drug itself when intended for home administration by beneficiaries who are not homebound and not covered under a home health benefit episode. For those beneficiaries participating in the demonstration, specialty pharmacies shall bill for the demonstration covered services on the same claim as the drug itself. Claims for the demonstration bundled service (Q2052) billed in the absence of the "J" code for the IVIG drug will not be payable. The new demonstration covered services will be paid as a bundle and will be subject to coinsurance and deductible in the same manner as other Part B services.

For 2014, the nationwide Medicare allowable for Q2052 will be $300 each time the IVIG is administered. While this is expected to be approximately monthly, it can be more or less frequent depending upon a patient's medical need.

As with all DMEPOS claims, specialty pharmacies will bill these claims to the appropriate DME MAC jurisdiction based on the beneficiary's state.

The following "J" codes represent immune globulin drugs that are administered intravenously and payable in 2014 under Medicare Part B for services rendered in the home (or home-like setting) for beneficiaries with PIDD: Privigen, (J1459), Bivigam (J1556), Gammaplex (J1557), Gamunex (J1561), Immune Globulin Not Otherwise Specified (J1566 and J1599), Octagam (J1568), Gammagard liquid (J1569), and Flebogamma (J1572). Immune globulin drugs covered under Medicare Part B for administration in the home for patients with PIDD are subject to change; coverage of any drugs under the demonstration shall not differ from drugs that are eligible for payment under Part B for beneficiaries not enrolled in the demonstration.

If the claim for IVIG is not otherwise payable under Medicare Part B, the Q2052 claim line is not payable under the demonstration. The claim for Q2052 must have the same date of service and place of service code on the claim line as the IVIG (J code) for which it is applicable. If

See **IMMUNE**, next page

IMMUNE

From previous page

multiple administrations of IVIG are submitted on a single claim, each date of service must be on a separate claim line.

If these requirements are not met, the claim will not be processed and Medicare will return a group code of CO (Contractual Obligation), a remittance advice remarks code (RARC) of M51 (Missing/incomplete/invalid procedure code(s)) and a claim adjustment remarks code (CARC) of B15 (This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/ adjudicated).

If a claim is submitted with the HCPCS Q2052 code and the beneficiary is not enrolled in the demonstration on the date of service, the claim will be denied with a RARC of M138 (Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.), a CARC of 96 (Non-covered charge(s)), and a group code of CO.

Coverage of demonstration services shall be subject to the usual coordination of benefit process and the usual Medicare secondary payer process as well.

How Beneficiaries can apply for the IVIG Demonstration

To participate in this demonstration the beneficiary must complete and submit an application form. All applications must be signed by the beneficiary as well as his or her physician. **Submission of an application does not guarantee that a beneficiary will be accepted to participate in the demonstration.**

CMS has contracted with NHIC, Corp., DME MAC Jurisdiction A, to help administer the demonstration. NHIC will review all applications for eligibility and will create and upload an enrollment file to be used by CMS' claims processing systems. .

CMS will conduct an initial enrollment period from 8/08/2014 – 9/12/2014. Completed applications must be received by NHIC, Corp. no later than 5:00 p.m. ET on 9/12/2014 to be considered.

The enrollment application and the application completion guide are available at Incomplete applications will be returned to the beneficiary and will not be reviewed. Beneficiaries will be notified by 9/30/2014 whether or not they have been accepted.

Since the number of beneficiaries and funds available to implement this demonstration are limited, not all beneficiaries who are eligible may be accepted if more eligible beneficiaries apply than can be served with the funds available.

If the number of eligible beneficiaries that apply during the initial enrollment period is below the statutory limits, then additional applications will continue to be accepted after

the 9/12/2014 deadline on a rolling basis until enrollment and/or funding limits are reached.

http://www.medicarenhic.com or through the IVIG Demo Hot Line at: (844)-625-6284. Completed applications may be submitted by fax or mail to NHIC, Corp. at the following address:

NHIC, Corp.
IVIG Demo
P.O. Box 9140
Hingham, MA. 02043-9140

For overnight mailings:

NHIC, Corp
IVIG Demo
75 William Terry Dr.
Hingham, MA. 02043

Applications may be faxed to: Fax 781-741-3533

Additional Information

If you have any questions, please contact your DME MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - *How Does It Work*.

MLN Matters® Number: SE1424
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation: N/A

Diagnosis code reporting on religious nonmedical health care institution claims

Note: *This article was revised on August 1, 2014, to show the new ICD-10 implementation date of October 1, 2015. While the change request (CR) may not reflect the new date, CMS has made the date change. All other information is unchanged. This article was previously published in the September 2013 edition of Medicare A Connection, Page 15.*

Provider types affected

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

Provider action needed

This article is based on CR 8350 which informs Medicare contractors about enforcement in Medicare systems of longstanding diagnosis coding instructions on religious nonmedical health care institution (RNHCI) claims.

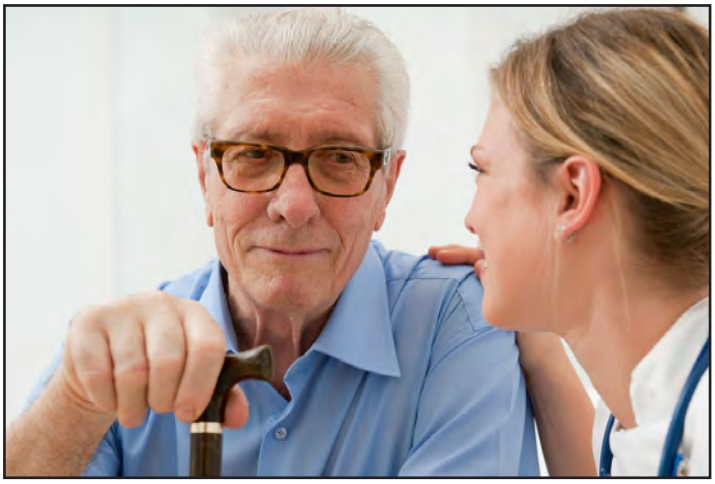
It also clarifies diagnosis code reporting on RNHCI claims for the ICD-10 transition. Make sure that your billing staffs are aware of these changes.

Background

While coding of diagnoses is not consistent with the nonmedical nature of religious nonmedical heath care institution (RNHCI) services, the presence of diagnosis codes is a requirement for standard claims transactions.

Longstanding instructions in the *Medicare Claims Processing Manual*, Chapter 3, Section 170, direct RNHCIs to use the following pair of ICD-9 diagnosis codes to satisfy the claim requirement:

- Principal diagnosis: 799.9 “other unknown and unspecified cause”
- Other diagnosis: V62.6 “refusal of treatment for reasons of religion or conscience” RNHCI claims received on or after January 1, 2014 (with any claim “through” date prior to October 1, 2015), will be returned to the provider if they do not contain the above ICD-9 principal diagnosis and first other diagnosis codes.
- The implementation of ICD-10 effective October 2015 will require RNHCI to instead report the following pair of ICD-10 diagnosis codes to satisfy the claim requirement:
- Principal diagnosis: R69 “illness, unspecified”
- Other diagnosis: Z53.1 “procedure and treatment not carried out because of patient’s decision for reasons of belief” RNHCI claims received with a claim “through” date on or after October 1, 2015, will be returned to the provider if they do not contain the above ICD-10 principal diagnosis and first other diagnosis codes or if they contain any ICD-9 code.



Additional Information

The official instruction, CR 8350 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2765CP.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

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

Correct billing of Aprepitant (J8501)

According to the Centers for Medicare & Medicaid Services' (CMS) national coverage determination (NCD) 110.18 (Aprepitant for chemotherapy-induced emesis), Medicare covers the use of the oral three-drug regimen of Aprepitant (Emend®), a 5-HT3 antagonist, and dexamethasone for patients receiving certain highly emetogenic chemotherapy agents in the treatment of reducing chemotherapy-induced emesis.

On May 29, 2013, CMS revised the NCD to extend coverage for highly and moderately emetogenic chemotherapy.

Per the CMS, Internet-only manual (IOM), Medicare *National Coverage Determination (NCD)Manual* (Publication 100-03, Chapter 1, 110.18),

CMS defines highly emetogenic chemotherapy and moderately emetogenic chemotherapy as those anticancer agents so designated in at least two of three guidelines published by the National Comprehensive Cancer Network (NCNN), American Society of Clinical Oncology (ASCO), and European Society of Medical Oncology (ESMO)/ Multinational Association of Supportive Care in Cancer (MASCC).

The defined patient population for which the use of oral anti-emetic three drug combination was determined to be reasonable and necessary is for patients who received one or more of the following anti-cancer chemotherapeutic agents:

- Carmustine (J9050)
- Cisplatin (J9060)
- Cyclophosphamide (J8530, J9070)
- Dacarbazine (J9130)
- Mechlorethamine (J9230)
- Streptozocin (J9320)
- Doxorubicin (J9000, Q2049)
- Epirubicin (J9178)
- Lomustine (J8999)
- The following drugs are effective for dates of service on or after May 29, 2013:
- Alemtuzumab (J9010)
- Azacitidine (J9025)
- Bendamustine (J9033)
- Carboplatin (J9045)
- Clofarabine (J9027)
- Cytarabine (J9098, J9100)

- Daunorubicin (J9150, J9151)
- Idarubicin (J9211)
- Ifosfamide (J9208)
- Irinotecan (J9206)
- Oxaliplatin (J9263)
- Dactinomycin (J9120) (added; identified by at least two of the three guidelines as a highly emetogenic chemotherapy agent).

Billing requirements

Services must be bill using Healthcare Common Procedure Coding System (HCPCS) code J8501 (Aprepitant , oral, 5 mg) with the appropriate cancer diagnosis. Providers submitting claims to Medicare fiscal intermediaries (FIs) must bill HCPCS J8501 with revenue code 0636 (drugs requiring detailed coding).

Effective for claims with dates of service on or after May 29, 2013, Medicare administrative contractors (MACs) will deny lines for oral Aprepitant if an encounter for antineoplastic chemotherapy (ICD-9 V58.11 or ICD-10 Z51.11) is not present. If Aprepitant denies on a claim, the 5HT3 and dexamethasone will also deny.

Effective July 7, 2014, an audit was implemented to suspend claims for medical review when Aprepitant (J8501) is billed without a 5HT3 antagonist (HCPCS codes Q0162, Q0166, or Q0180); and dexamethasone (HCPCS J8540) on the same claim. In the case where a patient already has the oral agents at home, the provider must include a supporting statement to that fact.

Source: *Change request 8418*

Cardiac rehabilitation programs for chronic heart failure

Provider types affected

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

What you need to know

Effective for dates of service on and after February 18, 2014, Medicare covers cardiac rehabilitation services for beneficiaries with stable, chronic heart failure. This article, based on change request (CR) 8758, informs you that, effective for dates of service on and after February 18, 2014, Medicare covers cardiac rehabilitation services for beneficiaries with stable, chronic heart failure, defined as patients with left ventricular ejection fraction of 35 percent or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least six weeks. Stable patients are defined as patients who have not had recent (=6 weeks) or planned (=6 months) major cardiovascular hospitalizations or procedures. Make sure your billing staffs are aware of these changes.

Background

On June 4, 2013, the Centers for Medicare & Medicaid Services (CMS) initiated a national coverage analysis (NCA) to expand Medicare coverage of cardiac rehabilitation for beneficiaries diagnosed with chronic heart failure. Items and services furnished under a cardiac rehabilitation (CDR) program may be covered under Medicare Part B per Section 1861(s)(2)(CC) and 1861(eee)(1) of the Social Security Act. Among other things, Medicare regulations define key terms, address the components of a cardiac rehabilitation program, establish the standards for physician supervision, and limit the maximum number of program sessions that may be furnished. These regulations may be viewed at *42 Code of Federal Regulations* (CFR), Section 410.49, available at *http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A2.0.1.2.10*.

CDR services mean a physician-supervised program that furnishes physician prescribed exercise, cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment, outcomes assessment, and other items/services as determined by the Secretary under certain conditions. The regulations describe the cardiac conditions that would enable a beneficiary to obtain CDR services. Specifically, coverage is permitted for beneficiaries who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months;
- A coronary artery bypass surgery;
- Current stable angina pectoris;
- Heart valve repair or replacement;
- Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or
- A heart or heart-lung transplant.

Effective for dates of service on or after February 18, 2014, this change request adds stable, chronic heart failure to the list of cardiac conditions above that would enable a beneficiary to obtain cardiac rehabilitation services. CMS may add "other cardiac conditions as specified through a national coverage determination" (*42 CFR Section 410.49(b)(vii)*.

Any cardiac indication not specifically identified in *42 CFR 410.49(b)(l)(vii*) or identified as covered in any national coverage determination (NCD) is considered non-covered. Also, note that MACs will not search for and adjust claims processed prior to the implementation of CR 8758. However, your MAC will adjust such claims that you bring to their attention.

Additional Information

CR 8758 consists of four transmittals, each of which relates to a Medicare manual. The transmittal related to the *National Coverage Determination Manual* is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R171NCD.pdf*.

The transmittal related to the *Medicare Claims Processing Manual* is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2989CP.pdf*, the transmittal related to the *Medicare Program Integrity Manual* is *at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R530PI.pdf*, and the transmittal related to the *Medicare Benefit Policy Manual* is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R191BP.pdf*.

You may also want to review *MLN Matters*® article MM6850, which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm6850.pdf* for more information on cardiac rehabilitation services. 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: MM8758
Related Change Request (CR) #: CR 8758
Related CR Release Date: July 18, 2014
Effective Date: February 18, 2014
Related CR Transmittal #: R171NCD, R2989CP, R530PI, and R191BP
Implementation Date: August 18, 2014

Changes to the laboratory national coverage determination software for ICD-10 codes

Note: *This article was revised August 1, 2014, to show the new ICD-10 implementation date of October 1, 2015. While the change request (CR) may not reflect the new date, CMS has made the date change. All other information is unchanged. This article was previously published in the February 2014 edition of Medicare A Connection, Page 26.*

Provider types affected

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

Provider action needed

CR 8494, from which this article is taken, provides that the Laboratory National Coverage Determination (NCD) Edit Software will be updated to accommodate the processing of the International Classification of Diseases, Tenth Revision (ICD-10) diagnosis codes.

This is a follow-up to CR 8202 Changes to the Laboratory National Coverage Determination (NCD) Software for ICD-10 (dated February 1, 2013), that extended the ICD-9 to ICD-10 implementation date to October 1, 2015. (You can find this CR at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1174OTN.pdf*.)

Background

In accordance with the *Medicare Claims Processing Manual*, Chapter 16 (Laboratory Services), Section 120.2 (Implementation and Updates of Negotiated National Coverage Determinations (NCDs) for Clinical Diagnostic Laboratory Services), the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintaining codes in the negotiated NCDs and for biannual updates of the ICD-9-CM codes.

CR 8494, from which this article is taken, instructs the Medicare shared systems maintainers to update the laboratory NCD edit software to accommodate the processing of the ICD-10 diagnosis codes. There are no updates to the laboratory NCD code lists for this quarter.

Additional Information

The official instruction, CR 8494 issued to your A/B MAC regarding this change, may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2865CP.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: MM8494 *Revised*
Related Change Request (CR) #: CR 8494
Related CR Release Date: January 31, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R2865CP
Implementation Date: January 6, 2014

Local Coverage Determinations

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 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.

More information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

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.**

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**

Revised LCDs

Mohs micrographic surgery – revision to the Part A LCD

LCD ID number L28932 (Florida)
LCD ID number L28953 (Puerto Rico, U.S. Virgin Islands)

The local coverage determination (LCD) for Mohs micrographic surgery (MMS) was revised and presented during the October 2011 Contractor Advisory Committee (CAC) cycle.

An extensive number of comments were received related to defect closure and repair, as well as, which physician specialties are considered qualified to perform Mohs procedures. The revised LCD draft was not finalized at that time, but pended, awaiting the publication of appropriate use criteria by the American Academy of Dermatology. A new draft was released again in October 2013, based on ongoing issues identified through medical review and data analysis.

Of note, the 2013 data for Mohs services billed in Florida indicated that over 92 million dollars were allowed (not adding the reconstruction of the surgical defect that add considerable cost when utilized) for approximately 67,000 Medicare beneficiaries. Also, the 2012 Medicare provider utilization and payment data for all services is available on the public domain.

Since the October 2013 policy cycle, the medical policy staff and medical directors have collaborated with practicing physicians representing the specialties of dermatology and plastic surgery and further revised the draft to incorporate the appropriate use criteria by the American Academy of Dermatology. Due to the inclusion of more restrictive language, the draft was re-released in February 2014 for an additional 45-day comment period and presented for discussion at both the Florida and Puerto Rico CAC meetings.

In summary, major revisions to the current LCD are being implemented to address the various issues that were presented during the comment periods for October 2011, October 2013, and February 2014. This LCD has been revised to update the following sections: “Indications and Limitations of Coverage and/or Medical Necessity,” “ICD-9 Codes that Support Medical Necessity,” and “Documentation Guidelines” for the performance of Mohs micrographic surgery. In addition, the “Sources of Information and Basis for Decision” section of this LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after October 6, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database 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 N, please *click here*.

Self-administered drug (SAD) list – Part A

Myalept ™ (metreleptin for injection) J3490/ J3590/C9399

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician’s service. The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare.

Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician’s service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered on or after October 13, 2014, the following drug has been added to the MAC JN Part B SAD list.

- J3490/J3590/C9399 Metreleptin for injection (Myalept™ for subcutaneous use) 11.3mg

The evaluation of drugs for addition to the self-administered drug (SAD) list is an ongoing process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

The SAD lists are available through the First Coast Service Options, Inc. (First Coast) website.at: *http://medicare.fcso.com/Self-administered_drugs/*

Myocardial imaging, positron emission tomography scan – revision to the Part A LCD

LCD ID number L28933 (Florida)
LCD ID number L289543 (Puerto Rico, U.S. Virgin Islands)

The local coverage determination (LCD) for myocardial imaging, PET scan has been revised based on issues identified during medical review of documentation. Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, language was added to specify certain indications when a PET scan is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT).

Language throughout the LCD was updated and consolidated based on current CMS Manual language for PET scans.

Also, cardiac sarcoidosis was added to the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD.

Dual diagnoses are required for cardiac sarcoidosis, and therefore, ICD-9-CM codes 135 and 425.8 were added to the "ICD-9 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology*® (*CPT*®) code *78459*. Additionally, ICD-9-CM code for chest pain (786.50) was added. In addition, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

This LCD revision is effective for services rendered **on or after September 22, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database 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, please *click here*.

