

Medicare A CONNECTION

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A Newsletter for MAC Jurisdiction N Providers

September 2014



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Influenza resources for health care professionals

Provider types affected

All health care professionals who order, refer, or provide flu vaccines and vaccine administration to Medicare beneficiaries.

What you need to know

- Keep this special edition *MLN Matters*® article and refer to it throughout the 2014-2015 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the New Year.
- Remember to immunize yourself and your staff.

Introduction

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (Medicare provides coverage of the flu

vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of Medicare's coverage of the annual flu shot. As a reminder, please help prevent the spread of flu by immunizing yourself and your staff! **Know what to do about the flu!**

Educational products for health care professionals

The *Medicare Learning Network*® (MLN®) has developed a variety of educational resources to help you understand Medicare guidelines for seasonal flu vaccines and their administration.

- **MLN Matters® article MM8890: Influenza Vaccine Payment Allowances – Annual Update for 2014-2015 Season** – <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8890.pdf>

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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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

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General Information

RESOURCES

From front page

- **Quick reference information: Medicare Part B immunization billing chart** – http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qi_immun_bill.pdf
- **Quick reference information: preventive services chart** – http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf
- **MLN preventive services educational products Web page** – <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html>
- **Preventive services educational products PDF** – http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/education_products_prevserv.pdf

Other CMS resources

- **Seasonal influenza vaccines 2014 pricing** – <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2014ASPFiles.html>
- **Immunizations Web page** – <http://www.cms.gov/Medicare/Prevention/Immunizations/index.html>
- **Prevention general information** – <http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html>
- **CMS frequently asked questions** – <http://questions.cms.gov/faq.php>
- **Medicare Benefit Policy Manual – Chapter 15, Section 50.4.4.2 – Immunizations** <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>
- **Medicare Claims Processing Manual – Chapter 18, Preventive and Screening Services** – <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf>

The following non-CMS resources are just a few of the many available in you may find useful information and tools for the 2014 – 2015 flu season:

- **Advisory Committee on Immunization Practices** – <http://www.cdc.gov/vaccines/acip/index.html>

Other sites with helpful information include:

- **Centers for Disease Control and Prevention** – <http://www.cdc.gov/flu/>
- **Flu.gov** – <http://www.flu.gov/>
- **Food and Drug Administration** – <http://www.fda.gov/>
- **Immunization Action Coalition** – <http://www.immunize.org/>

- **Indian Health Services** – <http://www.ihs.gov/>
- **National Alliance for Hispanic Health** – <http://www.hispanichealth.org/>
- **National Foundation For Infectious Diseases** – <http://www.nfid.org/influenza/>
- **National Library of Medicine/NIH Medline Plus** – <http://www.nlm.nih.gov/medlineplus/immunization.html>
- **National Network for Immunization Information** – <http://www.immunizationinfo.org/>
- **Nat'l Vaccine Program** – <http://www.hhs.gov/nvpo/>
- **Office of Disease Prevention and Health Promotion** – <http://odphp.osophs.dhhs.gov/>
- **Partnership for Prevention** – <http://www.prevent.org/>
- **World Health Organization** – <http://www.who.int/en>

Beneficiary information

For information to share with your Medicare patients, please visit <http://www.medicare.gov>

Medicare provides coverage for one seasonal influenza virus vaccine per influenza season for all Medicare beneficiaries. Medicare generally provides coverage of pneumococcal vaccination and its administration once in a lifetime for all Medicare beneficiaries; however, Medicare may cover additional pneumococcal vaccinations based on risk or uncertainty of beneficiary pneumococcal vaccination status. Medicare provides coverage for these vaccines and their administration with no co-pay or deductible.

Remember to immunize yourself and your staff. Protect yourself from the flu.

Remember – The influenza vaccine plus its administration is a covered Part B benefit. The influenza vaccine is **not** a Part D covered drug. For information on coverage and billing of flu vaccine and its administration, visit the [CMS Medicare Learning Network® Preventive Services Educational Products](#) and [CMS Immunizations Web](#) pages. While some health care professionals may offer the flu vaccine, others can help their patients locate a vaccine provider within their local community. [HealthMap Vaccine Finder](#) is a free, online service where users can search for locations offering flu vaccines.

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Specific modifiers for distinct procedural services

Provider types affected

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

Provider action needed

Stop – impact to you

New coding requirements related to Healthcare Common Procedure Coding System (HCPCS) modifier 59 could impact your reimbursement.

Caution – what you need to know

Change request (CR) 8863 notifies MACs and providers that the Centers for Medicare & Medicaid Services (CMS) is establishing four new HCPCS modifiers to define subsets of the 59 modifier, a modifier used to define a “distinct procedural service.”

Go – what you need to do

Make sure your billing staffs are aware of the coding modifier changes.”

Background

The Medicare National Correct Coding Initiative (NCCI) has procedure to procedure (PTP) edits to prevent unbundling of services, and the consequent overpayment to physicians and outpatient facilities.

The underlying principle is that the second code defines a subset of the work of the first code. Reporting the codes separately is inappropriate. Separate reporting would trigger a separate payment and would constitute double billing.

CR 8863 discusses changes to HCPCS modifier 59, a modifier which is used to define a “distinct procedural service.” Modifier 59 indicates that a code represents a service that is separate and distinct from another service with which it would usually be considered to be bundled.

The 59 modifier is the most widely used HCPCS modifier. Modifier 59 can be broadly applied. Some providers incorrectly consider it to be the “modifier to use to bypass (NCCI).” This modifier is associated with considerable abuse and high levels of manual audit activity; leading to reviews, appeals and even civil fraud and abuse cases.

The primary issue associated with the 59 modifier is that it is defined for use in a wide variety of circumstances, such as to identify:

- Different encounters;
- Different anatomic sites; and
- Distinct services.

The 59 modifier is

- Infrequently (and usually correctly) used to identify a separate encounter;
- Less commonly (and less correctly) used to define a separate anatomic site; and
- More commonly (and frequently incorrectly) used to define a distinct service.

The 59 modifier often overrides the edit in the exact circumstance for which CMS created it in the first place. CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment.

CR 8863 provides that CMS is establishing the following four new HCPCS modifiers (referred to collectively as –X{EPSU} modifiers) to define specific subsets of the 59 modifier:

- XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter, XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure,
- XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner, and
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

CMS will continue to recognize the 59 modifier, but notes that *Current Procedural Terminology*® (CPT®) instructions state that the 59 modifier should not be used when a more descriptive modifier is available.

While CMS will continue to recognize the 59 modifier in many instances, it may selectively require a more specific -X{EPSU} modifier for billing certain codes at high risk for incorrect billing. For example, a particular NCCI PTP code pair may be identified as payable only with the -XE separate encounter modifier but not the 59 or other -X{EPSU} modifiers. The -X{EPSU} modifiers are more selective versions of the 59 modifier so it would be incorrect to include both modifiers on the same line.

The combination of alternative specific modifiers with a general less specific modifier creates additional discrimination in both reporting and editing.

As a default, at this time CMS will initially accept either a 59 modifier or a more selective -X{EPSU} modifier as correct coding, although the rapid migration of providers to the more selective modifiers is encouraged.

However, please note that these modifiers are valid even before national edits are in place. MACs are not prohibited from requiring the use of selective modifiers in lieu of the general 59 modifier, when necessitated by local program integrity and compliance needs.