Multiple local coverage determinations (LCDs) being retired

LCD ID number L28758, L28779, L28820, L28935 (Florida)
LCD ID number L28759, L28783, L28853, L28956 (Puerto Rico, U.S. Virgin Islands)

LCD ID number L31508 (Florida, Puerto Rico, U.S. Virgin Islands)

Based on data analysis the following local coverage determinations (LCDs) were retired.

1. Aldesleukin (Proleukin®, Interleukin-2, Recombinant, and RIL-2)
2. ATGAM (Lymphocyte Immune Globulin, Antithymocyte Globulin (Equine)
3. Denileukin Diftitox (Ontak®)
4. Nesiritide (Natrecor®) Intravenous Infusion Therapy
5. Selective Treatment of HAE with Cinryze™, Berinert® and Ecallantide

Effective date

The retirement of these LCDs is effective for services rendered **on or after August 7, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database 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, please *click here*.

Electronic Data Interchange

Tips for enrolling with electronic data interchange

The following are important tips to keep in mind when completing an EDI enrollment form:

- Effective September 1, 2014, Medicare EDI will return all EDI enrollment forms received containing a form revision date older than July 21, 2014.
- A link to the completion instructions is at the bottom of page 1 of the EDI enrollment form.
- The EDI enrollment form is interactive allowing you to complete the form online, print, sign and date it.
- All fields with an asterisk (*) are required.
- A required fax coversheet precedes the EDI enrollment form.
- The EDI enrollment form is a legal document and all pages must be returned with the request, otherwise, the entire application will be returned.
- Electronic billers will automatically be enrolled for electronic remittance advice (ERA) with the submitter on the request unless otherwise indicated in the ERA section.
- If requesting SPR (standard paper remittance) an exception form is also required. This can be obtained by contacting Medicare EDI and must be sent in with the EDI enrollment form. Note: An exception form requires a business justification for requesting remittance on paper.
- If you are enrolling in PC-ACE Pro32™, you must specify the manner in which you select to receive the software. Once the form is completed and printed, you must sign the authorized official original signature field in the PC-ACE Pro32™ section and the signature requirements section.

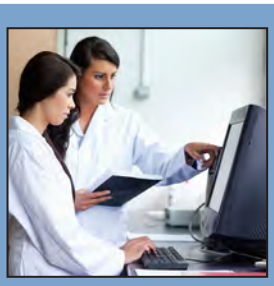
- Signature requirements: The authorized official original signature and title must be completed on all applications, signing this section confirms you have read and agree with the agreement, Centers for Medicare & Medicaid Services (CMS) obligations, and *Attestation* sections on page 3 and 4.
- It is highly recommended that you keep a copy of your completed enrollment form(s) for your records.
- A link has been provided on the EDI fax coversheet to the Medicare A data direct entry (DDE) page for obtaining the DDE user ID request form.
- EDI forms are processed in the order in which they are received. Notification will be sent to the contact listed on the form advising status of the form.
- Once the form has been completed, print, sign, date and return all pages including the EDI fax cover sheet.
- All forms received after 2:00 p.m. ET will have the date of the receipt of the next business day.

Online Medicare refreshers

The *Medicare Learning Network*® (MLN) Products Web-Based Training (WBT) courses are designed for self-paced training via the Internet.

These WBT courses provide information on a broad range of Medicare topics for health care professionals and their staff. Many of these courses offer continuing education credits.

Click here to explore the wide away of training opportunities.



Update on uniform use of CARCs and RARCs

Note: *This article was revised August 12, 2014, to reflect the revised change request (CR) 8711 issued August 8, 2014. The CR revised the CAQH CORE version number and the publication date. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are changed. All other information remains the same. This article was previously published in the July 2014 edition of Medicare A Connection, Page 13.*

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.

Provider action needed

This article is based on CR 8711, which instructs the MACs to update the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule. If you use Medicare's PC Print or Medicare Remit Easy Print (MREP) software, you will need to obtain the new version after it is updated on October 6, 2014. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the Affordable Care Act.

Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security 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.

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 will publish the next version of the code combination list on or about July 1, 2014. This update is based on March 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website. (Visit *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.)

Note: Per the Affordable Care Act mandate, all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/Group Code for a minimum set of four business scenarios.

Medicare can use any code combination if the business scenario is not one of the four CORE defined business scenarios but for the four CORE defined business scenarios,

Medicare must use the code combinations from the lists published by CAQH CORE.

Additional Information

The official instruction, CR 8711, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1418OTN.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.*

MLN Matters® Number: MM8711 *Revised*
Related Change Request (CR) #: CR 8711
Related CR Release Date: August 8, 2014
Effective Date: September 2, 2014
Related CR Transmittal #: R1418OTN
Implementation Date: September 2, 2014

Automation of the request for reopening claims process

Note: *To assist providers with coding a request to reopen claims that are beyond the filing timeframes a special edition article, SE1426, has been developed. That article contains some additional information on this process as well as condition codes and billing scenarios. The article may be reviewed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1426.pdf.*

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8581 which informs A/MACs about changes that will allow providers and their vendors to electronically request re-openings of claims. Make sure your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details.

Background

When a provider needs to correct or supplement a claim, and the claim remains within timely filing limits, providers may submit an adjustment claim to remedy the error. When the need for a correction is discovered beyond the claims timely filing limit, an adjustment bill is not allowed and a provider must utilize the reopening process to remedy the error.

Generally, re-openings are written requests for corrections that include supporting documentation. However, a standard process across all A/MACs has not been available. In an effort to streamline and standardize the process for providers to request re-openings, CMS petitioned the National Uniform Billing Committee (NUBC) for a "new" bill type frequency code to be used by providers indicating a request for reopening and a series of condition codes that can be utilized to identify the type of re-opening being requested. These institutional re-openings must be submitted with a "Q" frequency code to identify them as a reopening. The NUBC adopted these new codes and bill type frequency change effective with claims received on or after January 1, 2015.

A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Re-openings are different from adjustment bills in that adjustment bills are subject to normal claims processing timely filing requirements (i.e., filed within one year of the date of service), while re-openings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (e.g., claim determinations may be reopened within one year of the date of receipt of the initial determination for any reason, or within one to four years of the date of receipt of the initial determination upon a showing of good cause). Re-openings are also separate and distinct from the appeals process. A reopening will not be granted if an appeal decision is pending or in process.

Decisions to allow re-openings are discretionary actions on the part of your A/MAC. An A/MAC's decision to reopen a claim determination, or refusal to reopen a claim determination, is not an initial determination and is therefore not appealable. Requesting a reopening does not guarantee that request will be accepted and the claim determination will be revised, and does not extend the timeframe to request an appeal. If an A/MAC decides not to reopen an initial determination, the A/MAC will return to provider (RTP) the reopening request indicating that the A/MAC is not allowing this discretionary action.

In this situation, the original initial determination stands as a binding decision, and appeal rights are retained on the original initial determination. New appeal rights are not triggered by the refusal to reopen, and appeal filing timeframes on the original initial determination are not extended following a contractor's refusal to reopen. However, when an A/MAC reopens and revises an initial determination, that revised determination is a new determination with new appeal rights.

Providers are reminded that submission of adjustment bills or reopening requests in response to claim denials resulting from review of medical records (including failure to submit medical records in response to a request for records) is not appropriate. Providers must submit appeal requests for such denials. Additionally, many A/MACs allow re-openings to be submitted hardcopy (mail or fax) or through a provider online portal. The creation of this new process does not eliminate or negate those processes. Contact your MAC about ways to submit re-openings.

Additional information

The official instruction, CR 8581, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3022CP.pdf*.

For additional information regarding the distinction between adjustment bills, which are subject to normal claims processing timely filing limits, and re-openings, which may be requested beyond timely filing limitations, review Chapter 1, Section 70.5 of the *Medicare Claims Processing Manual* (IOM 100-4). That manual chapter is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf*.

See **REOPENING**, next page

REOPENING

From previous page

For more information regarding the processing of appeals, review Chapter 29 in the *Medicare Claims Processing Manual* at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf*.

For additional information regarding the processing of requests for reopening, review Chapter 34 in the *Medicare Claims Processing Manual at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf*. Attachment 1 will assist providers with coding claim's request for reopening.

Coding requirements:

These claims must be submitted with a "Q" in the 4th position of the type of bill (TOB xxxQ) to identify them as a reopening.

Condition code definitions for reopening

Condition code	Title	Definition
R1	Request for Reopening Reason Code - Mathematical or Computational Mistakes	Mathematical or computational mistakes
R2	Request for Reopening Reason Code - Inaccurate Data Entry	Inaccurate data entry, e.g., mis-keyed or transposed provider number, referring NPI, date of service, procedure code, etc.
R3	Request for Reopening Reason Code - Misapplication of a Fee Schedule.	Misapplication of a fee schedule
R4	Request for Reopening Reason Code - Computer Errors	Computer errors
R5	Request for Reopening Reason Code - Incorrectly Identified Duplicate	Claim claims denied as duplicates which the party believes were incorrectly identified as a duplicate.
R6	Request for Reopening Reason Code - Other Clerical Errors or Minor Errors and Omissions not Specified in R1-R5 above	Other clerical errors or minor errors and omissions not specified in R1-R5 above.
R7	Request for Reopening Reason Code - Corrections other than Clerical Errors	Claim corrections other than clerical errors within one year of the date of initial determination.
R8	Request for Reopening Reason Code - New and Material Evidence	A reopening for good cause (one to four years from the date of the initial determination) due to new and material evidence that was not available or known at the time of the determination or decision and may result in a different conclusion.
R9	Request for Reopening Reason Code - Faulty Evidence	A reopening for good cause (one to four years from the date of the initial determination) because the evidence that was considered in making the determination or decision clearly shows that an obvious error was made at the time of the determination or decision.

MLN Matters® Number: MM8581
Related Change Request (CR) #: CR 8581
Related CR Release Date: August 8, 2014
Effective Date: Claims received on/after January 1, 2015
Related CR Transmittal #: R3022CP
Implementation Date: April 6, 2015

Scenarios and coding instructions for submitting requests to reopen claims electronically

Provider types affected

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

Provider action needed

This article is intended to provide additional information, coding instructions and scenarios for requesting a reopening of a claim that is beyond the filing timeframe. It is a companion article to *MLN Matters*® article MM8581 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8581.pdf*).

MM8581 is based on change request (CR) 8581 which informs A MACs about changes that will allow providers and their vendors to electronically request reopening claims. Make sure your billing staffs are aware of these changes.

Background

When a provider needs to correct or supplement a claim, and the claim remains within timely filing limits, providers may submit an adjustment claim to remedy the error. When the need for a correction is discovered beyond the claims timely filing limit, an adjustment bill is not allowed and a provider must utilize the reopening process to remedy the error.

Generally, reopenings are written requests for corrections that include supporting documentation. However, a standard process across all A/MACs has not been available. In an effort to streamline and standardize the process for providers to request re-openings, CMS petitioned the National Uniform Billing Committee (NUBC) for a "new" bill type frequency code to be used by providers indicating a request for reopening and a series of condition codes that can be utilized to identify the type of reopening being requested. These institutional reopenings must be submitted with a "Q" frequency code to identify them as a reopening. The NUBC adopted these new codes and bill type frequency change effective with claims received on or after January 1, 2015.

A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Re-openings are different from adjustment bills in that adjustment bills are subject to normal claims processing timely filing requirements (i.e., filed within one year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (e.g., claim determinations may be reopened within one year of the date of receipt of the initial determination for any reason, or within one to four years of the date of receipt of the initial determination upon a showing of good cause).

Reopenings are also separate and distinct from the appeals process. A reopening will not be granted if an appeal decision is pending or in process.

Decisions to allow reopenings are discretionary actions on the part of your A/MAC. An A/MAC's decision to reopen a claim determination or refusal to reopen a claim determination is not an initial determination and is therefore not appealable. Requesting a reopening does not guarantee that request will be accepted and the claim determination will be revised, and does not extend the timeframe to request an appeal. If an A/MAC decides not to reopen an initial determination, the A/MAC will return to provider (RTP) the reopening request indicating that the A/MAC is not allowing this discretionary action. In this situation, the original initial determination stands as a binding decision, and appeal rights are retained on the original initial determination.

New appeal rights are not triggered by the refusal to reopen, and appeal filing timeframes on the original initial determination are not extended following a contractor's refusal to reopen. However, when an A/MAC reopens and revises an initial determination, that revised determination is a new determination with new appeal rights.

Providers are reminded that submission of adjustment bills or reopening requests in response to claim denials resulting from review of medical records (including failure to submit medical records in response to a request for records) is not appropriate. Providers must submit appeal requests for such denials.

Additionally, many A/MACs allow reopenings to be submitted hardcopy (by mail or fax) or through a provider online portal. The creation of this new process does not eliminate or negate those processes. Contact your MAC about other ways reopenings may be submitted.

Additional information

The related CR 8581 may be viewed at *http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3022CP.pdf*.
To assist providers with claims coding a request for reopening, the following attachment was prepared with condition codes that may be used and scenarios using adjustment reason codes, R1, R2 and R3.

Attachment - coding requirements

(1) Type of bill xxxQ

(2) An applicable condition code R1-R9

See **SCENARIOS**, next page

SCENARIOS

From previous page

R1=Mathematical or computational mistake
R2=Inaccurate data entry
R3=Misapplication of a fee schedule
R4=Computer Errors
R5=Incorrectly Identified Duplicate
R6=Other Clerical Error or Minor Error or Omission (Failure to bill for services is not considered a minor error)
R7=Correction other than Clerical Error
R8=New and material evidence is available
R9=Faulty evidence (Initial determination was based on faulty evidence)

(3) A Condition Code to identify what was changed (if appropriate):

D0=Changes in service date
D1= Changes to charges
D2=Changes in Revenue Code/HCPCS/HIPPS Rate Codes
D4=Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes
D9=Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, Provider ID, Modifiers and other changes
E0=Change in patient status

(4) A Condition Code W2=Attestation that there is no Appeal in Process

(5) For DDE claims only) An Adjustment Reason Code on page
R1 = < 1 yr Initial Determination
R2 = 1-4 yr Initial Determination
R3 = > 4 yr Initial Determination

(6) Reopenings that require "Good Cause" to be documented must have a Remark/Note from the provider. Remarks/notes should be formatted as shown below **without the parenthetical explanation** (this is not an exhaustive list) and a narrative explanation after the word "because". If the change or addition affects a line item (shown as bold) instead of a claim item, please indicate which lines are being changed in the remark/note. The first fifteen (15) characters of the remark/note must match exactly as shown below.

GOOD CAUSE: C/A CC (CHANGED OR ADDED CONDITION CODE) BECAUSE…

GOOD CAUSE: C/A OC (CHANGED OR ADDED OCCURRENCE CODE) BECAUSE…

GOOD CAUSE: C/A OSC (CHANGED OR ADDED OCCURRENCE SPAN CODE) BECAUSE…

GOOD CAUSE: C/A VC (CHANGED OR ADDED VALUE CODE) BECAUSE…

GOOD CAUSE: C/A DX (CHANGED OR ADDED DIAGNOSIS CODE) BECAUSE…

GOOD CAUSE: C/A MOD (CHANGED OR ADDED MODIFIER) BECAUSE…

GOOD CAUSE: C/A PX (CHANGED OR ADDED PROCEDURE CODE) BECAUSE…

GOOD CAUSE: C/A LIDOS (CHANGED OR ADDED LINE ITEM DATES OF SERVICE) BECAUSE…

GOOD CAUSE: C/A PSC (CHANGED OR ADDED PATIENT STATUS CODE) BECAUSE…

GOOD CAUSE: C/A HCPCS

GOOD CAUSE: C/A HIPPS

GOOD CAUSE: C/A OTHER BECAUSE…

GOOD CAUSE: NME (NEW AND MATERIAL EVIDENCE) BECAUSE…

GOOD CAUSE: F/E (FAULTY EVIDENCE) BECAUSE…

(7) To assist in quickly processing a reopening, any reopening request that contains changes or additions from the original claim should contain a remark/note explaining what has been changed. If the change or addition affects a line item instead of a claim item, please indicate which lines are being changed in the remark/note.

Reopening request scenarios (Examples are not all-inclusive)

Scenario A – adjustment reason code R1

Claim 1: Clerical error – minor error – new pricer/new fee-scheduled, revised MCE, revised IOCE, revised NCD edits, revised MUE edits

TOB	xxxQ	Reason for adjustment
Reopening condition code	R1	Mathematical or computational mistakes
Adjustment condition code	D9	Other

See **SCENARIOS**, next page

SCENARIOS

From previous page

TOB	xxxQ	Reason for adjustment
Adjustment reason code	R1	< 1 yr initial determination
Remarks – (good cause)	Not Required	May be added to provide additional information for claims processing.

Claim 2: Clerical error – minor error – keying error

TOB	xxxQ	Reason for adjustment
Reopening condition code	R2	Inaccurate data entry (inverted code)
Adjustment condition code	D0 D1 D2 D4 D9 E0	Changes in service date Changes to charges Changes in revenue code/ HCPCS/HIPPS rate codes Change in clinical codes (icd) for diagnosis and/or procedure codes Change in condition codes, occurrence codes, occurrence span codes, or modifiers Change in patient status
Adjustment reason code	R1	< 1 yr initial determination
Remarks – (good cause)	Not	May be added to provide additional information for claims processing.

Claim 3: Clerical error – minor error – wrong locality or wrong payment system used to price the claim (Claim paid using the wrong locality or the locality wasn't loaded; or claim paid at CLFS and should have been paid cost or OPPS) Provider file not set up correctly.

TOB	xxxQ	Reason for adjustment
Reopening condition code	R3	Misapplication of a fee schedule
Adjustment condition code	D9	Other
Adjustment reason code	R1	< 1 yr initial determination
Remarks – (good cause)	Not required	May be added to provide additional information for claims processing.

Claim 4: Clerical error – minor error – (Provider had wrong code or units hardcoded/loaded in their charge master or billing software)

TOB	xxxQ	Reason for adjustment
Reopening condition code	R4	Computer errors
Adjustment condition code	D1 D2 D4 D9 E0	Changes to charges Changes in revenue code/ HCPCS/HIPPS rate codes Change in clinical codes (icd) for diagnosis and/or procedure codes Change in condition codes, occurrence codes, occurrence span codes, or modifiers Change in patient status
Adjustment Reason Code	R1	< 1 yr initial determination
Remarks – (good cause)	Not required	May be added to provide additional information for claims processing.

Claim 5: Clerical error – minor error – incorrectly identified duplicate

TOB	xxxQ	Reason for adjustment
Reopening condition code	R5	Incorrectly identified duplicate
Adjustment condition code	D9	Other
Adjustment reason code	R1	< 1 yr initial determination
Remarks – (good cause)	Not required	May be added to provide additional information for claims processing.

See **SCENARIOS**, next page

SCENARIOS

From previous page

Claim 6a: **Other clerical errors – minor errors – coding error** (i.e., Incorrect data items such as discharge status, modifier or date of service.)

TOB	xxxQ	Reason for adjustment
Reopening condition code	R6	Incorrect data entry (used wrong code completely)
Adjustment condition code	D0 D1 D2 D4 D9 E0	Changes in service date Changes to charges Changes in Revenue Code/ HCPCS/HIPPS Rate Codes Change in clinical codes (ICD) for diagnosis and/or procedure codes Change in condition codes, occurrence codes, occurrence span codes, or modifiers Change in patient status
Adjustment reason code	R1	< 1 yr initial determination
Remarks – (good cause)	Not required	May be added to provide additional information for claims processing.

Claim 6b: Other clerical errors – omissions (i.e., incorrect data items such as modifier or clinical information.)

TOB	xxxQ	Reason for adjustment
Reopening condition code	R6	Incorrect data entry (left off the code from billing)
Adjustment condition code	D2 D4 D9	Changes in Revenue Code/ HCPCS/HIPPS Rate Codes Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers
Adjustment reason code	R1	< 1 yr initial determination
Remarks – (good cause)	Not required	May be added to provide additional information for claims processing.

Claim 7: Corrections other than clerical errors – computer system omissions (i.e., Off-site provider zip code, condition code, occurrence code, occurrence span code, value code, modifier)

TOB	xxxQ	Reason for adjustment
Reopening condition code	R7	Computer system omission
Adjustment condition code	D2 D4 D9	Changes in revenue code/ HCPCS/HIPPS rate codes Change in clinical codes (ICD) for diagnosis and/or procedure codes Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, Value Codes or Modifiers
Adjustment reason code	R1	< 1 yr Initial Determination
Remarks – (good cause)	Not Required	May be added to provide additional information for claims processing.

Claim 8: **Corrections other than clerical errors – new and material evidence** (subsequent test results, new documentation has become available since the initial determination)

TOB	xxxQ	Reason for adjustment
Reopening condition code	R8	New and material evidence
Adjustment condition code	D9	Other
Adjustment reason code	R1	< 1 yr initial determination
Remarks – (good cause)	Not required	May be added to provide additional information for claims processing.

See **SCENARIOS**, next page

SCENARIOS

From previous page

Claim 9: Corrections other than clerical errors – faulty evidence

TOB	xxxQ	Reason for adjustment
Reopening condition code	R9	Faulty evidence
Adjustment condition code	D9	Other
Adjustment reason code	R1	< 1 yr initial determination
Remarks – (good cause)	Not required	May be added to provide additional information for claims processing.

Scenario B – Adjustment reason code R2

Claim 1: Clerical error – minor error – new pricer/new fee-scheduled, revised MCE, revised IOCE, revised NCD edits, revised MUE edits

TOB	xxxQ	Reason for adjustment
Reopening condition code	R1	Mathematical or computational mistakes
Adjustment condition code	D9	Other
Adjustment reason code	R2	1 -4 yrs from initial determination
Remarks – (good cause)	Yes	

Claim 2: **Clerical error – minor error – keying error**

TOB	xxxQ	Reason for adjustment
Reopening condition code	R2	Inaccurate data entry (inverted code)
Adjustment condition code	D0 D1 D2 D4 D9 E0	Changes in service date Changes to charges Changes in revenue code/ HCPCS/HIPPS rate codes change in clinical codes (ICD) for diagnosis and/or procedure codes Change in condition codes, occurrence codes, occurrence span codes, or modifiers Change in patient status
Adjustment reason code	R2	1 -4 yrs from initial determination
Remarks – (good cause)	Yes	

Claim 3: Clerical error – minor error – wrong locality or wrong payment system used to price the claim (Claim paid using the wrong locality or the locality wasn't loaded; or claim paid at CLFS and should have been paid cost or OPPS) Provider file not set up correctly.

TOB	xxxQ	Reason for adjustment
Reopening condition code	R3	Misapplication of a fee schedule
Adjustment condition code	D9	Other
Adjustment reason code	R2	1 -4 yrs from initial determination
Remarks – (good cause)	Yes	

Claim 4: **Clerical error – minor error** – (i.e., Provider had wrong code or units hardcoded/loaded in their charge master or billing software)

TOB	xxxQ	Reason for adjustment
Reopening condition code	R4	Computer errors
Adjustment condition code	D1 D2 D4 D9 E0	Changes to charges Changes in revenue code/ HCPCS/HIPPS rate codes Change in clinical codes (ICD) for diagnosis and/or procedure codes Change in condition codes, occurrence codes, occurrence span codes, or modifiers Change in patient status
Adjustment reason code	R2	1 -4 yrs from initial determination
Remarks – (good cause)	Yes	

Claim 5: **Clerical error – minor error – incorrectly identified duplicate**

TOB	xxxQ	Reason for adjustment
Reopening condition code	R5	Incorrectly identified duplicate

See **SCENARIOS**, next page

SCENARIOS

From previous page

TOB	xxxQ	Reason for adjustment
Adjustment condition code	D9	Other
Adjustment reason code	R2	1 - 4 yrs from initial determination
Remarks – (good cause)	Yes	

Claim 6a: **Other clerical errors – minor errors – coding error** (i.e., incorrect data items such as discharge status, modifier or date of service.)

TOB	xxxQ	Reason for adjustment
Reopening condition code	R6	Incorrect data entry (used wrong code completely)
Adjustment condition code	D0 D1 D2 D4 D9 E0	Changes in service date Changes to charges Changes in revenue code/ HCPCS/HIPPS rate codes Change in clinical codes (ICD) for diagnosis and/or procedure codes Change in condition codes, occurrence codes, occurrence span codes, or modifiers Change in patient status
Adjustment reason code	R2	1 - 4 yrs from Initial Determination
Remarks – (good cause)	Yes	

Claim 6b: **Other clerical errors – omissions** (i.e., incorrect data items such as modifier or clinical information.)

TOB	xxxQ	Reason for adjustment
Reopening condition code	R6	Incorrect data entry (left off the code from billing)
Adjustment condition code	D2 D4 D9	Changes in revenue code/ HCPCS/HIPPS rate codes Change in clinical codes (ICD) for diagnosis and/or procedure codes Change in condition codes, occurrence codes, occurrence span codes, or modifiers

TOB	xxxQ	Reason for adjustment
Adjustment reason code	R2	1 - 4 yrs from initial determination
Remarks – (good cause)	Yes	

Claim 7: **Corrections other than clerical errors – computer system omissions** (i.e., off-site provider zip code, condition code, occurrence code, occurrence span code, value code, modifier)

TOB	xxxQ	Reason for adjustment
Reopening condition code	R7	Computer system omission
Adjustment condition code	D2 D4 D9	Changes in revenue code/HCPCS/ HIPPS Rate Codes Change in clinical codes (ICD) for diagnosis and/or procedure codes Change in condition codes, occurrence codes, occurrence span codes, value codes or modifiers
Adjustment reason code	R2	1 - 4 yrs from initial determination
Remarks – (Good Cause)	Yes	

See **SCENARIOS**, next page

SCENARIOS

From previous page

Claim 8: **Corrections other than clerical errors – new and material evidence** (subsequent test results, new documentation has become available since the initial determination)

TOB	xxxQ	Reason for adjustment
Reopening condition code	R8	New and material evidence
Adjustment condition code	D9	Other
Adjustment reason code	R2	1 - 4 yrs from initial determination
Remarks – (good cause)	Yes	

Claim 9: **Corrections other than clerical errors – faulty evidence**

TOB	xxxQ	Reason for adjustment
Reopening condition code	R9	Faulty evidence
Adjustment condition code	D9	Other
Adjustment reason code	R2	1 - 4 yrs from initial determination
Remarks – (good cause)	Yes	

Scenario C – Adjustment reason code R3

Claim 1: **Corrections other than clerical errors – new and material evidence** (subsequent test results, new documentation has become available since the initial determination)

TOB	xxxQ	Reason for adjustment
Reopening condition code	R8	New and material evidence
Adjustment condition code	D9	Other

TOB	xxxQ	Reason for adjustment
Adjustment reason code	R3	>4 yrs from initial determination
Remarks – (good cause)	Yes	

Claim 2: **Corrections other than clerical errors – faulty evidence**

TOB	xxxQ	Reason for adjustment
Reopening condition code	R9	Faulty evidence
Adjustment condition code	D9	Other
Adjustment reason code	R3	>4 yrs from initial determination
Remarks – (good cause)	Yes	

MLN Matters® Number: SE1426
Related Change Request (CR) #: CR 8581
Related CR Release Date: August 8, 2014
Effective Date: Claims received on or after January 1, 2015
Related CR Transmittal #: R3022
Implementation Date: April 6, 2015

Remittance advice remark and claims adjustment reason code and Medicare remit easy print and PC Print update

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare administrative contractors (MACs), including durable medical equipment (DME) MACs and home health & hospice (HH&H) MACs, for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 8855 instructs the MACs to make programming changes to incorporate updates to the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists. It also instructs Medicare system maintainers to update Medicare remit easy print (MREP) and PC print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP or PC print software if you use that software.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that claim adjustment reason codes (CARCs) and appropriate remittance advice remark codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice and coordination of benefits transactions.

For transaction 835 (health care claim payment/advice) and standard paper remittance advice, there are two code sets, CARC and RARC, that must be used along with a group code to report payment adjustments and Informational RARCs to report appeal rights, and other adjudication related information. If there is any adjustment, the appropriate group code must be reported. Additionally, for transaction 837 coordination of benefits (COB), CARC and RARC must be used. CARC and RARC code sets are updated three times a year on a regular basis. Medicare contractors must report only currently valid codes in both the remittance advice and COB Claim transaction, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met.

MACs must make the necessary CARC/RARC code list updates on a regular basis. Any modification and/or deactivation, even if not initiated by Medicare, will be implemented.

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. MACs are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

Medicare has the responsibility to implement code deactivation (making sure that any deactivated code is not used in original business messages), but the deactivated code in derivative messages is allowed.

Medicare must be sure to not report any deactivated code on or before the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR 8855, MACs must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only three times a year and may not match the CMS release schedule. CR 8855 lists only the changes that have been approved since the last code update CR (CR 8703, Transmittal 2920, issued on April 4, 2014; see *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8703.pdf* on the CMS website), and does not provide a complete list of codes for these two code sets.

The MACs must get the complete list for both CARC and RARC from the WPC website that is updated three times a year (around March 1, July 1, and November 1) to get the comprehensive lists for both code sets. The implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three times a year according to the Medicare release schedule and/or specific CR from a CMS component implementing a policy change that impacts remittance advice code use.

You can find the WPC website, which has four listings available for both CARC and RARC, at *http://www.wpc-edi.com/Reference*.

See **CARC**, next page

CARC

From previous page

Changes in CARC list since CR 8703

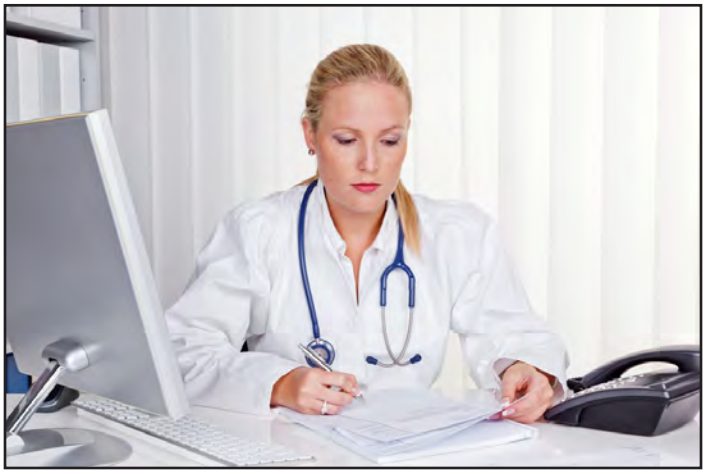
The following tables list the changes in the CARC database since the last code update in CR 8703. The full CARC list is available from the WPC website at *http://wpc-edi.com/Reference*.

New codes – CARC:

Code	Modified narrative	Effective date
261	The procedure or service is inconsistent with the patient's history.	06/01/2014

Modified codes – CARC:

Code	Modified narrative	Effective date
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR) Notes: Not for use by Workers' Compensation payers; use code P3 instead. **CMS Note**: This code was previously deactivated, however it is being reactivated.	06/01/2014
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one remark code must be provided (may be comprised of either the National Council of Prescription Drugs Programs (NCPDP) reject reason code, or remittance advice remark code that is not an ALERT).	06/01/2014
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT).	06/01/2014



Code	Modified narrative	Effective date
257	The disposition of the claim/service is undetermined during the premium payment grace period, per health insurance exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with group code OA) Notes: To be used after the first month of the grace period.	06/01/2014

Deactivated codes – CARC: None

Changes in RARC list since CR 8703

The following tables list the changes in the RARC database since the last code update in CR 8703. The full RARC list is available from the WPC website at: *http://wpc-edi.com/Reference*.

New Codes – RARC: None

Modified Codes – RARC:

Code	Modified narrative	Effective date
N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.	07/01/2014
M77	Missing/incomplete/invalid/ inappropriate place of service.	03/14/2014
M84	Medical code sets used must be the codes in effect at the time of service.	03/14/2014

See **CARC**, next page

CARC

From previous page

Code	Modified narrative	Effective date
MA100	Missing/incomplete/invalid date of current illness or symptoms.	03/14/2014
N202	Additional information/ explanation will be sent separately.	03/14/2014
N203	Missing/incomplete/invalid anesthesia time/units.	03/14/2014
N205	Information provided was illegible.	03/14/2014
N208	Missing/incomplete/invalid DRG code.	03/14/2014
N210	Alert: You may appeal this decision.	03/14/2014
N211	Alert: You may not appeal this decision.	03/14/2014
N212	Charges processed under a point of service benefit.	03/14/2014
N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.	03/14/2014
N214	Missing/incomplete/invalid history of the related initial surgical procedure(s).	03/14/2014
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	03/14/2014
N217	We pay only one site of service per provider per claim.	03/14/2014
N238	Incomplete/invalid physician certified plan of care.	03/14/2014
N245	Incomplete/invalid plan information for other insurance.	03/14/2014
N354	Incomplete/invalid invoice.	03/14/2014
N388	Missing/incomplete/invalid prescription number.	03/14/2014
N433	Resubmit this claim using only your national provider identifier (NPI).	03/14/2014

Code	Modified narrative	Effective date
N438	This jurisdiction only accepts paper claims.	03/14/2014
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	03/14/2014
N467	Missing Tests and Analysis Report.	03/14/2014
N474	Incomplete/invalid certification.	03/14/2014
N476	Incomplete/invalid completed referral form.	03/14/2014
N478	Incomplete/invalid dental models.	03/14/2014
N482	Incomplete/invalid models.	03/14/2014
N484	Incomplete/invalid periodontal charts.	03/14/2014
N488	Incomplete/invalid prosthetics or orthotics certification.	03/14/2014
N490	Incomplete/invalid referral form.	03/14/2014
N543	Incomplete/invalid income verification.	03/14/2014
N544	Alert: Although this was paid, you have billed with a referring/ ordering provider that does not match our system record. Unless corrected this will not be paid in the future.	03/14/2014
N554	Missing/Incomplete/Invalid Family Planning Indicator.	03/14/2014
N570	Missing/incomplete/invalid credentialing data.	03/14/2014

See **CARC**, next page

CARC

From previous page

Code	Modified narrative	Effective date
N609	80 percent of the provider's billed amount is being recommended for payment according to Act 6.	03/14/2014
N645	Mark-up allowance.	03/14/2014
N667	Missing prescription.	03/14/2014
N668	Incomplete/invalid prescription.	03/14/2014
N687	Alert: This reversal is due to a retroactive disenrollment.	03/14/2014
N688	Alert: This reversal is due to a medical or utilization review decision.	03/14/2014
N689	Alert: This reversal is due to a retroactive rate change.	03/14/2014
N690	Alert: This reversal is due to a provider submitted appeal.	03/14/2014
N691	Alert: This reversal is due to a patient submitted appeal.	03/14/2014
N692	Alert: This reversal is due to an incorrect rate on the initial adjudication.	03/14/2014
N693	Alert: This reversal is due to a cancellation of the claim by the provider.	03/14/2014
N696	Alert: This reversal is due to a coordination of benefits or third party liability recovery retroactive adjustment.	03/14/2014
N697	Alert: This reversal is due to a payer's retroactive contract incentive program adjustment.	03/14/2014
N698	Alert: This reversal is due to non-payment of the health insurance exchange premiums by the end of the premium payment grace period, resulting in loss of coverage.	03/14/2014

Code	Modified narrative	Effective date
N704	Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.	03/14/2014

Deactivated codes – RARC: None

Additional Information

The official instruction, CR 8855 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2996CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - *How Does It Work*.

MLN Matters® Number: MM8855
Related Change Request (CR) #: CR 8855
Related CR Release Date: July 24, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R2996CP
Implementation Date: October 6, 2014

Partial code freeze prior to ICD-10 implementation

Note: *This article was revised August 1, 2014, to make changes as a result of the delay of ICD-10 implementation until October 1, 2015.It was previously published in the October 2012 edition of Medicare A Connection, Page 8-9.*

Provider types affected

This *MLN Matters*® special edition article affects all Medicare fee-for-service (FFS) physicians, providers, suppliers, and other entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health setting.

What you need to know

At a meeting September 14, 2011, the ICD-9-CM Coordination & Maintenance (C&M) Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10 which would end one year after the implementation of ICD-10.

The implementation of ICD-10 was delayed from October 1, 2014, to October 1, 2015, by final rule CMS-0043-F issued on July 31, 2014. This final rule is available at *https://www.federalregister.gov/articles/2014/08/04/2014-18347/change-to-the-compliance-date-for-the-international-classification-of-diseases-10th-revision*.

There was considerable support for this partial freeze. The partial freeze will be implemented as follows:

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on October 1, 2011.
- On October 1, 2012, October 1, 2013, and October 1, 2014, there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by Section 503(a) of Pub. L. 108-173.
- On October 1, 2015, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by Section 503(a) of Pub. L. 108-173. No further updates will be made to ICD-9-CM on or after October 1, 2015, as it will no longer be used for reporting; and
- On October 1, 2016, regular updates to ICD-10 will begin.