See **MODIFIERS**, next page

Examining the differences between a NPI and a PTAN

Note: This article was revised September 5, 2014, to add the "Where Can I Find My PTAN?" section on Page 3. All other information is the same. This information was previously published in the [May 2012 Medicare A Connection](#), pages 3-4.

Provider types affected

This *MLN Matters*® special edition article is intended for physicians, providers, and suppliers who are enrolled in Medicare.

What you need to know

This article explains the difference between a national provider identifier (NPI) and a provider transaction access number (PTAN). There are no policy changes in this article.

Background

New enrollees

All providers and suppliers who provide services and bill Medicare for services provided to Medicare beneficiaries must have an NPI. Upon application to a Medicare administrative contractor (MAC), the provider or supplier will also be issued a provider transaction access number (PTAN). While only the NPI can be submitted on claims, the PTAN is a critical number directly linked to the provider or supplier's NPI.

Revalidation

Section 6401(a) of the Affordable Care Act established a requirement for all enrolled physicians, providers, and suppliers to revalidate their enrollment information under new enrollment screening criteria.

Providers and suppliers receiving requests to revalidate their enrollment information have asked the Centers for Medicare & Medicaid Services (CMS) to clarify the differences between the NPI and the PTAN.

National provider identifier (NPI)

The NPI is a **national** standard under the Health Insurance Portability and Accountability Act (HIPAA) administrative simplification provisions.

- The NPI is a unique identification number for covered health care providers.
- The NPI is issued by the National Plan and Provider Enumeration System (NPPES).
- Covered health care providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions (for example, insurance claims) adopted under HIPAA.
- The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). The NPI does not carry information about healthcare providers, such as the state in which they live or their medical specialty. This reduces the chances of insurance fraud.
- Covered providers and suppliers must share their NPI with other suppliers and providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

Since May 23, 2008, Medicare has required that the NPI be used in place of all legacy provider identifiers, including the unique physician identification number (UPIN), as the unique identifier for all providers, and suppliers in HIPAA standard transactions. You should note that individual health care providers (including physicians who are sole proprietors) may obtain only one NPI for themselves (entity type 1 individual).

Incorporated individuals should obtain one NPI for themselves (Entity Type 1 Individual) if they are health care providers and an additional NPI(s) for their corporation(s) (entity type 2 organization). Organizations that render health care or furnish health care supplies may obtain NPIs (entity type 2 organization) for their organizations and

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MODIFIERS

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Additional information

The official instruction, CR 8863 issued to your MAC regarding this change is available at

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.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.

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PTAN

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their subparts (if applicable). For more information about the NPI, visit the NPPES website at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.

Provider transaction access number (PTAN)

A PTAN is a Medicare-only number issued to providers by MACs upon enrollment to Medicare. When a MAC approves enrollment and issues an approval letter, the letter will contain the PTAN assigned to the provider.

- The approval letter will note that the NPI must be used to bill the Medicare program and that the PTAN will be used to authenticate the provider when using MAC self-help tools such as the interactive voice response (IVR) phone system, internet portal, on-line application status, etc.
- The PTAN's use should generally be limited to the provider's contacts with their MAC.

Where can I find my PTAN?

You can find your PTAN by doing any one of the following:

1. View the letter sent by your MAC when your enrollment in Medicare was approved.
2. Log into [Internet-based PECOS](#). Click on the "My Enrollments" button and then "View Enrollments". Locate the applicable enrollment and click on the "View Medicare ID Report" link which will list all of the provider or supplier's active PTANs in one report.
3. The provider (or, in the case of an organizational provider, an authorized or delegated official) shall send a signed written request on company letterhead to your [MAC](#); include your legal name/ legal business name, national provider identifier (NPI), telephone and fax numbers.

Relationship of the NPI to the PTAN

The NPI and the PTAN are related to each other for Medicare purposes. A provider must have one NPI and will have one, or more, PTAN(s) related to it in the Medicare system, representing the provider's enrollment. If the provider has relationships with one or more medical groups or practices or with multiple Medicare contractors, separate PTANS are generally assigned.

Together, the NPI and PTAN identify the provider, or supplier in the Medicare program. CMS maintains both the NPI and PTAN in the provider enrollment chain & ownership system (PECOS), the master provider and supplier enrollment system.

Protect Your Information in PECOS

All providers and suppliers should carefully review their PECOS records in order to protect themselves and their practices from identity theft. PECOS should only contain active enrollment records that reflect current practice and group affiliations. You can review and update your PECOS records in the following ways:

- Use Internet-based PECOS: Log on to Internet-based PECOS at <https://pecos.cms.hhs.gov/pecos/login.do>.
- Use the paper CMS 855 enrollment application (i.e., 855A, 855B, 855I, 855O, 855R, or 855S).
- **Note:** The Medicare contractor may not release provider specific information to anyone other than the individual provider, authorized/delegated official of the provider organization, or the contact person. The request must be submitted in writing on the provider's letterhead and signed by the individual provider, authorized/delegated official of the organization or the contact person.

The *MLN*[®] fact sheet titled "How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)," provides guidelines and steps you can take to protect your identity while using Internet-based PECOS. This fact sheet is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_ProID_FactSheet_ICN905103.pdf.

Additional information

MLN Matters[®] special edition article SE1126 titled "Further Details on the Revalidation of Provider Enrollment Information," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf>.

"Medicare Provider–Supplier Enrollment National Educational Products," contains a list of products designed to educate Medicare fee-for-service (FFS) providers about important Medicare enrollment information, including how to use Internet-based PECOS to enroll in the Medicare program and maintain their enrollment information. This resource is available at http://www.cms.gov/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.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*.

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October 2014 healthcare provider taxonomy codes update

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 (HH&H) MACs and durable medical equipment (DME) MACs for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 8866 implements the National Uniform Claim Committee (NUCC) healthcare provider taxonomy codes (HPTC) code set that is effective on October 1, 2014, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used.

Both the current accredited standards committee (ASC) x12 837 institutional and professional technical report type three (TR3s) require the NUCC HPTC set be used to identify provider specialty information on a health care claim. The standards do not mandate the reporting of provider specialty information via a HPTC on every claim, nor for every provider to be identified by specialty.

The standard implementation guides state this information is:

- "Required when the payer's adjudication is known to be impacted by the provider taxonomy code," and
- If not required by this implementation guide, do not send."

Note: Medicare does not use HPTCs to adjudicate its claims. It would not expect to see these codes on a Medicare claim. However, currently, it validates any HPTC that a provider happens to supply against the NUCC HPTC code set.

The *Transactions and Code Sets Final Rule*, published August 17, 2000, establishes that the maintainer of the

code set determines its effective date. This rule also mandates that covered entities must use the nonmedical data code set specified in the standard implementation guide that is valid at the time the transaction is initiated. For implementation purposes, Medicare generally uses the date the transaction is received for validating a particular nonmedical data code set required in a standard transaction.

The HPTC set is maintained by the NUCC for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) website at www.wpc-edi.com/codes.

When reviewing the HPTC set online, revisions made since the last release can be identified by the color code:

- New items are green;
- Modified items are orange; and
- Inactive items are red.

Additional information

The official instruction, CR 8866 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3037CP.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: MM8866

Related Change Request (CR) #: CR 8866

Related CR Release Date: August 22, 2014

Effective Date: October 1, 2014

Related CR Transmittal #: R3037CP

Implementation Date: January 5, 2015 – If capable, MACs can implement this effective October 1, 2014.

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Revised modification to the medically unlikely edit program

Provider types affected

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

Provider action needed

Change request (CR) 8853 informs MACs about additional modifications being updated in the medically unlikely edit (MUE) program. The updates include clarifications, general processing instructions, and detailed explanations of MUE requirements and specifications. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) implemented the medically unlikely edit (MUE) program on January 1, 2007, to reduce the Medicare Part B paid claims error rate. At the onset or implementation of the MUE Program, regarding the adjudication process, the MUE value for a Healthcare Common Procedure Coding System (HCPCS) code was only adjudicated against the units of service (UOS) reported on each line of a claim. On April 1, 2013, CMS modified the MUE program so that some MUE values would be date of service edits rather than claim line edits.

At that time, CMS introduced a new data field to the MUE edit table termed “MUE adjudication indicator” or “MAI”. CMS is currently assigning a MAI to each HCPCS code. CR 8853 contains current and updated background information for these modifications, including general processing instructions.

MUEs for HCPCS codes with a MAI of “1”

MUEs for HCPCS codes with a MAI of “1” will continue to be adjudicated as a claim line edit.

MUEs for HCPCS codes with a MAI of “2”

MUEs for HCPCS codes with a MAI of “2” are absolute date of service edit. These are “per day edits based on policy”. HCPCS codes with an MAI of “2” have been rigorously reviewed and vetted within CMS and obtain this MAI designation because UOS on the same date of service (DOS) in excess of the MUE value would be considered impossible because it was contrary to statute, regulation, or sub-regulatory guidance. This sub-regulatory guidance includes clear correct coding policy that is binding on both providers and the MACs.

Limitations created by anatomical or coding limitations are incorporated in correct coding policy, both in the Health Insurance Portability & Accountability Act of 1996 (HIPAA) mandated coding descriptors and CMS approved coding guidance as well as specific guidance in CMS and



National Correct Coding Initiatives (NCCI) manuals. For example, it would be contrary to correct coding policy to report more than one unit of service for *Current Procedural Terminology*® (CPT®) 94002 “ventilation assist and management . . . initial day” because such usage could not accurately describe two initial days of management occurring on the same DOS as would be required by the code descriptor.

Note: Although the qualified independent contractors (QICs) and the administrative law judges (ALJs) are not bound by sub-regulatory guidance, they do give deference to it and are being made aware that CMS considers all edits with an MAI of 2 to be firm limits based on sub-regulatory guidance, while some MUE edits with an MAI “2” may be based directly on regulation or statute.

MUEs for HCPCS codes with a MAI of “3”

MUEs for HCPCS codes with a MAI of “3” are date of service edits. These are “per day edits based on clinical benchmarks”. If claim denials based on these edits are appealed, MACs may pay UOS in excess of the MUE value if there is adequate documentation of medical necessity of correctly reported units. If MACs have pre-payment evidence (e.g. medical review) that UOS in excess of the MUE value were actually provided, were correctly coded, and were medically necessary, the MACs may bypass the MUE for a HCPCS code with an MAI of “3” during claim processing, reopening, or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.

General processing instructions

- Since ambulatory surgical center (ASC) providers (specialty code 49) cannot report modifier 50, the MUE value used for editing will be doubled for HCPCS codes with an MAI of “2” or “3” if the bilateral surgery indicator for the HCPCS code is “1”.
- CMS will continue to set the units of service for each

See **UNLIKELY**, next page

UNLIKELY

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MUE high enough to allow for medically likely daily frequencies of services provided in most settings.

Because MUEs are based on current coding instructions and practices, MUEs are prospective edits applicable to the time period for which the edit is effective. A change in an MUE is not retroactive and has no bearing on prior services unless specifically updated with a retroactive effective date. In the unusual case of a retroactive MUE change, MACs are not expected to identify claims but should reopen impacted claims that you bring to their attention.

- Since MUEs are auto-deny edits, denials may be appealed. Appeals shall be submitted to your MAC not the NCCI/MUE contractor. MACs adjudicating an appeal for a claim denial for a HCPCS code with an MAI of “1” or “3” may pay correctly coded correctly counted medically necessary UOS in excess of the MUE value.
- Finally, a denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an advance beneficiary notice (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE. If during reopening or redetermination medical records are provided with respect to an MUE denial for an edit with an MAI of “3”, MACs will review the records to determine if the provider actually furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary.
- If the units were actually provided but one of the other conditions is not met, a change in denial reason may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under section 1862(a)(1)). This may also be true for certain edits with an MAI of “1.”

CMS interprets the notice delivery requirements under Section 1879 of the Social Security Act (the Act) as applying to situations in which a provider expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under section 1879 of the Social Security Act. Thus, ABN issuance based on an MUE is NOT appropriate.

- CMS reminds providers to report bilateral surgical procedures on a single claim line with modifier 50 and one (1) UOS. When modifier 50 is required by manual or coding instructions, claims submitted with two lines or two units and anatomic modifiers will be

denied for incorrect coding. MACs may reopen or allow resubmission of those claims in accordance with their policies and with the policy in Chapter 34, Section 10.1, of the *Medicare Claims Processing Manual* at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf>. Clerical errors (which includes minor errors and omissions) may be treated as re-openings.

- CMS encourages providers to change and resubmit their own claims where possible and to change their coding practices, but during reopening MACs may, when necessary, correct the claim to modifier 50 from an equivalent 2 units of bilateral anatomic modifiers. The original submitted version of the claim is retained in the Medicare IDR.
- CMS also reminds providers to use anatomic modifiers (e.g. RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate. Many MUEs are based on the assumption that correct modifiers are used.
- On your remittance advice, MACs will continue to use group code CO (contractual obligation), and remark codes N362 and MA01 for claims that fail the MUE edits, when the UOS on the claim exceed the MUE value, and deny the entire claim line(s) for the relevant HCPCS code.

Additional information

The official instruction, CR 8853 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1421OTN.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*.

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Related CR Transmittal #: R1421OTN
Implementation Date: January 5, 2015

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Fingerprint-based background check begins

Provider types affected

This *MLN Matters*® special edition article is intended for providers and suppliers subject to fingerprint-based background check, submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

Stop – impact to you

Fingerprint-based background checks will be required for all individuals with a five percent or greater ownership interest in a provider or supplier that falls into the high risk category and is currently enrolled in Medicare or has submitted an initial enrollment application.

Caution – what you need to know

The fingerprint-based background requirement was implemented August 6, 2014, and will be conducted in phases. Providers or suppliers will receive notification of the fingerprint requirements from their MAC. Initially, not all providers and suppliers in the “high” screening category will be a part of the first phase of the fingerprint-based background check requirement. See the *Background* section below for more details.

Go – what you need to do

If you receive notification of the fingerprint requirements, you will have 30 days from the date of the letter to be fingerprinted. Make sure that your staffs are aware of these requirements.

Background

The Centers for Medicare & Medicaid Services (CMS) awarded the fingerprint-based background check contract to Accurate Biometrics located in Chicago, Illinois July 8, 2014.

Fingerprint-based background checks will be required for all individuals with a five percent or greater ownership interest in a provider or supplier that falls into the high risk category and is currently enrolled in Medicare or has submitted an initial enrollment application. The fingerprint-based background requirement was implemented August 6, 2014, and will be conducted in phases. Initially, not all providers and suppliers in the “high” screening category will be included in the first phase of the fingerprint-based background check requirement.

Applicable providers or suppliers will receive notification of the fingerprint requirements from their MAC. The MAC will send a letter to the applicable providers or suppliers listing all five percent or greater owners who are required to be fingerprinted. The letter will be mailed to the provider or supplier’s correspondence address and the special

payments address on file with Medicare.