The ICD-9-CM Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze. At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease.

Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on and after October 1, 2016, once the partial freeze has ended.

The code freeze was initially discussed at the September

15, 2010, meeting of the committee. To view the transcript of that meeting, go to: *http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html*. From there, select the September 15-16, 2010, meeting documents and transcripts from the *Downloads* section, and then from the ZIP files, select the '091510_Morning_Transcript' file.

This section appears on page 4 of the 78-page document. To view the Summary Report of the meeting, go to: *http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html*.

From there, select the September 15-16, 2010, meeting documents and transcripts from the *Downloads* section, and then from the ZIP files, select the '091510_ICD9_Meeting_Summary_report.pdf' file. Information on the code freeze begins on page five of the document.

Additional information

The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources to help Medicare FFS providers understand and prepare for the transition to ICD-10. General information about ICD-10 is available at *http://www.cms.gov/Medicare/Coding/ICD10/index.html*. In addition, the following CMS resources are available to assist in your transition to ICD-10:

- *Medicare Fee-for-Service Provider Resources* Web Page -This site links Medicare Fee-For-Service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this Web page.
- Bookmark *http://www.cms.gov/Medicare/Coding/ICD10/index.html* and check back regularly for access to ICD-10 implementation information of importance to you. **Note**: Use the links on the left side of the Web page to navigate to ICD-10 and 5010 information applicable to your specific interest.

See **FREEZE**, next page

FREEZE

From previous page

- CMS sponsored national provider conference calls - During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts.

These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls.

For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit *http://www.cms.gov/Medicare/Coding/ICD10/index.html*.

- See MLN Matters® special edition article, SE1239, at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf* for an overview of what is needed to implement ICD-10.
- Frequently asked questions (FAQs) - To access FAQs related to ICD-10, please visit the CMS ICD-10 web page at *http://www.cms.gov/Medicare/Coding/ICD10/index.html*, select the Medicare fee-for-service provider resources link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs". Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

The following organizations offer providers and others ICD-10 resources:

- Workgroup for Electronic Data Interchange (WEDI) *http://www.wedi.org*; and
- Health Information and Management Systems Society (HIMSS*) http://www.himss.org/icd10*.

MLN Matters® Number: SE1240 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

ICD-10 testing opportunities for Medicare FFS providers

On July 31, HHS issued a rule (*CMS-0043-F*) finalizing October 1, 2015, as the new compliance date for health care providers and health plans to transition to ICD-10. ICD-10 represents a significant code set change that impacts the entire health care community.

CMS is taking a comprehensive four-pronged approach to preparedness and testing for ICD-10 to ensure that CMS, as well as the Medicare Fee-For-Service (FFS) provider community, is ready:

- CMS internal testing of its claims processing systems
- CMS Beta testing tools available for download
- Acknowledgement testing
- End-to-end testing

For more information, see *MLN Matters® Special Edition Article #SE1409*, "Medicare FFS ICD-10 Testing Approach."

Acknowledgement testing

This past March, CMS conducted *a successful ICD-10 acknowledgement testing week*. Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the October 1, 2015, implementation date.

In addition, special acknowledgement testing weeks in November, March, and June 2015 will give submitters access to real-time help desk support and allows CMS to analyze testing data.

Registration is not required for these virtual events. Contact your *Medicare administrative contractor* (MAC) for more information about acknowledgment testing.

End-to-end testing

CMS plans to offer providers and other Medicare submitters the opportunity to participate in end-to-end testing with MACs and the common electronic data interchange (CEDI) contractor in January, April, and July of 2015.

As planned, approximately 2,550 volunteer submitters will have the opportunity to participate over the course of three testing periods. The goals of this testing are to demonstrate that:

- Providers and submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems

Billing instructions for institutional split claims that span ICD-10 transition

Note: *This article was revised August 4, 2014, to reflect the new ICD-10 implementation date of October 1, 2015. Other adjustments required for that new date have been made. It was previously published in the June 2013 edition of Medicare A Connection, Page 34-41*

Provider types affected

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

Provider action needed

SE1325 clarifies the policy for processing claims for certain institutional encounters that span the International Classification of Diseases, 10th Edition (ICD-10) implementation date of October 1, 2015.

Background

In this special edition article, the Centers for Medicare & Medicaid Services (CMS) clarifies the policy for processing split claims for certain institutional encounters that span the ICD-10 implementation date (that is, when ICD-9 codes are effective for that portion of the services rendered on September 30, 2015, and earlier, and when ICD-10 codes are effective for that portion of the services rendered on October 1, 2015, and later)

The following excerpt from a table in *MLN Matters*® article SE1408 provides you further guidance for such split claims. (You can find this article at *http://www.cms.gov/Outreachand-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf*.)

Table A – Institutional providers

Bill type	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
12x	Inpatient Part B hospital services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
13x	Outpatient hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
14x	Non-patient laboratory services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
22x	Skilled nursing facilities (Inpatient Part B)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

See **SPLIT**, next page

SPLIT

From previous page

Bill type	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
23x	Skilled nursing facilities (outpatient)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
34x	Home health – (outpatient)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
71x	Rural health clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
72x	End stage renal disease (ESRD)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
74x	Outpatient therapy	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
75x	Comp. outpatient rehab facilities	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later	FROM

See **SPLIT**, next page

SPLIT

From previous page

Bill type	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
76x	Community mental health clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
77x	Federally qualified health clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
81x	Hospice-hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

Bill type	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
82x	Hospice non-hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
85x	Critical access hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

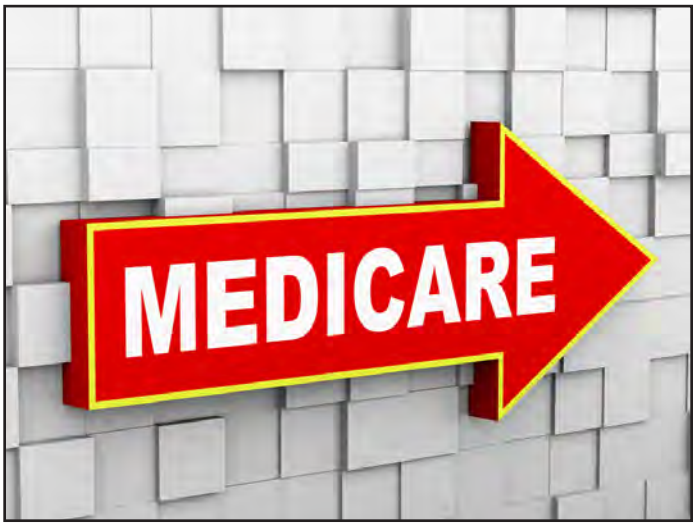
Important details

1. Please note that creating multiple/interim claims on a single encounter is not a new concept, and that these instructions will apply to relatively few claims per institution because only claims that span this single implementation date (October 1, 2015) will be impacted.

See **SPLIT**, next page

SPLIT

From previous page



2. When you split claims for an encounter spanning the ICD-10 implementation date, remember to maintain all charges with the same line item date of service (LIDOS) on the correct corresponding claim for the encounter.

- Single item services whose time-frame cross over midnight on September 30, 2015 (e.g., Emergency Room Visits and Observation), are not split into 2 separate charges, rather the single item service should be placed in the claim based upon the LIDOS: 1) For ER encounters the LIDOS is the date the patient enters the ER; and 2) for observation encounters it is the date that observation care begins.
- (Please refer to the Medicare Claims Processing Manual, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Sections 180.6 Emergency Room (ER) Services That Span Multiple Service Dates and 290.2.2 (Reporting Hours of Observation for observation services); respectively, for more information about emergency department and observation claims. You can find this manual at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*.
- If there is no service for the encounter with a LIDOS on the split claim with an October 2015 date, do not send an October 2015 claim to Medicare for payment.
- If there are services with a LIDOS on the split claim with an October date, but there is no payment allowed on any of the charges (i.e., all charges are packaged), you should maintain a log of these charges for cost reporting purposes.

Claim examples

Emergency department and observation service encounters are the most common scenarios for which CMS has received requests for clarification about interim billing. The following ED and observation service examples on the following pages are provided to help you better understand the split billing concept. This concept can be applied to any of the encounters that require split billing.

Please remember to follow the ICD-9-CM and ICD-10-CM official coding guidelines (covering both inpatient and outpatient guidelines), which you can find at *http://www.cdc.gov/nchs/icd/icd9cm.htm#addenda* and *http://www.cdc.gov/nchs/icd/icd10cm.htm*, respectively.

When coding an encounter that straddles implementation, you should use an ICD-9 code on the September interim claim for the encounter and a corresponding ICD-10 code on the October interim claim for the encounter.

You can learn more about the mapping of these codes in the *Diagnosis Code Set General Equivalence Mappings*, ICD-10-CM to ICD-9-CM and ICD-9-CM to ICD-10-CM, which is available at *http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html*.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - *How Does It Work*.

MLN Matters® Number: SE1325 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

See **SPLIT**, next page

Example 1A: ED Visit Encounter – 1st Claim

Field	Value
1	
2	
3a PAT. CNTL #	
b. MED. REC #	
4 TYPE OF BILL	0132
5. FED.TAX NO.	
6. STATEMENT COVERS PERIOD FROM	09302015
6. STATEMENT COVERS PERIOD THROUGH	09302015
7	
8 PATIENT NAME a	MEDICARE SMITH
9 PATIENT ADDRESS a	
10 BIRTHDATE	
11 SEX	
ADMISSION 12 DATE / 13 HR / 14 TYPE / 15SRC	
16 D HR	
17 STAT	30
CONDITION CODES 18–28	
29. ACDT STATE	
30.	
31–34 OCCURENCE CODE / DATE	
35–36 OCCURENCE SPAN CODE / FROM / THROUGH	
37	
38	
39–41 VALUE CODES CODE / AMOUNT (a–d)	

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250			09302015	3	50 00		
0270			09302015	3	100 00		
0324		71010	09302015	1	225 00		
0450		99283	09302015	1	750 00		
	PAGE __1__ OF __1__	CREATION DATE	10052015	TOTALS	1125 00		

ON THIS STRADDLE CLAIM, YOU WOULD PUT ALL THE CHARGES FROM THIS EMERGENCY DEPARTMENT ENCOUNTER WITH A LINE ITEM DATE OF SERVICE (LIDOS) THAT OCCURRED WITH A SEPTEMBER DATE. ICD-9 CODES (SHOWN IN YELLOW BELOW) WOULD BE DISPLAYED ON THIS PORTION OF THE CLAIM FROM THE E.D. ENCOUNTER. ANY CHARGE FROM THIS ENCOUNTER WITH A LINE ITEM DATE OF SERVICE THAT OCCURRED IN OCTOBER WOULD GO ON A SEPARATE CLAIM THAT WOULD DISPLAY ICD-10 CODES.

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
MEDICARE		Y	Y		

Field	Value
56 NPI	9876543210
57 OTHER PRV ID	

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SMITH, MEDICARE	18	123456789A		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

Field	Value
66 DX / 67 A–Q	67, A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q
68	
69 ADMIT DX	
70 PATIENT REASON DX	a, b, c
71 PPS CODE	
72 ECI	
73	
74 PRINCIPAL PROCEDURE CODE / DATE	
a.–e. OTHER PROCEDURE CODE / DATE	
75	
76 ATTENDING NPI	1234567890
76 ATTENDING LAST	WELLBY
76 ATTENDING FIRST	MARCUS
77 OPERATING NPI / QUAL / LAST / FIRST	
78 OTHER NPI / QUAL / LAST / FIRST	
78 OTHER NPI / QUAL / LAST / FIRST	
80 REMARKS	
81CC a–d	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREO

See **SPLIT**, next page

Example 1B: ED Visit Encounter – 2nd Claim

1

2

3a PAT. CNTL #

b. MED. REC #

4 TYPE OF BILL: 134

5. FED.TAX NO.

6. STATEMENT COVERS PERIOD FROM: 10012015 THROUGH: 10012015

7

8 PATIENT NAME a MEDICARE SMITH

9 PATIENT ADDRESS a

b

b c d e

10 BIRTHDATE | 11 SEX | ADMISSION 12 DATE 13 HR 14 TYPE 15SRC | 16 D HR | 17 STAT: 01 | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29. ACDT STATE | 30.

31 OCCURENCE CODE DATE | 32 OCCURENCE CODE DATE | 33 OCCURENCE CODE DATE | 34 OCCURENCE CODE DATE | 35. OCCURRENCE SPAN CODE FROM THROUGH | 36. OCCURRENCE SPAN CODE FROM THROUGH | 37

38

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

a b c d

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250			10012015	3	75 00		
0270			10012015	1	50 00		
0450		12001	10012015	1	350 00		
	PAGE _1_ OF _1_	CREATION DATE	10052015	TOTALS ⇨	475 00		

ON THIS STRADDLE CLAIM, YOU WOULD PUT ALL THE CHARGES FROM THIS EMERGENCY DEPARTMENT ENCOUNTER WITH A LINE ITEM DATE OF SERVICE (LIDOS) THAT OCCURRED WITH AN OCTOBER DATE. ICD-10 CODES (SHOWN IN YELLOW BELOW) WOULD BE DISPLAYED ON THIS PORTION OF THE CLAIM FROM THE E.D. ENCOUNTER. ANY CHARGE FROM THIS ENCOUNTER WITH A LINE ITEM DATE OF SERVICE THAT OCCURRED IN SEPTEMBER WOULD GO ON A SEPARATE CLAIM THAT WOULD DISPLAY ICD-9 CODES.

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
MEDICARE		Y	Y			9876543210

57

OTHER

PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SMITH, MEDICARE	18	123456789A		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX | 67 A B C D E F G H | 68

I J K L M N O P Q

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1234567890 QUAL

LAST WELLBY FIRST MARCUS

77 OPERATING NPI QUAL

LAST FIRST

78 OTHER NPI QUAL

LAST FIRST

78 OTHER NPI QUAL

LAST FIRST

80 REMARKS

81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform Billing Committee LIC3810506

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREO

See **SPLIT**, next page

Example 2A: Observation Encounter – 1st Claim

1 | 2 | 3a PAT. CNTL # | b. MED. REC # | 4 TYPE OF BILL: 0132

5. FED.TAX NO. | 6. STATEMENT COVERS PERIOD FROM: 09302015 THROUGH: 09302015 | 7

8 PATIENT NAME a: CMS JONES | b | 9 PATIENT ADDRESS a | b | c | d | e

10 BIRTHDATE | 11 SEX | ADMISSION 12 DATE 13 HR 14 TYPE 15SRC | 16 D HR | 17 STAT: 30 | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29. ACDT STATE | 30.

31 OCCURENCE CODE DATE | 32 OCCURENCE CODE DATE | 33 OCCURENCE CODE DATE | 34 OCCURENCE CODE DATE | 35. OCCURRENCE SPAN CODE FROM THROUGH | 36. OCCURRENCE SPAN CODE FROM THROUGH | 37

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT
a
b
c
d

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250			09302015	3	250 00		
0260		96361	09302015	1	50 00		
0270			09302015	1	100 00		
0324		71010	09302015	1	225 00		
0450		96360	09302015	1	300 00		
0450		99284 25	09302015	1	800 00		
0762		G0378	09302015	10	500 00		
	PAGE __1__ OF __1__	CREATION DATE	10052015	TOTALS	2275 00		

ON THIS STRADDLE CLAIM, YOU WOULD PUT ALL THE CHARGES FROM THIS OBSERVATION ENCOUNTER WITH A LINE ITEM DATE OF SERVICE (LIDOS) THAT OCCURRED WITH A SEPTEMBER DATE. ICD-9 CODES (SHOWN IN YELLOW BELOW) WOULD BE DISPLAYED ON THIS PORTION OF THE CLAIM FROM THE OBV. ENCOUNTER. ANY CHARGE FROM THIS ENCOUNTER WITH A LINE ITEM DATE OF SERVICE THAT OCCURRED IN OCTOBER WOULD GO ON A SEPARATE CLAIM THAT WOULD DISPLAY ICD-10 CODES.

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
MEDICARE		Y	Y			9876543210

57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
JONES, CMS	18	123456789A		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX | 67 A B C D E F G H | 68
I J K L M N O P Q

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1234567890 QUAL
LAST WELLBY FIRST MARCUS
77 OPERATING NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST
78 OTHER NPI QUAL
LAST FIRST

80 REMARKS | 81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform Billing Committee LIC3810506

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

See **SPLIT**, next page

Example 2B Observation Encounter – 2nd Claim

Field	Value
1	
2	
3a PAT. CNTL #	
b. MED. REC #	
4 TYPE OF BILL	0134
5. FED.TAX NO.	
6. STATEMENT COVERS PERIOD FROM	10012015
6. STATEMENT COVERS PERIOD THROUGH	10012015
7	
8 PATIENT NAME a	CMS JONES
9 PATIENT ADDRESS	
10 BIRTHDATE	
11 SEX	
ADMISSION 12 DATE / 13 HR / 14 TYPE / 15 SRC	
16 D HR	
17 STAT	01
CONDITION CODES 18–28	
29 ACDT STATE	
30	
31–34 OCCURENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	
39–41 VALUE CODES CODE / AMOUNT (a–d)	

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250			10012015	1	75 00		
0260		96361	10012015	9	900 00		
0324		71020	10012015	1	184 00		
	PAGE 1 OF 1	CREATION DATE	10052015	TOTALS	1159 00		

ON THIS STRADDLE CLAIM, YOU WOULD PUT ALL THE CHARGES FROM THIS OBSERVATION ENCOUNTER WITH A LINE ITEM DATE OF SERVICE (LIDOS) THAT OCCURRED WITH AN OCTOBER DATE. ICD-10 CODES (SHOWN IN YELLOW BELOW) WOULD BE DISPLAYED ON THIS PORTION OF THE CLAIM FROM THE OBV. ENCOUNTER. ANY CHARGE FROM THIS ENCOUNTER WITH A LINE ITEM DATE OF SERVICE THAT OCCURRED IN SEPTEMBER WOULD GO ON A SEPARATE CLAIM THAT WOULD DISPLAY ICD-9 CODES.