Generally the relevant individual will be required to be fingerprinted only once, but CMS reserves the right to request additional fingerprints if needed. The relevant individuals will have 30 days from the date of the letter to be fingerprinted.

If the provider or supplier finds a discrepancy in the ownership listing, the provider or supplier should contact their MAC immediately to communicate the discrepancy and take the appropriate action to update the enrollment record to correctly reflect the ownership information.

The relevant individuals should contact Accurate Biometrics prior to being fingerprinted to ensure the fingerprint results are accurately submitted to the Federal Bureau of Investigation (FBI) and properly returned to CMS. Accurate Biometrics may be contacted by phone (866-361-9944) or by accessing their website at www.cmsfingerprinting.com if you have any questions.



If an initial enrollment application is received by the MAC and the provider or supplier is required to obtain a fingerprint-based background check, the MAC will not begin processing the application until the fingerprint-based background check has been completed and the results are received. The effective date of enrollment will be determined by the date the fingerprint results are received.

Additional information

For more information on the fingerprint-based background check requirement, view *MLN Matters*® article SE1417, “Implementation of Fingerprint-Based Background Checks”, available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1417.pdf>.

You may also want to review MM7350 titled, “Implementation of provider enrollment provisions in CMS-6028-FC” available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7350.pdf>.

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Implementation Date: N/A

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General Coverage

Cardiac rehabilitation programs for chronic heart failure

Note: This article was revised September 4, 2014, to reflect changes to change request (CR) 8758. In the article, the transmittal numbers, the CR release date, and the Web addresses for accessing the transmittals are revised. All other information remains the same. This article was previously published in the August 2014 edition of Medicare A Connection, Page 14.

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

STOP – Impact to You

Effective for dates of service on and after February 18, 2014, Medicare covers cardiac rehabilitation services for beneficiaries with stable, chronic heart failure.

CAUTION – What You Need to Know

This article, based on 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.

GO – What You Need to Do

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 (CAR) 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>.



CR 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 CAR 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)(1)(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.

See **REHAB**, next page

Screening for hepatitis C virus in adults

Provider types affected

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

Provider action needed

Change request (CR) 8871 states, effective June 2, 2014, the Centers for Medicare & Medicaid Services (CMS) will cover screening for HCV consistent with the grade B recommendations by the United States Preventive Services Task Force (USPSTF) for the prevention or early detection of an illness or disability and is appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Part B. Make sure your billing staffs are aware of these changes.

Background

HCV is an infection that attacks the liver and is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring, called cirrhosis. A cirrhotic liver fails to perform the normal functions of the liver which leads to liver failure. Cirrhotic livers are more prone to become cancerous and liver failure leads to serious complications, even death. HCV is reported to be the leading cause of chronic hepatitis, cirrhosis, and liver cancer, and a primary indication for liver transplant in the western world.

Prior to June 2, 2014, CMS did not cover screening for HCV in adults. Pursuant to §1861(ddd) of the Social Security Act, CMS may add coverage of “additional preventive services” through the national coverage determination (NCD) process.

Effective June 2, 2014, CMS will cover screening for HCV with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests (used consistently with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations) when ordered by the beneficiary’s primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

1. Adults at high risk for HCV infection. “High risk” is defined as persons with a current or past history of illicit injection drug use, and persons who have a history of receiving a blood transfusion prior to 1992. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.
2. Adults who do not meet the high risk definition as defined above, but who were born from 1945 through 1965. A single, once-in-a-lifetime screening test is covered for these individuals.

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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/R3058CP.pdf>, the transmittal related to the *Medicare Program Integrity Manual* is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R539PI.pdf>, and the transmittal related to the *Medicare Benefit Policy Manual* is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R193BP.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>.

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Related Change Request (CR) #: CR 8758
Related CR Release Date: August 29, 2014
Effective Date: February 18, 2014
Related CR Transmittal #: R171NCD, R3058CP, R539PI, and R193BP
Implementation Date: August 18, 2014

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The determination of “high risk for HCV” is identified by the primary care physician or practitioner who assesses the patient’s history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

General claims processing requirements for claims with dates of service on and after June 2, 2014:

1. New G code G0472, short descriptor - HEP screen high risk/other and long descriptor-Hepatitis C antibody screening for individual at high risk and other covered indication(s), will be used.
2. Beneficiary coinsurance and deductibles do not apply to code G0472.
3. For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk, HCV screening is limited to once per lifetime, claims shall be submitted with:
 - HCPCS G0472
4. For those determined to be high-risk initially, claims must be submitted with:
 - HCPCS G0472
 - ICD-9 diagnosis code v69.8, other problems related to life style/ICD-10 diagnosis code Z72.89, other problems related to lifestyle (once ICD-10 is implemented)
5. Screening may occur on an annual basis if appropriate, as defined in the policy. Claims for adults at high risk who have had continued illicit injection drug use since the prior negative screening shall be submitted with:
 - HCPCS G0472,
 - ICD diagnosis code v69.8/Z72.89, and
 - ICD diagnosis code 304.91, unspecified drug dependence, continuous/F19.20, other psychoactive substance abuse, uncomplicated (once ICD-10 is implemented).

Note: Annual is defined as 11 full months must pass following the month of the last negative HCV screening.

Institutional billing requirements

Effective for claims with dates of service on and after June 2, 2014, institutional providers may use types of bill (TOB) 13x and 85x when submitting claims for HCV screening, HCPCS G0472. Medicare will deny G0472 service line-items on other TOBs using the following messages:

- Claim adjustment reason code (CARC) 170 – Payment denied when performed/billed by this type of provider.
Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- Remittance advice remarks code (RARC) N95 - This provider type/provider specialty may not bill this service.

The service is paid on the following basis:

- Outpatient hospitals – TOB 13x - based on clinical diagnostic lab fee schedule;
- Critical access hospitals (CAHs) – TOB 85x – based on reasonable cost; and
- CAH Method II – TOB 85x – based on 115 percent of the lesser of the Medicare physician fee schedule (MPFS) amount or actual charge as applicable with revenue codes 096x, 097x, or 098x.

Note: For outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.

Professional billing requirements

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCPCS G0472, only when services are submitted by the following provider specialties found on the provider’s enrollment record:

- 01 – General practice
- 08 – Family practice
- 11 – Internal medicine
- 16 – Obstetrics/gynecology
- 37 – Pediatric medicine
- 38 – Geriatric medicine
- 42 – Certified nurse midwife
- 50 – Nurse practitioner
- 89 – Certified clinical nurse specialist
- 97 – Physician assistant

Medicare will deny claims submitted for these services by providers other than the specialty types noted above. When denying such claims, Medicare will use the following messages:

- CARC 184 - The prescribing/ordering provider is not eligible to prescribe/order the service. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N574 - Our records indicate the ordering/referring provider is of a type/specialty that cannot order/refer. Please verify that the claim ordering/referring information is accurate or contact the ordering/referring provider.
- Group code CO (contractual obligation) if claim received without GZ modifier.

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCV screening, G0472, only when submitted with one of the following

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place of service (POS) codes:

- 11 – Physician's Office
- 22 – Outpatient Hospital
- 49 – Independent Clinic
- 71 – State or Local Public Health Clinic

Medicare will deny claims submitted without one of the POS codes noted above with the following messages:

- CARC 171 – Payment denied when performed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N428 – Not covered when performed in this place of service.