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
MEDICARE		Y	Y			9876543210

57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
JONES, CMS	18	123456789A		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX | 67 A B C D E F G H I J K L M N O P Q | 68

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

Field	NPI	QUAL	LAST	FIRST
76 ATTENDING	1234567890		WELLBY	MARCUS
77 OPERATING				
78 OTHER				
79 OTHER				

80 REMARKS | 81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform Billing Committee LIC3810506 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Medicare fee-for-service (FFS) claims processing guidance for implementing ICD-10

Note: *This article was revised on August 1, 2014, to show the new ICD-10 implementation date of October 1, 2015. While the change request may not reflect the new date, CMS has made the date change. All other information is unchanged. This article was previously published in the February 2014 edition of Medicare A Connection, Page 39-45.*

Provider types affected

This article is intended for all physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs (HH&H MACs), and durable medical equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider action needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA.

The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2015.

As a result of CR 7492 (and related *MLN Matters*® article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013, implementation date for ICD-10. This article updates MM7492 to reflect the October 1, 2015, implementation date. Make sure your billing and coding staffs are aware of these changes.

Key points of SE1408

General reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to *http://www.cms.gov/Medicare/Coding/ICD10/index.html* for more information on the format of ICD-10 codes. In addition, ICD-10 procedure codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

General claims submissions information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be returned to provider (RTP) as unprocessable.

Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2015, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes.

Medicare will RTP all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code.

Likewise, Medicare will also RTP all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim. For claims with dates of service prior to October 1, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, submit with the appropriate ICD-10 procedure code.

Remember that ICD-10 codes may only be used for services provided on or after October 1, 2015. Institutional claims containing ICD-10 codes for services prior to October 1, 2015, will be returned to provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Claims that span the ICD-10 implementation date

The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2015, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2015, and later.

See **CLAIMS**, next page

CLAIMS

From previous page

In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2015. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A – Institutional providers

Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
11x	Inpatient hospitals (incl. TERFHA hospitals, prospective payment system (PPS) hospitals, long term care hospitals (LTCHs), critical access hospitals (CAHs)	If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.	THROUGH
12x	Inpatient Part B hospital services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
13x	Outpatient hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
14x	Non-patient laboratory services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
18x	Swing beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH

See **CLAIMS**, next page

CLAIMS

From previous page

Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
21x	Skilled nursing (inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
22x	Skilled nursing facilities (inpatient Part B)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
23x	Skilled nursing facilities (outpatient)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
32x	Home health (inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.	THROUGH
3x2	Home health – request for anticipated payment (RAPs)*	* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.	*See Note

See **CLAIMS**, next page

CLAIMS

From previous page

Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
34x	Home health – (outpatient)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
71x	Rural health clinics	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
72x	End-stage renal disease (ESRD)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
73x	Federally qualified health clinics (prior to 4/1/10)	N/A – always ICD-9 code set.	N/A
74x	Outpatient therapy	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

See **CLAIMS**, next page

CLAIMS

From previous page

Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
75x	Comp. outpatient rehab facilities	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
76x	Community mental health clinics	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
77x	Federally qualified health clinics (effective 4/4/10)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
81x	Hospice-hospital	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

See **CLAIMS**, next page

CLAIMS

From previous page

Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
82x	Hospice – Non hospital	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM
83x	Hospice – hospital based	N/A	N/A
85x	Critical access hospital	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015, and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015, and later.	FROM

Table B - Special outpatient claims processing circumstances

Scenario	Claims processing requirement	Use FROM or THROUGH Date
3-day /1-day payment window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2015, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

Table C – Professional claims

Type of claim	Claims processing requirement	Use FROM or THROUGH Date
All anesthesia claims	Anesthesia procedures that begin on 9/30/2015, but end on 10/1/2015, are to be billed with ICD-9 diagnosis codes and use 9/30/2015, as both the FROM and THROUGH date.	FROM

Table D –Supplier claims

Supplier type	Claims processing requirement	Use FROM or THROUGH/TO Date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/2015, (i.e., the FROM date of service occurs prior to 10/1/2015, and the TO date of service occurs after 10/1/2015).	FROM

See **CLAIMS**, next page

Deadline for ICD-10 allows health care industry ample time to prepare for change

Deadline set for October 1, 2015

On July 31, the Department of Health & Human Services *issued a rule* finalizing October 1, 2015, as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10.

This deadline allows providers, insurance companies, and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready to go on October 1, 2015.

The ICD-10 codes on a claim are used to classify diagnoses and procedures on claims submitted to Medicare and private insurance payers. By enabling more detailed patient history coding, ICD-10 can help to better coordinate a patient's care across providers and over time. ICD-10 improves quality measurement and reporting, facilitates the detection and prevention of fraud, waste, and abuse, and leads to greater accuracy of reimbursement for medical services.

The code set's granularity will improve data capture and analytics of public health surveillance and reporting, national quality reporting, research and data analysis, and provide detailed data to enhance health care delivery.

Health care providers and specialty groups in the United States provided extensive input into the development of ICD-10, which includes more detailed codes for the conditions they treat and reflects advances in medicine and medical technology.

"ICD-10 codes will provide better support for patient care, and improve disease management, quality measurement, and analytics," said Marilyn Tavenner, Administrator of CMS. "For patients under the care of multiple providers, ICD-10 can help promote care coordination."

Using ICD-10, doctors can capture much more information, meaning they can better understand important details about the patient's health than with ICD-9-CM. Moreover, the level of detail that is provided for by ICD-10 means researchers and public health officials can better track diseases and health outcomes.

ICD-10 reflects improved diagnosis of chronic illness and identifies underlying causes, complications of disease, and conditions that contribute to the complexity of a disease. Additionally, ICD-10 captures the severity and stage of diseases such as chronic kidney disease, diabetes, and asthma.

The previous revision, ICD-9-CM, contains outdated, obsolete terms that are inconsistent with current medical practice, new technology, and preventive services.

ICD-10 represents a significant change that impacts the entire health care community. As such, much of the industry has already invested resources toward the implementation of ICD-10.

CMS has implemented a comprehensive testing approach, including end-to-end testing in 2015, to help ensure providers are ready. While many providers, including physicians, hospitals, and health plans, have completed the necessary system changes to transition to ICD-10, the time offered by Congress and this rule ensure all providers are ready.

For additional information about ICD-10, please *visit the ICD-10* website.

CLAIMS

From previous page

Additional information

You may also want to review SE1239 at *http://www.cms.gov/Outreach-andEducation/Medicare-Learning-NetworkMLN/MLNMattersArticles/Downloads/SE1239.pdf*. SE1239 announces the revised ICD-10 implementation date of October 1, 2015. You may review SE1410 at *http://www.cms.gov/Outreach-andEducation/Medicare-Learning-NetworkMLN/MLNMattersArticles/Downloads/SE1410.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-LearningNetwork-MLN/MLNMattersArticles/index.html* under - *How Does It Work*.

MLN Matters® Number: SE1408 *Revised*
Related Change Request (CR) #: 7492
Related CR Release Date: N/A
Effective Date: October 1, 2015
Related CR Transmittal #: N/A
Implementation Date: N/A

Medicare fee-for-service International Classification of Diseases, 10th Edition (ICD-10) testing approach

Note: *This article was revised on July 31, 2014, to show the new ICD-10 implementation date of October 1, 2015. In addition, the portions of the article that discuss ICD-10 acknowledgement testing and end-to-end testing are updated as a result of the new implementation date. This article was previously published in the March 2014 edition of Medicare A Connection, Page 18-19.*

Provider types affected

This article is intended for all physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health and hospice MACs (HH&H MACs), and durable medical equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider action needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which International Classification of Diseases, 10th Edition (ICD-10) codes must be used for dates of service on and after October 1, 2015. Be sure you are ready. This *MLN Matters*® special edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

Background

The implementation of ICD-10 represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2015, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing for ICD-10 to ensure that CMS as well as the FFS provider community is ready.

When "you" is used in this publication, we are referring to the FFS provider community. The four-pronged approach includes:

- CMS internal testing of its claims processing systems;
- Provider-initiated Beta testing tools;
- Acknowledgement testing; and
- End-to-end testing.

Each approach is discussed in more detail below.

CMS internal testing of its claims processing systems

CMS has a very mature and rigorous testing program for its Medicare FFS claims processing systems that supports the implementation of four quarterly releases per year. Each release is supported by a three-tiered and time-sensitive testing methodology:

- Alpha testing is performed by each FFS claims processing system maintainer for four weeks;
- Beta testing is performed by a separate integration contractor for eight weeks; and
- Acceptance testing is performed by each MAC for four weeks to ensure that local coverage requirements are met and the systems are functioning as expected.

CMS began installing and testing system changes to support ICD-10 in 2011. As of October 1, 2013, all Medicare FFS claims processing systems were ready for ICD-10 implementation. CMS continues to test its ICD-10 software changes with each quarterly release.

Provider-initiated beta testing tools

To help you prepare for ICD-10, CMS recommends that you leverage the variety of Beta versions of its software that include ICD-10 codes as well as national coverage determination (NCD) and local coverage determination (LCD) code crosswalks to test the readiness of your own systems. The following testing tools are available for download:

- NCDs and LCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at *http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html*;
- The ICD-10 Medicare Severity-Diagnosis Related Groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the General Equivalence Mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at *http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html*. On this Web page, you can also find current versions of the ICD-10-CM MS-DRG Grouper, Medicare Code Editor (available from National Technical Information Service), and *MS-DRG Definitions Manual* that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and
- A pilot version of the October 2013 Integrated Outpatient Code Editor (I/OCE) that utilizes ICD-10-CM located at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/ICD-10-IOCE-Code-Lists.pdf*. The final version of the I/OCE that utilizes ICD-10-CM is scheduled for release in the near future.

Acknowledgement testing

Providers, suppliers, billing companies, and

See **TESTING**, next page

TESTING

From previous page

clearinghouses are welcome to submit acknowledgement test claims anytime up to the October 1, 2015, implementation date. In addition, CMS will be highlighting this testing by offering three separate weeks of ICD-10 acknowledgement testing. These special acknowledgement testing weeks give submitters access to real-time help desk support and allows CMS to analyze testing data. Registration is not required for these virtual events.

All MACs and the DME MAC common electronic data interchange (CEDI) contractor will promote this ICD-10 acknowledgement testing with trading partners. This testing allows all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A) that confirms whether the submitted test claims were accepted or rejected.

MACs and CEDI will be appropriately staffed to handle increased call volume on their electronic data interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during these testing weeks. The testing weeks will occur in November 2014, March 2015, and June 2015. For more information about acknowledgement testing, refer to the information on your MAC's website.

End-to-end testing

During 2015, CMS plans to offer three separate end-to-end testing opportunities. Each opportunity will be open to a limited number of providers that volunteer for this testing. As planned, approximately 2,550 volunteer submitters will have the opportunity to participate over the course of the three testing periods. End-to-end testing includes the submission of test claims to Medicare with ICD-10 codes and the provider's receipt of a remittance advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

- Providers or submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems;
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims (based on the pricing data used for testing purposes); and
- Accurate RAs are produced.

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. Information about the volunteer registration will be available shortly. Volunteer submitters will be selected nationwide to participate in the end-to-end testing. The sample group of participants will be selected to represent a broad cross-section of provider types, claims types, and submitter types.

Additional details about the end-to-end testing process will be disseminated at a later date in a separate *MLN Matters*® article.

Claims submission alternatives

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2015, you should investigate downloading the free billing software that CMS offers via their MAC websites. The software has been updated to support ICD-10 codes and requires an internet connection.

This billing software only works for submitting FFS claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance. Alternatively, all MACs offer provider internet portals, and a subset of these MAC portals offer claims submission; providers submitting to this subset of MACs may choose to use the portal for submission of ICD-10 compliant claims. Register in the portals that offer claims submission to ensure that you have the flexibility to submit professional claims this way as a contingency. More information may be found on your MAC's website.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - *How Does It Work*.

In addition to showing the toll-free numbers, you will find your MAC's website address at this site in the event you want more information on the free billing software or the MAC's provider internet portals mentioned above.

MLN Matters® Number: SE1409 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: October 1, 2015
Related CR Transmittal #: N/A
Implementation Date: N/A

Special instructions for the ICD-10 coding on home health episodes that span October 1, 2015

Note: *This article was revised on August 1, 2014, to show the new ICD-10 implementation date of October 1, 2015. All other information is unchanged. This article was previously published in the March 2014 edition of Medicare A Connection, Page 20-21.*

Provider types affected

This *MLN Matters*® special edition article is intended for physicians, providers, suppliers, and other covered entities who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in home health (HH) care settings.

Provider action needed

Special edition (SE) 1410 alerts providers that October 1, 2015, all Medicare claims submissions of diagnosis codes will change from the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) to the 10th Edition (ICD-10-CM). All entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must make this transition requiring systems changes throughout the entire health care industry.

Background

In 2011, the Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 7492, which provided information on reporting guidelines and claims submissions requirements for ICD-10-CM. Particularly, CR 7492 provided instructions regarding claims with service dates that span the ICD-10 effective date.

Recently, CMS issued an updated article (SE1408) at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf*, which provides special billing instructions for home health agencies (HHAs) to apply to HH claims where the episode begins in August or September 2015 and ends in October 2015.

MLN Matters® article SE1408 also provides details for coding other types of claims for services that span the ICD-10 implementation date of October 1, 2015. This article provides further details regarding HH claims for episodes that span the October 1 date.

Key points of this article

Three factors affect how ICD-10-CM must be used on these episodes for services that span the October 1 date:

1. The claim "From" date (episode start date);
2. The outcome and assessment information set (OASIS) assessment completion date (OASIS item M0090 date); and
3. The claim "Through" date.

In the case of initial HH episodes, the OASIS assessment must be completed within five days of the start of care. The assessment completion date (M0090 date) determines whether the HH Grouper software that determines the payment group for the episode will apply ICD-9-CM or ICD-10-CM codes to the episode.

In the case where the episode start of care date is before October 1, 2015, and the M0090 date is also before October 1, 2015, ICD-9-CM codes will be used on the OASIS and to determine the payment group code (the health insurance prospective payment system (HIPPS) code).

Episodes starting before October 1, 2015, with OASIS completion dates before October 1, 2015

For HH claims (type of bill 032x), ICD-10-CM reporting is required based on the claim "Through" date. On requests for anticipated payment (RAPs), Medicare billing instructions require that the "From" and "Through" dates are the same. So if the episode begins in September 2015, the "From" and "Through" dates on the RAP would report the same date in September. These RAPs would report ICD-9-CM diagnosis codes using codes matching the OASIS assessment.

If the HH episode spans into October 2015, the corresponding final claim for the episode will be required to report ICD-10-CM codes. HH claims cannot be split into periods before and after October 1, 2015, so these claims will have claim "Through" dates of October 1, 2015, or later. The HIPPS code on the final claim must match the HIPPS code that was reported on the RAP. The HIPPS code on the RAP was based on the ICD-9-CM codes matching the OASIS assessment.

CR 7492 stated that CMS will: "allow HHAs to use the payment group code derived from ICD-9-CM codes on claims which span 10/1, but require those claims to be submitted using ICD-10-CM codes."

This means that HHAs do not have to re-group the episode based the ICD-10-CM codes. But this could result in some inconsistency between the HIPPS code and the ICD-10-CM codes on the claim. CMS will alert medical reviewers at our MACs to ensure that the ICD-10-CM codes on these claims are not used in making determinations. CMS will also alert researchers using CMS data files of this inconsistency. The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes that were used on the RAP and which are stored in the OASIS system.

These same procedures will apply to resumption of care assessments (M0100 = 03) and to recertification (M0100 = 04) and follow-up (M0100 = 05) assessments when the episode start date and the M0090 date on those assessments are both before October 1, 2015, but the episode ends in October 2015 (see table on next page).

See **SPAN**, next page

SPAN

From previous page

Episodes starting before October 1, 2015, with OASIS completion dates in October 2015

There may be cases where the episode start of care date is before October 1, 2015, and, due to the five-day completion window, the M0090 date is in October 2015. For example, an initial episode with a start of care date of September 28, 2015, could have an M0090 date of October 2, 2015. In these cases, ICD-10-CM codes will be used on the OASIS and to determine the HIPPS code.

The RAP for this example would have "From" and "Through" dates of September 28, 2015. As a result, these RAPs would need to report ICD-9-CM diagnosis codes even though ICD-10-CM codes were used on the OASIS assessment.

Since RAPs are not subject to medical review and are replaced in Medicare claims history by the final claim, there is no need to account for adverse impacts in these situations. The ICD-9-CM codes are required in order for the RAP to be processed. The corresponding final claim for the episode will report ICD-10-CM codes matching the OASIS assessment.

Recertification episodes beginning in the first days of October 2015

In the case of recertification episodes, the M0090 date can be up to five days earlier than the episode start date. So, a recertification episode starting on October 2, 2015, could have an M0090 date of September 28, 2015. ICD-9-CM codes are used on the OASIS assessment and will be used to determine the HIPPS code. But in this case, both the RAP and claim will require ICD-10-CM codes since the "Through" date on both will be after October 1, 2015.

The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes which are stored in the OASIS system. In these cases also, CMS will alert medical reviewers at our MACs and researchers using CMS data files to prevent adverse impacts. Table 1 at the bottom of the page summarizes the above scenarios:

Additional information

To find additional information about ICD-10, visit *http://www.cms.gov/Medicare/Coding/ICD10/index.html* The ICD-10-related implementation date is now October 1, 2015.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - *How Does It Work*.