Other billing information for both professional and institutional claims

On both institutional and professional claims, Medicare will deny claims line-items for HCPCS G0472 with dates of service on or after June 2, 2014, where it is reported more than once in a lifetime for beneficiaries born from 1945 through 1965 and who are not high risk.

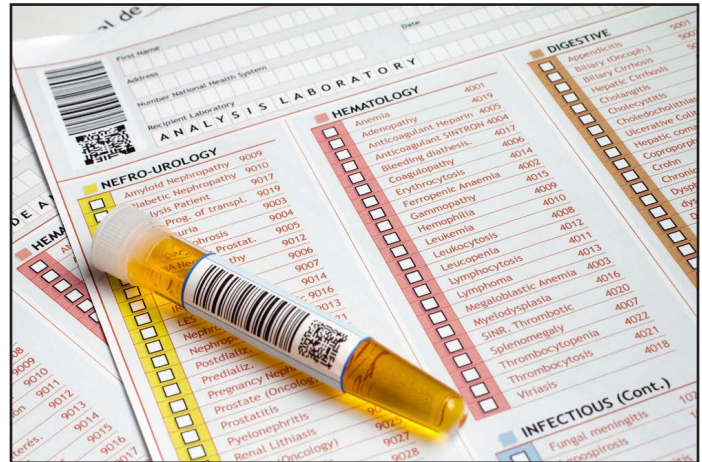
Medicare will also line-item deny when more than one HCV screening is billed for the same high-risk beneficiary prior to their annual eligibility criteria being met. In denying these claims, Medicare will use:

- CARC 119 – Benefit maximum for this time period or occurrence has been reached.
- RARC N386 – This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code – CO if claim received without GZ modifier.

When applying the annual frequency limitation, MACs will allow both a claim for a professional service and a claim for a facility fee.

In addition, remember that the initial HCV screening for beneficiaries at high risk must also contain ICD-9 diagnosis code V69.8 (ICD-10 code Z72.89 once ICD-10 is implemented). Then, for the subsequent annual screenings for high risk beneficiaries, you must include ICD-9 code V69.8 and 304.91 (ICD-10 of Z72.89 and F19.20). Failure to include the diagnosis code(s) for high risk beneficiaries will result in denial of the line item. In denying these payments, Medicare will use the following:

- CARC – This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.



- RARC N386 – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO if claim received without GZ modifier.

Additional information

The official instruction, CR 8871, was issued to your MAC regarding this change via two transmittals.

The first transmittal updates the *Medicare Claims Processing Manual* and it is available at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3063CP.pdf>. The second transmittal updates the *NCD Manual*. It is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R174NCD.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: MM8871

Related Change Request (CR) #: CR 8871

Related CR Release Date: September 5, 2014

Effective Date: June 2, 2014

Related CR Transmittal #: R3063CP and R174NCD

Implementation Date: January 5, 2015

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Ventricular assist devices for bridge-to-transplant and destination therapy

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8803 which instructs that, effective for claims with dates of service on and after October 30, 2013, the Centers for Medicare & Medicaid Services (CMS) is modifying the criteria for coverage of ventricular assist devices (VADs) as bridge-to-transplant (BTT) and is modifying the facility criteria for coverage as destination therapy (DT). Make sure your billing staffs are aware of these changes.

Background

CR 8803 states that Medicare covers VADs for the following three general indications:

1. Postcardiotomy – Postcardiotomy refers to the placement of VADs following open-heart surgery.
2. Bridge-to-transplantation (BTT) – Coverage for BTT is restricted to patients listed for heart transplantation; and,
3. Destination therapy (DT) – Coverage for DT is restricted to patients who are not candidates for heart transplantation, require mechanical cardiac support, and who meet specific clinical criteria.

Note: VADs implanted as DT are only covered when implanted in a facility that is approved by CMS to provide this procedure.

Effective for claims with dates of service on and after October 30, 2013, CMS has determined that the evidence is adequate to conclude that VAD implantation is reasonable and necessary with the following modifications to current CMS policy at 20.9.1:

- **VADs for BTT:** CMS clearly identifies that the patient must be active on the wait list maintained by the Organ Procurement and Transplantation Network and removes the general time requirement that patients receive a transplant as soon as medically reasonable.
- **VADs for DT:** CMS expands the credentialing requirement to allow credentialing by other organizations approved by Medicare and include requirements for a multidisciplinary team. CMS removes mandatory participation in the INTERMACS registry, but encourages facilities to track patient outcomes.

Note that coverage for items and services under the Social Security Act (the Act) (Section 1862(a)(1)(A); see http://www.ssa.gov/OP_Home/ssact/title18/1862.htm) in these situations will be made by your MAC within its jurisdiction.

CR 8803 revises the *Medicare National Coverage Determinations (NCD) Manual* (Chapter 1) by revising Section 20.9 (Artificial Hearts and Related Devices) and adding a new Sub-section (20.9.1) titled 'Ventricular Assist Devices.'

CR 8803 also revises the *Medicare Claims Processing Manual* (Chapter 32, Section 320 (Artificial Hearts and Related Devices)). ICD-10 codes related to these services are included in this manual update. The revised portions of these two manuals are available as attachments to CR 8803.

All other indications for the use of VADs not otherwise listed remain non-covered, except in the context of Category B investigational device exemption clinical trials (42 CFR 405) or as a routine cost in clinical trials defined under Section 310.1 of the *NCD Manual*.

This policy does not address coverage of VADs for right ventricular support, biventricular support, use in beneficiaries under the age of 18, use in beneficiaries with complex congenital heart disease, or use in beneficiaries with acute heart failure without a history of chronic heart failure. Coverage under Section 1862(a)(1)(A) of the Act for VADs in these situations will be made by your MAC.

Additional information

The official instruction, CR 8803, consists of two transmittals issued to your MAC. The first transmittal updates the *NCD Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R172NCD.pdf>.

The second transmittal updates the *Medicare Claims Processing Manual* and is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3054CP.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: MM8803
Related Change Request (CR) #: CR 8803
Related CR Release Date: August 29, 2014
Effective Date: October 30, 2013
Related CR Transmittal #: R172NCD and R3054CP
Implementation Date: September 30, 2014

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New manual correction for extracorporeal photopheresis

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8808 which clarifies certain requirements for providers that are effective for claims with dates of service on or after April 30, 2012, the Centers for Medicare & Medicaid Services (CMS) covers extracorporeal photopheresis for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation only when provided under a clinical research study that meets specific requirements to assess the effect of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation. Make sure your billing staffs are aware of the changes.

Background

CR 8808 reformats language in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 32, Section 190, to make instructions clearer and to avoid misinterpretation.

Additionally, ICD-9 diagnosis code 996.88 (complications of transplanted organ, stem cell) and ICD-10 diagnosis code T86.5 (complications of stem cell transplant) are added for correctness and to align with coding implemented in CR 8197, TR1199, dated March 14, 2013, and effective and implemented July 1, 2013. An article related to CR 8197 is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8197.pdf>.