MLN Matters® Number: SE1410 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Table 1 – Claim scenarios for home health services spanning ICD-10 implementation

Type of OASIS assessment	RAP "From/ Through" dates	OASIS M0090 date/ OASIS version	Claim "Through" date	Diagnosis coding used on OASIS	Diagnosis coding used on RAP	Diagnosis coding used on claim
Start of care/ resumption of care	9/28/2015	9/30/2015 OASIS-C	11/26/2015	ICD-9-CM	ICD-9-CM	ICD-10-CM
Recertification	9/28/2015	9/25/2015 OASIS-C	11/26/2015	ICD-9-CM	ICD-9-CM	ICD-10-CM
Start of care/ resumption of care	9/28/2015	10/2/2015 OASIS-C1	11/26/2015	ICD-10-CM	ICD-9-CM	ICD-10-CM
Recertification	10/2/2015	9/28/2015 OASIS-C	11/30/2015	ICD-9-CM	ICD-10-CM	ICD-10-CM

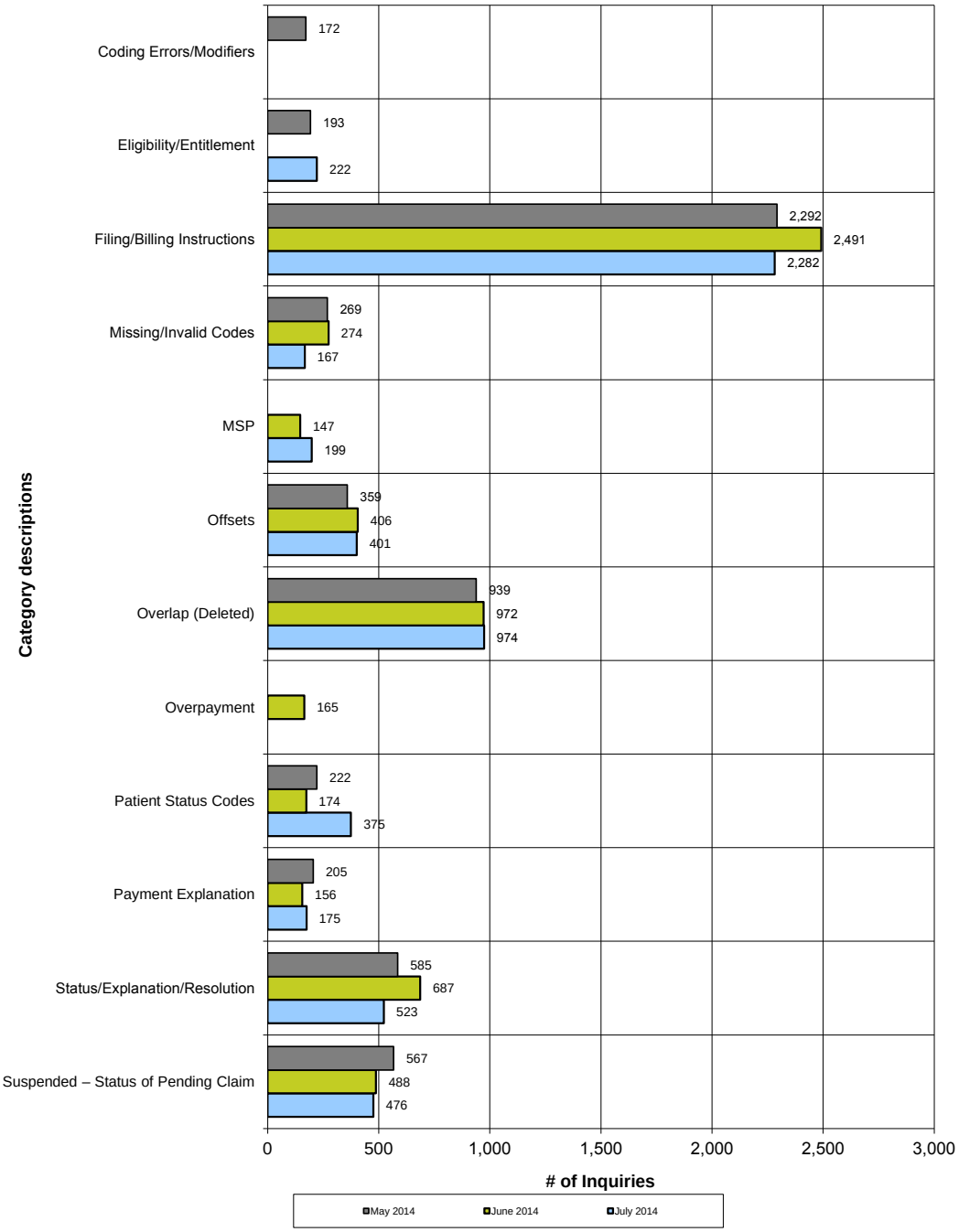
Claims and Inquiry Summary Data

Top inquiries, rejects, and return to provider claims

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 May 2014 through July 2014.

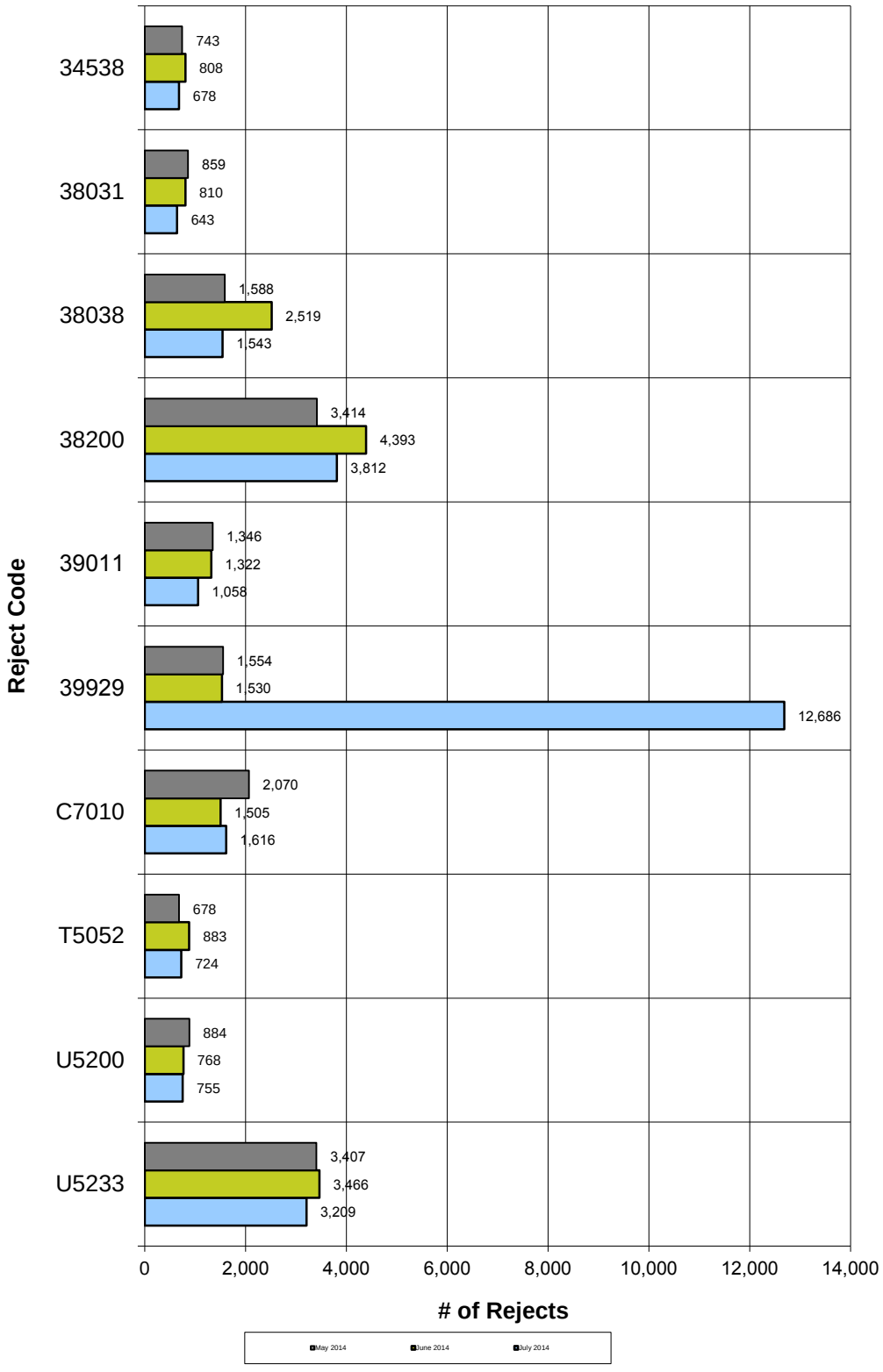
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the *Inquiries and Denials* section of our website at *http://medicare.fcso.com/Inquiries_and_denials/index.asp*.

Top inquiries for May-July 2014



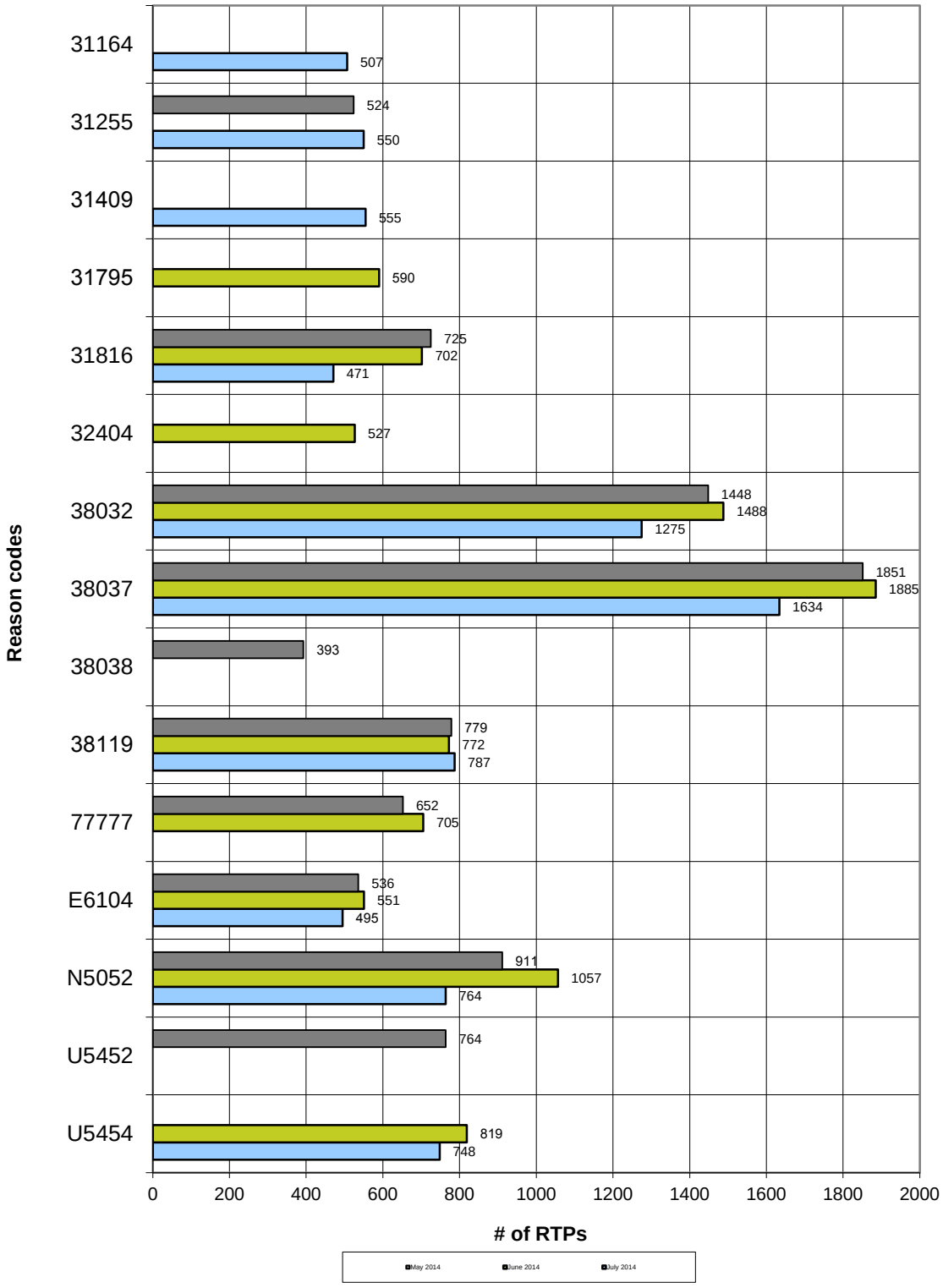
Part A top rejects for May 2014 through July 2014

Top rejects for May-July 2014



Part A top return to providers (RTPs) for May 2014 through July 2014

Top RTPs for May-July 2014



Reimbursement

Implementation of a prospective payment system for federally qualified health centers

Note: *This article was revised on July 18, 2014, to reflect the revised change request (CR) 8743 issued on July 16. In the article, the CR release date, transmittal number, and the Web address for accessing CR 8743 are updated. All other information remains the same. This article was previously published in the May 2014 edition of Medicare A Connection, Page 24-26.*

Provider types affected

Stop – impact to you

This *MLN Matters*® article is intended for federally qualified health centers (FQHCs) submitting claims to Part A Medicare administrative contractors (A MACs) for services furnished to Medicare beneficiaries.

Caution – what you need to know

CR 8743, from which this article is taken, implements the FQHC prospective payment system (PPS), effective for cost reporting periods beginning on or after October 1, 2014. This article does not apply to any FQHC claims that are not subject to the PPS. FQHCs will remain under the all-inclusive rate (AIR) system until their first cost reporting period beginning on or after October 1, 2014.

Make sure your billing staffs are aware of these new coding requirements.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) is establishing a FQHC prospective payment system (PPS) with specific payment codes that FQHCs must use in order to ensure payment.

Background

Except for services that are paid at 100 percent of costs, Medicare currently pays FQHCs 80 percent of their AIR. MACs reconcile costs and visits at year-end through cost report settlement.

In compliance with the statutory requirements of the Affordable Care Act, CMS established a national encounter-based prospective payment rate for all FQHCs, determined based on an average of the reasonable costs of all FQHCs.

FQHCs will transition to the FQHC PPS based on their cost reporting periods. For FQHCs with cost reporting periods beginning before October 1, 2014, MACs shall continue to pay the FQHCs using the current AIR system. For FQHCs with cost reporting periods beginning on or after October 1, 2014, MACs shall pay the FQHCs using the FQHC PPS.

Under the FQHC PPS, Medicare will pay FQHCs based

on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically-necessary, face-to-face FQHC visit is furnished to a Medicare beneficiary. Medicare will allow for an additional payment when an illness or injury occurs subsequent to the initial visit, or when a mental health visit is furnished on the same day as a medical visit.

The PPS rate will be adjusted when a FQHC furnishes care to a patient who is new to the FQHC or to a beneficiary receiving an initial preventive physical examination (IPPE) or an annual wellness visit (AWV). CMS is establishing specific payment codes to be used under the FQHC PPS based on descriptions of services that will correspond to the appropriate PPS rates.

The PPS rates will also be adjusted to account for geographic differences in the cost of inputs by applying FQHC geographic adjustment factors (FQHC GAFs). In calculating the total payment amount, the FQHC GAF will be based on the locality of the site where the services are furnished. For FQHC organizations with multiple sites, the FQHC GAF may vary depending on the location of the FQHC delivery site.

From October 1, 2014, through December 31, 2015, the FQHC PPS base payment rate is $158.85. Updates to the FQHC PPS base payment rate and the FQHC GAF will be made available through program instruction.

The FQHC PPS rates will be calculated as follows:

Base payment rate x FQHC GAF = PPS rate

If the patient is new to the FQHC, or the FQHC is furnishing an IPPE, initial AWV, or subsequent AWV, the PPS rate will be adjusted by 1.3416. This is a composite adjustment factor and would only be applied once per day.

See **FQHC**, next page

FQHC

From previous page

The PPS rate in this case would be calculated as follows:

Base payment rate x FQHC GAF x 1.3416 = PPS rate

To qualify for an encounter-based payment, a FQHC visit must meet all applicable coverage requirements. Additional information on the coverage requirements for FQHC visits can be found in the *Medicare Benefit Policy Manual*, Pub 100-02, Chapter 13, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf*.

FQHC specific payment codes

CMS is establishing five specific payment codes to be used by FQHCs submitting claims under the PPS:

1. G0466 – FQHC visit, new patient

A medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.

2. G0467 – FQHC visit, established patient

A medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.

3. G0468 – FQHC visit, IPPE or AWV

A FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.

4. G0469 – FQHC visit, mental health, new patient

A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

5. G0470 – FQHC visit, mental health, established patient

A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

FQHCs shall use the specific payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment, and these codes will correspond to the appropriate PPS rates. Each FQHC shall report a

charge for the FQHC visit code that would reflect the sum of regular rates charged to both beneficiaries and other paying patients for a typical bundle of services that would be furnished per diem to a Medicare beneficiary.

Basic billing requirements

When reporting an encounter/visit for payment, the claim (77x TOB) must contain a FQHC specific payment code (G0466, G0467, G0468, G0469 or G0470) that corresponds to the type of visit.

FQHC specific payment specific codes G0466, G0467 and G0468 must be reported under revenue code 052x or under revenue code 0519. **Note**: Revenue code 0519 is only used for Medicare Advantage (MA) supplemental claims.

FQHC specific payment codes G0469 and G0470 must be reported under revenue code 0900 or 0519.

FQHCs must continue to report detailed HCPCS coding on the claim to describe all services that occurred during the encounter. All service lines must be reported with their associated charges.

Payment for a FQHC encounter requires a medically necessary face-to-face visit. Each FQHC specific payment code (G0466-G0470) must have a corresponding service line with a HCPCS code that describes the qualifying visit.

See Attachment A of CR 8743 for a list of qualifying visits that correspond to the specific payment codes.

(**Note**: A link to CR 8743 is available in the *Additional information* section at the end of this article.)

When submitting a claim for a mental health visit furnished on the same day as a medical visit, FQHCs must report a specific payment code for a medical visit (G0466, G0467, or G0468) and a specific payment code for a mental health visit (G0470), and each specific payment code must be accompanied by a service line with a qualifying visit.

When submitting a claim for a subsequent illness or injury,

See **FQHC**, next page

FQHC

From previous page

FQHCs must report the appropriate specific payment code (G0467 for a medical visit or G0470 for a mental health visit) with modifier 59. Modifier 59 is the FQHC's attestation that the patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day.

Modifier 59 should only be used when reporting unrelated services that occurred at separate times during the day (e.g., the patient had left the FQHC and returned later in the day for an unscheduled visit for a condition that was not present during the first visit). **Note**: A qualifying visit is still required when reporting modifier 59 with G0467 or G0470. FQHCs must report all services that occurred on the same day on one claim.

FQHC may submit claims that span multiple days of service. However, FQHCs transitioning to the PPS must submit separate claims for services subject to the PPS and services paid based on the AIR. MACs shall reject claims with multiple dates of service that include both PPS and non-PPS dates, as determined based on the individual FQHC's cost reporting period.

Durable medical equipment (DME), laboratory services (excluding *36415*), ambulance services, hospital-based services, group services, and non-face-to-face services will be rejected.

Diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services are subject to the frequency edits described in Pub 100-04, Chapter 18, and should not be reported on the same day. FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on a FQHC claim, and these HCPCS codes will be considered informational only. MACs shall continue to pay for the influenza and pneumococcal vaccines through the cost report.

Please refer to the examples in Attachment B of CR 8743 for additional billing guidance.