Accordingly, Chapter 32, Section 190.3, of the *Medicare Claims Processing Manual* is reformatted to clearly state that:

- Medicare coverage for extracorporeal photopheresis is restricted to the inpatient or outpatient hospital settings specifically for BOS, and not for the other covered diagnosis (including chronic graft versus hosts disease) which remain covered in the hospital inpatient, hospital outpatient, and non-facility (physician-directed clinic or office settings) settings.
- MACs will deny claims for extracorporeal photopheresis for BOS when the service is not rendered to an inpatient or outpatient setting of a hospital, including critical access hospitals using the following codes:
 - Claim adjustment reason code (CARC) 96 – Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification

Segment (loop 2110 Service Payment Information REF), if present;

- CARC 171 – Payment is denied when performed/ billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;
- Remittance advice remark code (RARC) N428 – Not covered when performed in this place of service. (A/MACs only) ; and
- Group code CO (contractual obligations) or PR (Patient Responsibility) dependent on liability.
- MACs will return to provider/return as unprocessable claims for BOS containing HCPCS procedure code 36522 along with one of the following ICD-9-CM diagnosis codes: 996.84, 491.9, 491.20, 491.21, and 496 but is missing diagnosis code V70.7 (as primary/ secondary diagnosis, institutional only), condition code 30 (institutional claims only), clinical trial modifier Q0/ Q1, and value code D4 with an 8-digit clinical trial identifier number (A/MACs only). In doing so, MACs will use the following messages:
 - CARC 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
 - RARC N517 – Resubmit a new claim with the requested information.

Additional information

The official instruction, CR 8808, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Transmittals/Downloads/R3050CP.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: MM8808
 Related Change Request (CR) #: CR 8808
 Related CR Release Date: August 22, 2014
 Effective Date: September 23, 2014
 Related CR Transmittal #: R3050CP
 Implementation Date: September 23, 2014

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Intravenous immune globulin demonstration - implementation

Note: This article was revised August 28, 2014, to amend some of the billing instructions, particularly with regard to date of service on the Q2052 claim line. Also, some questions and answers related to supplier eligibility are added to the article. This article was previously published in the [August 2014 edition of Medicare A Connection](#), Page 9-11.

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.

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 October 1, 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.

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

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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 (has 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 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 "(as updated by CR 8724)" 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: Priven, (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.

Note: 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. In cases where the drug is mailed or delivered to the patient prior to administration, the date of service for the administration of the drug (the "Q2052" claim line) may be no more than 30 calendar days after the date of service on the drug claim line.

If multiple administrations of IVIG are submitted on a single claim, each date of service for the administration of the drug (Q2052) 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

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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.

Questions and answers relating to supplier eligibility

Question: Is the DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies) Supplier required to be certified to bill the A/B MACs in order to provide the nursing component of the Q2052 - services, supplies and accessories used in the home under the Medicare intravenous immune globulin (IVIG) demonstration?"

Answer: No. The DMEPOS supplier must currently be able to bill the DME MACs (enrolled and current with the national supplier clearinghouse) and meet all regulatory and statutory requirements. If a state requires licensure to furnish certain items or services, a DMEPOS supplier: Must be licensed to provide the item or service; and may contract with a licensed individual or other entity to provide the licensed services unless expressly prohibited by state law. A supplier may not contract with any entity that is currently excluded from the Medicare program, any state health care programs or from any other federal procurement or non-procurement programs.

Question: Can the supplier/pharmacy contract or subcontract nursing services for the administration of the IVIG to bill the Q2052 - services, supplies and accessories used in the home under the Medicare intravenous immune globulin (IVIG) demonstration?

Answer: Yes. If a state requires licensure to furnish certain items or services, a supplier/pharmacy: Must be licensed to provide the item or service; and may contract with a licensed individual or other entity to provide the licensed services unless expressly prohibited by state law.

A supplier may not contract with any entity that is currently excluded from the Medicare program, any state health care programs, or from any other federal procurement or non-procurement programs.

How beneficiaries 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 September 12, 2014, to be considered.

Incomplete applications will be returned to the beneficiary and will not be reviewed. Beneficiaries will be notified by September 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 September 12, 2014, deadline on a rolling basis until enrollment and/or funding limits are reached.

The enrollment application and the application completion guide are available at <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

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CMS updates NCD manual to reflect ICD-10 transition

Note: This article was revised September 8, 2014, to reflect the revised change request (CR) 8506 issued September 4. The CR release date, effective and implementation dates, transmittal number, and the Web address for accessing the CR are revised. All other information is unchanged. This article was previously published in the February 2014 edition of Medicare A Connection, Page 23.

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8506 as an informational alert to providers that language-only changes—updates to the *Medicare National Coverage Determinations (NCD) Manual*, Pub 100-03—were made.

The changes were made to comply with:

1. Conversion from ICD-9 to ICD-10;
2. Conversion from ASC x12 version 4010 to version 5010;
3. Conversion of former contractor types to MACs; and,
4. Other miscellaneous editorial and formatting updates provided for better clarity, correctness, and consistency.

Update to preventive services provided in health centers

In response to several recent inquiries, the Centers for Medicare & Medicaid Services (CMS) has determined that the screening pelvic and clinical breast examination, Healthcare Common Procedure Coding System (HCPCS) code G0101, is a billable visit when furnished by a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner to a RHC or FQHC patient.

Note: The edits made to the *NCD Manual* are technical/editorial only and in no way alter existing NCD policies.

Background

These edits to *Pub. 100-03* are part of a CMS-wide initiative to update its manuals and bring them in line with recently released instructions regarding the above-noted subject matter.

Additional information

The official instruction, CR 8488 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R173NCD.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: MM8506 Revised
Related Change Request (CR) #: CR 8506
Related CR Release Date: September 4, 2014
Effective Date: Upon ICD-10 Implementation
Related CR Transmittal #: R173NCD
Implementation Date: Upon ICD-10 Implementation

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To avoid delays in payment until the system is updated, providers should follow the guidance in the preventive services chart on the [RHC](#) or [FQHC](#) center pages.

Submit adjustments for any claims with G0101, rejected on or after January 1, 2014, to your Medicare administrative contractor, using this billing guidance.

[illegible]

- **Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an advance beneficiary notification (ABN) signed by the beneficiary.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

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

New LCDs

CYP2C19, CYP2D6, CYP2C9, and VKORC1 genetic testing – new LCD

LCD ID number: L35366
(Florida/Puerto Rico/U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) via the coverage and analysis department has facilitated a national contractor medical director collaboration workgroup known as, “The local coverage determination (LCD) writers.”

The workgroup includes medical directors from all of the A/B Medicare administrative contractors (MACs). One of the goals of all MACs is collaboration with other contractors and consensus LCDs is one outcome of this collaboration. In most cases, the contractor medical directors worked with the relevant specialty physicians in developing certain consensus draft LCDs.

When a consensus draft LCD is adopted by a contractor, there is no major change to the LCD development process, which includes a 45-day comment period, the finalization of the draft based on comments received from physicians representing their society and/or any stakeholder in the community, and a 45-day notice period. The finalized LCD remains the local contractor’s discretion and responsibility.

This LCD limits CYP2C19 [*Current Procedural Terminology (CPT®) 81225*] and CYP2D6 (*CPT® 81226*) genetic testing to defined indications. All other testing for CYP2C19 and CYP2D6 is non-covered until definitive clinical utility is established to justify coverage. The LCD also non-covers CYP2C9 (*CPT® 81227*) and VKORC1 (*CPT® 81355*) genetic testing for all medications as not reasonable and necessary under §1862(a)(1)(A). The available literature

does not support that CYP2C9 and VKORC1 testing for drug responsiveness, improves health outcomes in Medicare beneficiaries.

This policy is not addressing coverage with evidence development (CED) under section 1862(a)(1)(E). CYP2C9 and VKORC1 when performed for CED for warfarin responsiveness [Healthcare Common Procedure Coding System (HCPCS) code G9143]] will be covered when provided in accordance to the coverage limitations of the national coverage determination (NCD) for Pharmacogenomic Testing for Warfarin Response. For CED coverage please make reference to NCD 90.1 and the coding article related to this LCD

This new LCD has been developed to outline indications and limitations of coverage and/or medical necessity, *CPT®* codes, and ICD-9-CM diagnosis codes for CYP2C19, CYP2D6, CYP2C9, and VKORC1.

Effective date

This new LCD is effective for services rendered **on or after November 03, 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.

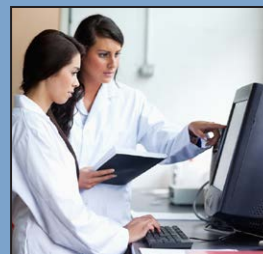
Note: To review active, future, and retired LCDs, please [click here](#).

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 array of training opportunities.



Revised LCDs

Low density lipoprotein (LDL) apheresis – revision to the Part A LCD

LCD ID number L33000
(Florida, Puerto Rico, U.S. Virgin Islands)

The local coverage determination (LCD) for low density lipoprotein (LDL) apheresis became effective on February 4, 2013. At that time, data analysis by the Program Safeguards Communication Group (PSCG) identified that the utilization of *Current Procedural Terminology*® (CPT®) code 36516 (therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion) had steadily increased since 2008.

Medicare Part B data analysis obtained for the second half of 2013 indicated a significant increase in carrier to nation ratio at nearly 800 percent above the national average. Due to the risk for a high dollar claim payment error, this LCD has been revised to address the limited indications

for this service and establish frequency parameters in the utilization guidelines section for LDL apheresis.

Effective date

This LCD revision is effective for services rendered **on or after November 3, 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](#).

Colorectal Cancer Screening – revision to the Part A LCD

LCD ID number L28803 (Florida)
LCD ID number L28805 (Puerto Rico, U.S. Virgin Islands)

The local coverage determination (LCD) for colorectal cancer screening has been revised to add diagnosis codes v76.41 (Special screening for malignant neoplasms, rectum) and v76.51 (Special screening for malignant neoplasms, colon) under the “ICD-9 Codes that Support Medical Necessity” section of the LCD for HCPCS codes G0105 (Colorectal cancer screening; colonoscopy on individual at high risk) and G0120 (Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema).

Effective date

This LCD revision is effective for claims processed **on or after September 10, 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](#).

Docetaxel (Taxotere®) – revision to the Part A LCD

LCD ID number: L28825 (Florida)
LCD ID number: L28858 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for docetaxel (taxotere®) was revised to include the off-label indication of endometrial carcinoma. The “Indications and Limitations of Coverage and /or Medical Necessity” section of the LCD was revised to include this off-label indication, and the “ICD-9 Codes that Support Medical Necessity” section was updated to add the correlating diagnosis code 182.0. In addition, the “Sources of Information and Basis for Decision” section was updated.

Effective date

This LCD revision is effective for services rendered **on or after September 24, 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](#).

Noncovered services – revision to the Part A LCD

LCD ID number: L28991 (Florida)

LCD ID number: L29023

(Puerto Rico/U.S. Virgin Islands)

Based on change request (CR) 8757 [Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)], the local coverage determination (LCD) for noncovered services was revised to remove *Current Procedural Terminology (CPT®)* code 0275T from the “CPT®/HCPCS Codes-Procedures” section of the LCD.

As stated in CR 8757, effective for services performed on or after January 09, 2014, the Centers for Medicare & Medicaid Services (CMS) has determined that PILD will be covered by Medicare when provided in a clinical study under section 1862(a)(1)(E) through coverage with evidence development (CED) for beneficiaries with LSS who are enrolled in an approved clinical study that meets the criteria outlined in National Coverage Determination (NCD) 150.13 (Percutaneous-image-guided lumbar decompression for lumbar spinal stenosis).

This LCD revision is effective for claims processed **on or after October 06, 2014**, for services rendered **on or after January 09, 2014**.

In addition, the following CPT®/HCPCS codes were evaluated and determined not to meet the Medicare reasonable and necessary threshold for coverage. Therefore, 81504, C9739, and C9740 have been added to the “CPT®/HCPCS-codes” section of the LCD. Any denied claim would have Medicare’s appeal rights. The second level of appeal (qualified independent contractor) requires review by a clinician to uphold any denial. Providers should submit for review all the relevant medical documentation and case specific information of merit and/or new information in the public domain.

Any interested stakeholder can request a reconsideration of an LCD after the notice period has ended and this revision becomes effective. Please refer to the attached article at the bottom of the noncovered services LCD



which includes a list of the articles and related information that were addressed by the medical policy department in making the noncoverage determination.

If the stakeholder has new information based on the evaluation of the list, LCD reconsideration can be initiated. It is the responsibility of the interested stakeholder to submit the additional articles, data, and related information in support of their request for coverage. The request must meet the LCD reconsideration requirements outlined on the web site.

Effective date

This LCD revision is effective for services rendered **on or after November 03, 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](#).



Puzzled about your enrollment status?

Put the pieces together using the enrollment status lookup. View all active applications, specific applications, and confirm if you have been sent a revalidation request at <http://medicare.fcso.com/Enrollment/PEStatus.asp>

Electronic Data Interchange

Update on the uniform use of CARCs and RARCs

Provider types affected

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

Provider action needed

Change request (CR) 8838 deals with the regular update in Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of CARCs and RARCs (835) Rule. CAQH CORE will publish the next version of the code combination list on or about October 1, 2014.

This update is based on July 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.

Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014 under the Patient Protection and Affordable Care Act of 2010.

The Health Insurance Portability and Accountability Act of 1996 (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.

More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to electronic data interchange (EDI) from paper has been slow and disappointing.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions.

This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.



Note: Per 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 8838 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3038CP.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: MM8838
Related Change Request (CR) #: CR 8838
Related CR Release Date: August 22, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3038CP
Implementation Date: January 5, 2015

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ICD-10 testing - acknowledgement testing with providers

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 (HH&H) MACs and durable medical equipment (DME) MACs, for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 8858 instructs MACs to promote three specific acknowledgement testing weeks with providers, and provide data and statistics to the Centers for Medicare & Medicaid Services (CMS) to demonstrate readiness for the International Classification for Disease, 10th Edition Clinical Modification (ICD-10) transition. Make sure that your billing staffs are aware of these ICD-10 testing opportunities.

Background

The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing ICD-10. All covered entities must be fully compliant on October 1, 2015.

CR 8858 instructs all MACs and the DME MAC common electronic data interchange (CEDI) contractor to promote ICD-10 acknowledgement testing with trading partners during three separate testing weeks, and to collect data about the testing. These testing weeks will be:

- November 17 – 21, 2014
- March 2 – 6, 2015
- June 1 – 5, 2015

The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing standards during the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 5010 implementation.

While submitters may acknowledgement test ICD-10 claims at any time through implementation, the ICD-10 testing weeks have been created to generate awareness and interest, and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

These testing weeks will allow trading partner's access to MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on the CMS website, the CEDI website and each MAC's website.

Key points of the testing process for CR 8858

- Test claims with ICD-10 codes must be submitted with

current dates of service since testing does not support future dates of service.

- Claims will be subject to existing national provider identifier (NPI) validation edits.
- MACs and CEDI will be staffed to handle increased call volume during this week.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected by Medicare.
- Test claims will be subject to all existing EDI front-end edits, including submitter authentication and NPI validation. Testing will not confirm claim payment or produce a remittance advice.