Medicare payment

The total payment amount for a FQHC visit shall be the lesser of the FQHC's reported charge for the FQHC payment code or the fully adjusted FQHC PPS rate for the specific payment code. Under the FQHC PPS, MACs shall generally pay 80 percent of the lesser of the FQHC's charge for the FQHC payment code or the corresponding FQHC PPS rate. Coinsurance will generally be 20 percent of the lesser of the actual charge or the FQHC PPS rate.

Medicare waives coinsurance for certain preventive services. For FQHC claims that consist solely of preventive services that are exempt from beneficiary coinsurance, MACs shall pay 100 percent of the lesser of the provider's charge for the FQHC payment code or the FQHC PPS rate, and no beneficiary coinsurance would be assessed.

For FQHC claims that include a mix of preventive and non-preventive services, MACs shall use the lesser of the provider's charge for the specific FQHC payment code or the corresponding FQHC PPS rate to determine the total payment amount.

To determine the amount of Medicare payment and the amount of coinsurance that should be waived, MACs shall use the FQHC's reported line-item charges and subtract the dollar value of the FQHC's reported line-item charge for the preventive services from the full payment amount. (See the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 18, Section 1.2, for a table of preventive services that are exempt from beneficiary coinsurance. That manual chapter is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf*.)

Claims for Medicare Advantage (MA) supplemental payments

FQHCs that have a written contract with a MA organization that furnishes care to beneficiaries covered by the MA plan are paid by the MA organization at the rate that is specified in their contract. If the MA contract rate is less than the Medicare PPS rate, Medicare will pay the FQHC the difference, less any cost sharing amounts owed by the beneficiary.

The supplemental payment is only paid if the contracted rate is less than the fully adjusted PPS rate. To facilitate accurate payment, claims for MA supplemental payments under the FQHC PPS must include the specific payment codes that correspond to the appropriate PPS rates and the detailed HCPCS coding required for all FQHC PPS claims.

Additional information

The official instruction, CR 8743, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1395OTN.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - *How Does It Work*.

MLN Matters® Number: MM8743 *Revised*
Related Change Request (CR) #: CR 8743
Related CR Release Date: July 16, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R1395OTN
Implementation Date: October 6, 2014

Bundled payments for care improvement initiative for skilled nursing facility claims

Provider types affected

This *MLN Matters*® article is intended for skilled nursing facilities (SNFs) 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) 8792, which directs MACs to engage in provider education regarding use of a demonstration code when utilizing a waiver of the 3-day hospital stay requirement for SNF claims. Specifically, CR 8792 supports the continuing implementation of Model 2 of the Bundled Payments for Care Improvement initiative (BPCI) by informing SNFs of the policies surrounding use of the 3-day stay waiver. Make sure that your billing staffs are aware of these changes.

Background

The Affordable Care Act provides a number of new tools and resources to help improve health care and lower health care costs for all Americans. Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals, and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. Such initiatives can help improve health, improve the quality of care, and lower costs.

The Centers for Medicare & Medicaid Services (CMS) is working in partnership with providers to develop models of bundling payments through the BPCI. Section 1115A of the Social Security Act provides authority for CMS to test the BPCI models. Model 1 awardees began the period of performance on or after April 1, 2013; Models 2, 3, and 4 awardees began the period of performance on or after October 1, 2013.

The BPCI models link payments for multiple services that beneficiaries receive during an episode of care.

- Under Model 1, the episode includes the acute inpatient hospital stay for all Medicare fee-for-service (FFS) beneficiaries admitted for all Medicare severity diagnosis related groups (MS-DRGs).
- Under Models 2 - 4, CMMI has developed 48 clinical episodes of care that BPCI awardees may select to test. Each episode of care is composed of a family of anchor MS-DRGs, and each model has a different set of services included in the episode. Select clinically-unrelated readmissions are excluded from these episodes on an MS-DRG basis, and select clinically-unrelated Part B services are excluded from these episodes on a principle ICD-9 diagnosis code basis.

The following summarizes each of the models.

- In Model 1, the episode of care is defined as the acute inpatient hospital stay and includes all inpatient hospital services. Medicare pays the awardee a discounted amount based on the payment rates established under the inpatient prospective payment system (IPPS). For each performance year, the aggregate Part A and Part B expenditures on Model 1 beneficiaries in the 30-day period following discharge from the Model 1 hospitalization are calculated and compared to expected post-episode expenditures. If the aggregate Part A and Part B expenditures exceed the expected post-episode spending threshold by a calculated risk threshold, the Model 1 awardee must repay Medicare for this excess spending amount. All Model 1 awardees are acute care hospitals paid under the IPPS.
- In Model 2, the episode of care is defined as the acute inpatient hospital stay and post-acute care and includes physician and non-physician practitioner services, care by post-acute providers, related inpatient hospital readmissions, and other Medicare Part A and Part B covered services such as clinical laboratory services; durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); and Part B drugs. An admission to a Model 2 episode-initiating IPPS hospital, or to any IPPS hospital where the operating or attending physician is a member of a Model 2 episode-initiating physician group practice, that results in a discharge assigned to a selected MS-DRG initiates a BPCI Model 2 episode. The episode ends, at the awardee's selection, either 30, 60, or 90 days after discharge. Payments to providers and suppliers are made at the usual fee-for-services rates through the usual claims processing, after which on a quarterly basis, the aggregate Medicare payments for services included in the episode are reconciled against a target price. The target price is set by calculating a baseline price using provider-specific historical data

See **BUNDLED**, next page

BUNDLED

From previous page

referenced to statewide or regional data, trending that baseline price to the performance period, and then subtracting a predetermined discount percentage from that baseline.

Any reduction in expenditures beyond the discount reflected in the target price is paid to the awardee; any expenditure above the target price must be repaid to Medicare by the awardee. Awardees are also liable for any excess spending amount. Model 2 awardees can be Medicare providers or suppliers, or conveners of health care providers caring for Medicare fee-for-service beneficiaries in IPPS hospitals.

In Model 3, the episode of care is defined as post-acute care including physician and non-physician practitioner services, care by post-acute providers, related inpatient hospital readmissions, and other Medicare Part A and Part B covered services such as clinical laboratory services; DMEPOS; and Part B drugs.

The episode is initiated upon admission to or initiation of post-acute services within 30 days of discharge from an IPPS hospital for a selected MS-DRG, with the awardee's episode-initiating post-acute care provider (home health agency, skilled nursing facility, long term care hospital, or inpatient rehabilitation facility) or upon initiation of post-acute care at any post-acute care provider where the operating or attending physician for the hospitalization was a member of a Model 3 episode-initiating physician group practice.

The episode ends, at the awardee's selection, either 30, 60, or 90 days after the episode is initiated. Payments to providers and suppliers are made at the usual fee-for-services rates, through the usual claims processing, after which on a quarterly basis, the aggregate Medicare payment for the episode is reconciled against a target price. The target price is set by calculating a baseline price using provider-specific historical data referenced to statewide or regional data, trending that baseline price to the performance period, and then subtracting a predetermined discount percentage from that baseline. Any reduction in expenditures beyond the discount reflected in the target price is paid to the awardee; any expenditure above the target price must be repaid to Medicare by the awardee.

Awardees are also liable for any excess spending amount. Model 3 awardees can be Medicare providers or suppliers, or conveners of health care providers caring for Medicare fee-for-service beneficiaries receiving post-acute services.

In Model 4, the episode of care is defined as the acute inpatient hospital stay and includes inpatient hospital services, Part B services furnished during the hospitalization, and hospital and Part B services furnished during related readmissions. A single, prospectively determined bundled payment is made to the episode-initiating hospital to encompass all services furnished to all beneficiaries with the selected MS-DRG during the inpatient stay by the hospital, physicians, and non-physician practitioners. Awardees are liable for any readmissions amount, the dollar amount of the aggregate Medicare payments made for a clinically related readmission of a Model 4 beneficiary at a hospital other than the episode-initiating hospital; any opt-out physicians amount, the dollar amount of any fee-for-service payments made to physicians declining payment under Model 4 for services covered in an episode; and any excess spending amount. Awardees can be Medicare providers or suppliers, or conveners of participating health care providers.

Medicare providers that provide the initial care to beneficiaries in an episode are referred to as episode initiators. Episode initiators are generally acute care hospitals paid under the IPPS (under Models 1, 2, and 4) or SNFs, long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), and home health agencies (HHAs) (under Model 3). Note that physician group practices (PGPs) are also eligible episode initiators under Models 2 and 3.

Awardees assuming financial risk under the BPCI models have signed a participation agreement with CMS, agreeing to BPCI model payment policies and obligating the awardees to repay the Medicare trust funds any outstanding amounts owed, as determined at the end of each quarter. Single awardees are those individual Medicare providers or suppliers that assume financial risk under the model and that are the sole episode initiator. Awardee conveners are parent companies, health systems, or other organizations that assume financial risk under the model on behalf of other episode Initiators, but may or may not be episode initiators themselves.

Awardee conveners may or may not be Medicare providers/suppliers themselves. Additionally, facilitator conveners are entities that serve administrative and technical assistance functions on behalf of designated awardees (which occupy roles identical to those of single awardees) and designated awardee conveners (which occupy roles identical to those of awardee conveners).

Participants in BPCI Model 2 may qualify for a waiver

See **BUNDLED**, next page

BUNDLED

From previous page

of the Medicare payment policy requiring a three-day hospital stay prior to coverage of SNF services for a given beneficiary. Under current SNF payment policy, as a prerequisite for Part A coverage of "extended care" services in a SNF, section 1861(i) of the Social Security Act (the Act) requires a beneficiary to have a qualifying hospital stay of at least three consecutive days (counting the day of hospital admission but not the day of discharge).

For SNF claims included in an episode under Model 2, CMS may waive the three-day hospital stay requirement. This waiver is granted on a Model 2 awardee-specific basis, in response to an awardee's request to use the waiver and CMS' determination that the awardee meets all the associated requirements for waiver use.

CR 8792 supports the continuing implementation of Model 2 of the Bundled Payments for Care Improvement initiative by informing Medicare providers of the policies surrounding use of the three-day stay waiver.

For Model 2 participants who qualify for use of the waiver and are granted use by CMS, the post-hospital extended care services furnished by SNFs during a Model 2 episode of care are covered under Medicare Part A in the case of Model 2 beneficiaries who are discharged from an inpatient hospital stay of less than three days, as long as all other coverage requirements for such services are satisfied.

In order to qualify for use of the waiver, the majority of the awardee's identified SNF partners as reported to CMS must have in effect a quality rating of three or more stars under the CMS Five-Star Quality Rating System, as reported on the nursing home compare website, for at least seven out of the preceding 12 months. CMS monitors the awardee's use of this waiver to ensure that discharges to a SNF are medically appropriate and that the majority of the Model 2 beneficiaries that are discharged to a SNF after an inpatient hospital stay of less than three days are cared for at SNFs rated three-stars or better.

When submitting claims to Medicare that require a waiver of the three-day hospital stay requirement for Part A SNF coverage, SNF billing staff must enter a "62" in the treatment authorization code field. This allows MACs to appropriately pay SNFs treating beneficiaries during Model 2 episodes.

In order to determine if use of the demonstration code "62" is appropriate, the following circumstances must be met:

- The hospitalization must not meet the prerequisite hospital stay requirement of at least three consecutive days for Part A coverage of "extended care" services in a SNF. If the hospital stay would lead to covered post-acute SNF treatment in the absence of the waiver, no demonstration code should be reported by the SNF;
- Model 2 awardee (hospital, physician group practice, or awardee convener) responsible for the episode-initiating hospital or physician member of the episode-initiating physician group practice has been approved by CMS to use the three-day stay waiver for the period of time of the beneficiary's hospitalization;
- The beneficiary's discharge MS-DRG is included in a Model 2 episode selected by the episode-initiating hospital or episode-initiating physician group practice;
- The beneficiary must have been discharged from a Model 2 episode-initiating hospital or an IPPS hospital where the beneficiary was treated by a physician member of a Model 2 episode-initiating physician group practice; and
- The beneficiary must have been discharged from an IPPS hospital within 30 days of the initiation of SNF services.

Any SNF with questions about determination of the above steps should consult with the episode-initiating hospital or physician group practice to identify the Model 2 awardee that has documentation from CMS applicable to the use of the waiver for episodes during a certain performance quarter.

The policies described above are enforced through the MACs, who receive quarterly updates from CMS to ensure that use of treatment authorization code 62 is appropriate. If a SNF claim does not meet the above requirements, then there shall be no waiver of the three-day stay requirement for that SNF claim.

Additional Information

The official instruction, CR 8792, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R106DEMO.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - *How Does It Work*.

MLN Matters® Number: MM8792
Related Change Request (CR) #: CR 8792
Related CR Release Date: July 25, 2014
Effective Date: October 27, 2014
Related CR Transmittal #: R106DEMO
Implementation Date: October 27, 2014

October 2014 durable medical equipment, prosthetics, orthotics, and supplies fee schedule update

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including hospice & home health MACs, and durable medical equipment MACs (DME MACs) for DMEPOS items or services paid under the DMEPOS fee schedule.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8865 to alert providers and suppliers that CMS issued instructions updating the DMEPOS fee schedule payment amounts, effective October 1, 2014. Make sure your billing staffs are aware of these changes.

Background

CMS updates DMEPOS fee schedules on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, and apply changes in payment policies. The quarterly 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*.

Key points of CR 8865

Splints, casts, and certain intraocular lenses (IOLs)

As part of this update, the splint and cast (SC) payment category indicator will be added to the file for the following SC Healthcare Common Procedure Coding System (HCPCS) codes reflecting payment calculated in accordance with the regulations at 42 CFR, Section 414.106 for splints and casts:

A4565, Q4001, Q4002, Q4003, Q4004, Q4005, Q4006, Q4007, Q4008, Q4009, Q4010, Q4011, Q4012, Q4013, Q4014, Q4015, Q4016, Q4017, Q4018, Q4019, Q4020, Q4021, Q4022, Q4023, Q4024, Q4025, Q4026, Q4027, Q4028, Q4029, Q4030, Q4031, Q4032, Q4033, Q4034, Q4035, Q4036, Q4037, Q4038, Q4039, Q4040, Q4041, Q4042, Q4043, Q4044, Q4045, Q4046, Q4047, Q4048, Q4049

The "IL" payment category indicator will be added to the file for V2630, V2631, and V2632 HCPCS codes for IOLs inserted in a physician's office reflecting payment calculated in accordance with the IOL payment regulations at 42 CFR, Section 414.108.

You may want to review *MLN Matters*® article MM8645, "April Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule" at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8645.pdf*, which includes discussion on the establishment of national fee schedule amounts for codes for splints, casts, and IOLs.

Off-the-shelf (OTS) orthotics

Effective October 1, 2014, the following two new codes are added to the HCPCS file to describe prefabricated knee orthoses that are furnished OTS:

K0901- Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf; and

K0902- Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf.

Since these two orthotic OTS codes represent a coding explosion of the prefabricated knee orthosis codes L1843 and L1845, the fees for the above codes will be added to the DMEPOS fee schedule file and established by applying the fees for codes L1843 and L1845 to the new OTS codes K0901 and K0902, respectively.

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. at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf*.

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*.

Specific coding and pricing issues

1. This update also notifies that HCPCS codes K0734, K0735, K0736, and K0737 found in Attachment B of CR 6270, were discontinued; and
2. Cross walked to HCPCS codes E2622, E2623, E2624, and E2625, respectively, effective January 1, 2011.

See **DMEPOS**, next page

October 2014 quarterly average sales price Medicare Part B drug pricing files and revisions

Provider types affected

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

Provider action needed

Change request (CR) 8836 instructs MACs to download and implement the October 2014 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the July 2014, April 2014, January 2014, and October 2013, ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 6, 2014, with dates of service October 1, 2014, through December 31, 2014. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

The average sales price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis.

Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that are in Chapter 4, section 50, of the *Medicare Claims Processing Manual* which is available at *http://www.cms.gov/ Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*. The following table shows how the quarterly payment files will be applied:

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

Note: CMS requires physicians and other providers to bill using the appropriate HCPCS or *Current Procedural Terminology* (*CPT*®) code and to accurately report the units of service. Physicians and other providers should ensure the units billed do not exceed the maximum number of units per day based on the code descriptor, reporting instructions associated with the code, and/or other CMS local or national policy, as noted at *http://www.cms.gov/Medi care/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html*.

See **DRUGS**, next page

DMEPOS

From previous page

Billing instructions for these wheelchair seat cushion items may refer to any of these codes.

Additional information

The official instruction, CR 8865 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3011CP.pdf*.

You may review Attachment B of CR 6270 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1630CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - *How Does It Work*.

MLN Matters® Number: MM8865
Related Change Request (CR) #: CR 8865
Related CR Release Date: August 1, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R3011CP
Implementation Date: October 6, 2014

Modifying Part B claims edits related to CMS-1599-F

Provider types affected

This *MLN Matters*® article is intended for hospitals submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 8820 directs MACs to use modified fiscal intermediary shared system (FISS) overlap edits for outpatient type of bill (TOB) 013x overlapping an inpatient TOB 012x. Effective January 1, 2015, Medicare's FISS system will use modified Part B duplicate claims edit logic to bypass the duplicate claims edits of the TOB 013x and TOB 012x claims if the "Through" date of the TOB 013x is equal to the "From" date of the TOB 012x. Make sure your billing staffs are aware of these changes.

Background

When an inpatient admission is found to be not reasonable and necessary, hospitals may bill for the Part B inpatient services specified in the *Medicare Benefit Policy Manual*, Chapter 6, Section 10, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf*.

A hospital may also be paid for Part B inpatient services if it determines under Medicare's utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, and the beneficiary has already been discharged from the hospital (commonly referred to as hospital self-audit). Hospitals may bill for the Part B inpatient services specified in the *Medicare Benefit Policy Manual*, Chapter 6, Section 10, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf*.

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

Additional information

The official instruction, CR 8820, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1412OTN.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - *How Does It Work*.

MLN Matters® Number: MM8820
Related Change Request (CR) #: CR 8820
Related CR Release Date: August 1, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R1412OTN
Implementation Date: January 5, 2015

DRUGS

From previous page

Additional information

The official instruction, CR 8836, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2990CP.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: MM8836
Related Change Request (CR) #: CR 8836
Related CR Release Date: July 18, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R2990CP
Implementation Date: October 6, 2014

Hospitals

October HCPCS codes update for skilled nursing facilities

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare contractors (Medicare administrative contractors (MACs), including durable medical equipment Medicare administrative contractors (DME MACs), for services provided to Medicare beneficiaries during a skilled nursing facility (SNF) stay.

Provider action needed

Change request 8829 provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the SNF prospective payment system (PPS), effective January 1, 2014. Make sure your billing staffs are aware of these HCPCS code updates.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are excluded from the consolidated billing (CB) provision of the SNF prospective payment system (PPS).

You should note that other providers (not just SNFs) may be paid for services that are excluded from SNF PPS and CB, even for those provided to beneficiaries in a SNF stay.

However, Medicare will only pay claims from SNFs (no other providers) that are submitted to MACs (including DME MACS) for services that do not appear on the exclusion lists. Additionally, SNF CB applies to non-therapy services only when furnished to a SNF resident during a covered Part A stay; however, it applies to physical and occupational therapies, and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare systems edit for services provided to SNF beneficiaries, both included and excluded from SNF CB.

The updated lists for institutional and professional billing are available at *http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Index.htm*. The following table displays HCPCS code updates that are effective for dates of service on or after January 1, 2014.

Code	Description	Action
Q2050	Injection, doxorubicin hydrochloride, liposomal, not otherwise specified, 10mg	Add to File 1 Coding List and Add to Major Category 3.A.
G0461	Immunohistochemistry or immunocytochemistry, per specimen; first single or multiplex antibody stain	Add to File 2 Coding List
G0462	Immunohistochemistry or immunocytochemistry, per specimen; each additional single or multiplex antibody stain (list separately in addition to code for primary procedure)	Add to File 2 coding list
G0463	Hospital outpatient clinic visit for assessment and management of a patient	Exclude for outpatient bill types 13x and 85x billed with revenue code 0510
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	Terminate in major category V. A. effective 12/31/13

Note: If you bring claims to your MAC's attention, they will re-open and re-process claims (with dates of service on, or after, January 1, 2014) that have previously been denied/rejected prior to the implementation of CR 8829.

Additional information

The official instruction, CR 8829 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2991CP.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: MM8829
Related Change Request (CR) #: CR 8829
Related CR Release Date: July 18, 2014
Effective Date: January 1, 2014
Related CR Transmittal #: R2991CP
Implementation Date: October 6, 2014

October 2014 update of the hospital OPPS

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs), including home health & hospice (HH&H) MACs for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 8873 describes changes to and billing instructions for various payment policies implemented in the October 2014 hospital outpatient prospective payment system (OPPS) update. Make sure your billing staff are aware of these changes.

Background

The October 2014 integrated outpatient code editor (IOCE) and OPPS pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, status indicator (SI), and revenue code additions, changes, and deletions identified in CR 8873.

The October 2014 revisions to I/OCE data files, instructions, and specifications are provided in the October 2014 I/OCE (CR8879). The *MLN Matters*® article related to CR 8879 will be available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8879.pdf* as soon as that CR is released. Key changes to and billing instructions for various payment policies implemented in the October 2014 OPPS update are as follows:

Changes to device edits for October 2014

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

New services

The new service in Table 1 is assigned for payment under the OPPS, effective October 1, 2014.

Table 1 – New service effective October 1, 2014

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	Payment	Minimum unadjusted copayment
C9741	10/01/2014	T	0319	Impl pressure sensor w/angio	Right heart catheterization with implantation of wireless pressure sensor in the pulmonary artery, including any type of measurement, angiography, imaging supervision, interpretation, and report, includes provision of patient home electronics unit	$15,509.99	$3,102.00

Billing for drugs, biologicals, and radiopharmaceuticals

a. Drugs and biologicals with payments based on average sales price (ASP) effective October 1, 2014

In the 2014 OPPS/ASC final rule with comment period, the Centers for Medicare & Medicaid Services (CMS) stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.

See **OUTPATIENT**, next page

OUTPATIENT

From previous page

In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the October 2014 release of the OPPS pricer.

The updated payment rates, effective October 1, 2014, will be included in the October 2014 update of the OPPS Addendum A and Addendum B, which will be posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

b. Drugs and biologicals with OPPS pass-through status effective October 1, 2014

Four drugs and biologicals have been granted OPPS pass-through status effective October 1, 2014. These items, along with their descriptors and APC assignments, are identified in Table 2.

Table 2 – Drugs and biologicals with OPPS pass-through status effective October 1, 2014

HCPCS code	Long descriptor	APC	Status indicator
C9023	Injection, testosterone undecanoate, 1 mg	1487	G
C9025	Injection, ramucirumab, 5 mg	1488	G
C9026	Injection, vedolizumab, 1 mg	1489	G
C9135	Factor ix (antihemophilic factor, recombinant), Alprolix, per 10 i.u.	1486	G

c. New HCPCS codes effective October 1, 2014 for certain drugs and biologicals

Two new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biological listed in Table 2) in the hospital outpatient setting for October 1, 2014. These codes are listed in Table 3, and are effective for services furnished on or after October 1, 2014.

Table 3 – New HCPCS codes for certain drugs and biologicals effective October 1, 2014

HCPCS code	Long descriptor	APC	Status indicator effective 10/1/14
Q9972	Injection, Epoetin Beta, 1 microgram, (For ESRD On Dialysis)	N/A	E
Q9973	Injection, Epoetin Beta, 1 microgram, (Non-ESRD use)	N/A	E

d. Revised status indicator for HCPCS codes J9160 and J9300

Effective October 1, 2014, the status indicator for HCPCS codes J9160 (Injection, denileukin diftitox, 300 micrograms) and J9300 (Injection, gemtuzumab ozogamicin, 5 mg) will change from SI=K (Paid under OPPS; separate APC payment) to SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)). Table 4 includes the drugs and biologicals with revised Status Indicators.

Table 4 – Drugs and biologicals with revised status indicators

HCPCS code	Long descriptor	APC	Status indicator	Effective date
J9160	Injection, denileukin diftitox, 300 micrograms	N/A	E	10/1/2014
J9300	Injection, gemtuzumab ozogamicin, 5 mg	N/A	E	10/1/2014

e. Reassignment of one skin substitute product that was new for 2014 from the low-cost group to the high-cost group

In the 2014 OPPS/ASC final rule, CMS finalized a policy to package payment for skin substitute products into the associated skin substitute application procedure. For packaging purposes, CMS created two groups of application procedures: application procedures that use high cost skin substitute products (billed using *CPT*® codes *15271-15278*) and application procedures that use low cost skin substitute products (billed using HCPCS codes C5271-C5278).

See **OUTPATIENT**, next page

OUTPATIENT

From previous page

Assignment of skin substitute products to the high cost or low cost groups depended upon a comparison of the July 2013 payment rate for the skin substitute product to $32, which is the weighted average payment per unit for all skin substitute products using the skin substitute utilization from the 2012 claims data and the July 2013 payment rate for each product. Skin substitute products with a July 2013 payment rate that was above $32 per square centimeter are paid through the high cost group and those with a July 2013 payment rate that was at or below $32 per square centimeter are paid through the low cost group for 2014.

CMS also finalized a policy that for any new skin substitute products approved for payment during 2014, and CMS will use the $32 per square centimeter threshold to determine mapping to the high or low cost skin substitute group. Any new skin substitute products without pricing information were assigned to the low cost category until pricing information becomes available. There is now pricing information available for three of the new skin substitute products. Table 5 shows the new products and the low/high cost status based on the comparison of the price per square centimeter for the products to the $32 square centimeter threshold for 2014.

Table 5 – Revised low/high cost status for certain skin substitute codes

HCPCS code	Long descriptor	Status indicator	Low/high cost status	Effective date
Q4137	Amnioexcel or Biodexcel, per square centimeter	N	High	07/01/2014
Q4138	BioDfence DryFlex, per square centimeter	N	High	10/01/2014
Q4140	BioDfence, per square centimeter	N	High	10/01/2014

f. Updated payment rate for HCPCS J9171, Effective January 1, 2014, through March 31, 2014

The payment rate for HCPCS code J9171 was incorrect in the January 2014 OPPS Pricer. The corrected payment rate is listed in Table 6, and has been installed in the October 2014 OPPS Pricer, effective for services furnished on January 1, 2014, through March 31, 2014. Your MAC will not automatically adjust claims already processed with the incorrect rate, but they will adjust such claims that you bring to the MAC's attention.

Table 6 – Updated payment rate for HCPCS code J9171, effective January 1, 2014, through March 31, 2014

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J9171	K	0823	Docetaxel injection	$4.63	$0.93

g. Updated payment rates for certain HCPCS codes effective April 1, 2014 through June 30, 2014

The payment rate for three HCPCS codes were incorrect in the April 2014 OPPS Pricer. The corrected payment rates are listed in Table 7, and have been installed in the October 2014 OPPS Pricer, effective for services furnished on April 1, 2014 through June 30, 2014.

Your MAC will not automatically adjust claims already processed with the incorrect rates, but they will adjust such claims that you bring to the MAC's attention.

Table 7 – Updated payment rates for certain HCPCS codes Effective April 1, 2014, through June 30, 2014

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J7335	K	9268	Capsaicin 8% patch	$25.49	$5.10
J8700	K	1086	Temozolomide	$6.94	$1.39
J9171	K	1086	Docetaxel injection	$4.35	$0.87

See **OUTPATIENT**, next page

OUTPATIENT

From previous page

h. Updated payment rates for certain HCPCS codes effective July 1, 2014 through September 30, 2014

The payment rate for two HCPCS codes were incorrect in the July 2014 OPPS Pricer. The corrected payment rates are listed in Table 8, and have been installed in the October 2014 OPPS Pricer, effective for services furnished on July 1, 2014, through September 30, 2014. Your MAC will not automatically adjust claims already processed with the incorrect rate, but they will adjust such claims that you bring to the MAC's attention.

Table 8 – Updated payment rates for certain HCPCS codes effective July 1, 2014, through September 30, 2014

HCPCS code	Status indicator	APC	Short descriptor	Corrected payment rate	Corrected minimum unadjusted copayment
J9047	G	9295	Injection, carfilzomib, 1 mg	$29.67	$5.93
J9315	K	9265	Romidepsin injection	$270.24	$54.05

Incorrect unadjusted copayment for APC 0066 (Level I stereotactic radiosurgery) in the 2014 OPPS final rule

CMS incorrectly calculated the national unadjusted copayment for APC 0066 (Level I Stereotactic Radiosurgery) in the 2014 OPPS final rule. The national unadjusted copayment for APC 0066 was set to an explicit value, but it should have been set to the minimum unadjusted copayment equivalent to a coinsurance percentage of 20 percent. CMS corrected this error in the July 2014 Pricer, and CMS is making the change for the copayment associated with APC 0066 retroactive to January 1, 2014. The correct copayment is included in the July 2014 update of the OPPS Addendum A and Addendum B at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

Providers should refer to the recent edition of the *MLN Connects® Provider eNews* which instructs

1. contractors to reprocess claims, and
2. providers to reimburse beneficiaries for any overpayment of beneficiary copayment created by correcting the National Unadjusted Copayment associated with APC 0066.

You can subscribe to *MLN Connects® Provider eNews* at *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/index.html*, and you can find archived copies of the *MLN Connects Provider eNews* at *http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive.html*.

Coverage determinations

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

Additional information

The official instruction, CR 8873 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3012CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - How Does It Work.

MLN Matters® Number: MM8873
Related Change Request (CR) #: CR 8873
Related CR Release Date: August 1, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R3012CP
Implementation Date: October 6, 2014

October 2014 integrated outpatient code editor specs

Provider types affected

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

Provider action needed

Change request (CR) 8879 informs MACs about the changes to the I/OCE instructions and specifications for the I/OCE that will be utilized under the outpatient prospective payment system (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the home health prospective payment system or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes.

Background

This instruction informs MACs and the fiscal intermediary shared system (FISS) maintainer that the I/OCE is being updated for October 1, 2014.

The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, which eliminates 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. CR 8879 includes an attachment with a summary of changes for October 2014 in Appendix N of the attachment with key changes for providers in the following table:

Effective date	Modification
10/1/2014	Modify the software to maintain 28 prior quarters (7 years) of programs in each release. Remove older versions with each release. (The earliest version date included in this October 2014 release is 01/01/2008).
1/1/2008	Add code *52630* to the male-only procedure list, retroactive to the earliest version of the program.
10/1/2014	Add logic for processing claims with bill type 77x that do not contain condition code 65 under new FQHC PPS logic (see page 10 and new Appendix L).
10/1/2014	Add new values to the following output fields returned in the APC Return Buffer (see Table 7) in support of FQHC processing: a) Payment Indicator: 10 – Paid FQHC encounter payment 11 – Not paid or not included under FQHC encounter payment 12 – No additional payment, included in payment for FQHC encounter 13 – Paid FQHC encounter payment for new patient or IPPE/AWV b) Packaging Flag: 5 – Packaged as part of FQHC encounter payment 6 – Packaged preventive service as part of FQHC encounter payment, not subject to coinsurance payment c) Payment Method Flag 5 – Payment for service determined under FQHC PPS d) Line Item Action Flag 5 - Non-covered service excluded from payment under FQHC PPS e) Composite Adjustment Flag 01 – FQHC medical clinic visit 02 – FQHC mental health clinic visit 03 – Subsequent FQHC clinic visit, medical or mental health (modifier 59 reported) Note: The values defined above for Composite Adjustment flag are used only for FQHC claims with bill type 77x when CC 65 is not present.
10/1/2014	New edit 88 - FQHC payment code not reported for FQHC claim (RTP) Criteria: FQHC payment code not reported for a claim with bill type 77x and without Condition Code 65 Note: If the bill type is 770 (No payment claim), edit 88 is not applicable.
10/1/2014	New edit 89 -FQHC claim lacks required qualifying visit code (RTP) Criteria: FQHC payment code reported for FQHC claim (bill type is 77x without Condition Code 65) without a qualifying visit HCPCS.

See **SPECS**, next page

SPECS

From previous page

Effective date	Modification
10/1/2014	New edit 90 - Incorrect revenue code reported for FQHC payment code (RTP) Criteria: FQHC payment code not reported with revenue code 519, 52x or 900.
10/1/2014	New edit 91 - Item or service not covered under FQHC PPS (LIR) Criteria: A service considered to be non-covered under FQHC PPS is reported.
10/1/2014	Add edit 6 (Invalid procedure code) and edit 84 (Claim lacks required primary code) to the list of edits to be applied for FQHC PPS claims.
10/1/2014	Update Appendix F(a) OCE Edits Applied by Bill Type table, to include a new row for edits applicable for FQHC (bill type 77x) effective 10/1/2014. Modified row10 to document the previous bill type 77x applicable versions.
10/1/2014	Update Appendix E(a) Logic for Assigning Payment Method Flag Values to Status Indicators by Bill type to add new Payment Method Flag value of 5.
10/1/2014	Make HCPCS/APC/SI changes as specified by CMS (data change files).
10/1/2014	Implement version 20.3 institutional providers). of the NCCI (as modified for applicable
7/1/2014	Updated skin substitute product list (Appendix O, List E) to move Q4137 from low cost to high cost (List A to List B).
10/1/2014	Updated skin substitute product list (Appendix O, List E) to move Q4138 and Q4140 from low cost to high cost (List A to List B).
1/1/2012	Remove the deductible/coinsurance N/A flag from HCPCS code G0448, which was erroneously flagged in the program, retroactively to 1/1/2012.
10/1/2014	Add new Appendix L (FQHC Processing Logic and Flowchart) and rename OCE Overview to Appendix M, rename the Summary of Modifications to Appendix N, and rename the Code Lists to Appendix O.
10/1/2014	Create 508-compliant versions of the specifications & summary of data changes documents for publication on the CMS web site.
10/1/2014	Deliver quarterly software update & all documentation and files related to users via electronic means

Additional information

The official instruction, CR 8879 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3018CP.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* under - *How Does It Work*.

MLN Matters® Number: MM8879
Related Change Request (CR) #: CR 8879
Related CR Release Date: August 8, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R3018CP
Implementation Date: October 6, 2014

Educational Events

Provider outreach and educational events October 2014

Medicare Part A/B changes and regulations

When: Thursday, October 2
Time: 10:30 a.m. - 11:30 a.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/273174.asp

How to register for SPOT

When: Tuesday, October 14
Time: 1:00 p.m. - 2:00 p.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/273099.asp

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: August 7, 2014
  http://go.usa.gov/NmS9
- CMS MLN Connects™ Provider eNews: August 14, 2014
  http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-08-14-eNews.pdf
- CMS MLN Connects™ Provider eNews: August 21, 2014
  http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2014-08-21-eNews.pdf

First Coast Service Options Phone Numbers

***(Note:** Specific geographic contact information is noted when phone numbers and addresses are different for providers in Florida, U.S. Virgin Islands or Puerto Rico.)*

Customer service
Monday to Friday
8:00 a.m. to 4:00 p.m

888-664-4112 (FL/USVI)
877-908-8433 (Puerto Rico)
877-660-1759 (TDD-FL/USVI)
888-216-8261 (TDD-Puerto Rico)

Electronic data interchange
888-670-0940 (FL/USVI)
888-875-9779 (Puerto Rico)

Interactive Voice Response
877-602-8816

Provider education/outreach
Event registration hotline
904-791-8103

Overpayments
904-791-6281

SPOT Help Desk
FCSOSPOTHelp@fcso.com
855-416-4199

Websites
medicare.fcso.com
medicareespanol.fcso.com

First Coast Service Options Addresses

Claims/correspondence
Florida/ U.S. Virgin Islands

Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

Puerto Rico

First Coast Service Options Inc.
P.O. Box 45003
Jacksonville, FL 32232-5003

Medicare EDI
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

FOIA requests
Provider audit/reimbursement
(relative to cost reports and audits)
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)
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

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

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

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

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

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

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/Appeals
P. O. Box 45053
Jacksonville, FL 32232-5053

Redetermination (cont'd)
U.S. Virgin Islands:
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Puerto Rico
First Coast Service Options Inc.
P.O. Box 45028
Jacksonville, FL 32232-5028

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

Other Medicare carriers and intermediaries

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

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

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

Regional home health/hospice intermediary
Palmetto GBA
Medicare Part A
34650 US HWY 19N
Palm Harbor, FL 34684

Contact CMS

Centers for Medicare & Medicaid Services (CMS) (*www.cms.gov*)

Centers for Medicare & Medicaid Services, Division of Financial Management and Fee for Service Operations

ROATLFM@CMS.HHS.GOV

Office of Inspector General (OIG)
Medicare fraud hotline
800-HHS-TIPS (800-447-8477)

Medicare beneficiary customer service
1-800-MEDICARE
1-800-633-4227

Hearing and speech impaired (TDD)
1-800-754-7820