- 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 this week.

Your MAC will announce and promote these testing weeks via their listserv messages and their website.

Additional information

The official instruction, CR 8858 issued to your MAC is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1423OTN.pdf>.

The EDI help desk numbers for institutional claim submitters are available at <http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/EDIHelplinePartA.pdf> and the numbers for professional claims submitters are available at <http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/EDIHelplinePartB.pdf>.

MLN Matters® Number: MM8858

Related Change Request (CR) #: CR 8858

Related CR Release Date: August 22, 2014

Effective Date: 30 Days from Issuance (See test dates)

Related CR Transmittal #: R1423OTN

Implementation Date: November 17 through 21, 2014, for the November Testing Week; March 2 through 6, 2015 for the March Testing Week; June 1 through 5, 2015, for the June Testing Week.

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Scenarios and coding instructions for submitting requests to reopen claims electronically

Note: This article was revised September 3, 2014, to reflect a new change request (CR). The revised CR corrected the effective date to "Claims received on or after April 1, 2015," and spread the implementation across four quarterly releases. In this article the CR release date, transmittal number and link to the CR also changed. All other information remains the same. It was previously published in the August 2014 edition of [Medicare A Connection](#), Pages 23-29.

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 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, 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 reopening 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 April 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 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>.

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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
 - 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 I/OCE, revised NCD edits, revised MUE edits

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

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TOB	xxxQ	Reason for adjustment
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 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	Changes in service date
	D1	Changes to charges
	D2	Changes in revenue code/HCPSCS/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, or modifiers
	E0	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 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	Changes to charges
	D2	Changes in revenue code/HCPSCS/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, or modifiers
	E0	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.

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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.

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	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, or modifiers
	E0	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	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, 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	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, value codes or modifiers

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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 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.

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

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 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	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, or modifiers
	E0	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

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TOB	xxxQ	Reason for adjustment
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	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, or modifiers
	E0	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
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	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, or modifiers
	E0	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	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, or modifiers

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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	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, value codes or modifiers
Adjustment reason code	R2	1 - 4 yrs from initial determination
Remarks – (good cause)	Yes	

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
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 April 1, 2015
 Related CR Transmittal #: R3060
 Implementation Date: July 6, 2015

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Automation of the request for reopening claims process

Note: This article was revised September 3, 2014, to reflect a new change request (CR). The revised CR corrected the effective date to "Claims received on or after April 1, 2015," and spread the implementation across four quarterly releases. In this article the CR release date, transmittal number and link to the CR also changed. All other information remains the same.

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>.

This article was previously published in the August 2014 edition of *Medicare A Connection*, Pages 21-22.

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.

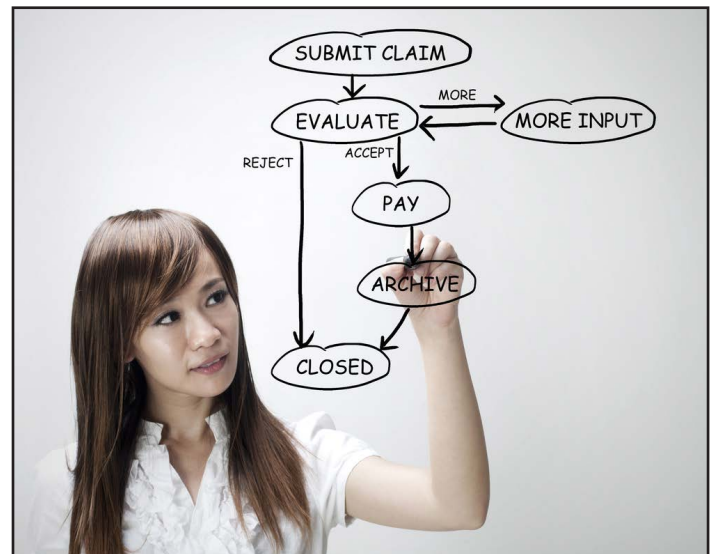
Provider action needed

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 regarding 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, 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 April 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

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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 (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 re-openings may be submitted.

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/R3060CP.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>.

For 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.

See **AUTOMATION**, next page

AUTOMATION

From previous page

Condition code	Title	Definition
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.

Condition code	Title	Definition
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: September 3, 2014

Effective Date: Claims received on or after April 1, 2015

Related CR Transmittal #: R3060CP

Implementation Date: July 6, 2015

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Modification of therapy functional reporting edit for discharge status

Outpatient therapy functional reporting requirements are designed to gather data reported by therapy providers and practitioners furnishing outpatient therapy services.

The Centers for Medicare & Medicaid Services (CMS) will make a system modification in response to the many inquiries regarding therapy functional reporting (THFR). This modification will be effective September 15, 2014. As a result of the modification, CMS believes this will

significantly reduce the number of THFR claim rejections.

Note: This does not impact editing for G code pairing. You will still need to report the discharge status G codes.

As a result of this change, providers who believe that their previous claims were erroneously returned or rejected due to a missing discharge date should resubmit those claims for re-processing on/after September 15, 2014.

Claim status category and claim status codes update

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 (HH&H MACs) and durable medical equipment Medicare administrative contractors (DME/MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8735 which informs MACs about the changes to claim status category codes and claim status codes. Make sure your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the x12 276/277 health care claim status request and response format adopted as the standard for national use (e.g. previous HIPAA named versions included 004010X093A1, more recent HIPAA named versions).

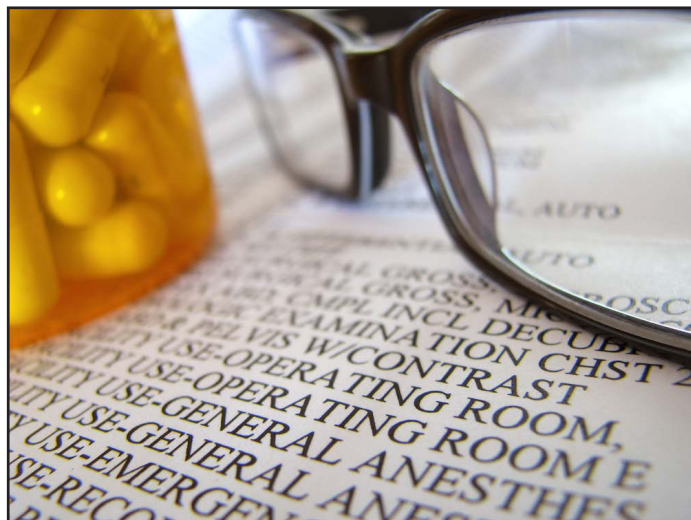
These codes explain the status of submitted claim(s). Proprietary codes may not be used in the x12 276/277 to report claim status.

The National Code Maintenance Committee meets at the beginning of each x12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at <http://www.wpc-edi.com/reference/codelist/healthcare/claim-status-category-codes/> and <http://www.wpc-edi.com/reference/codelist/healthcare/claim-status-codes/>.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the September/October 2014 committee meeting shall be posted on that site on or about November 1, 2014. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 8735.

These code changes are to be used in the editing of all x12 276 transactions processed on or after the date of implementation and are to be reflected in x12 277 transactions issued on and after the date of implementation of CR 8735.

All MACs must comply with the requirements contained in the versions 004010x093A1 and 005010x212 of ASC x12



276/277 Implementation Guide as well as the 005101X214 of the ASC x12 277 *Health Care Claim Acknowledgement Implementation Guide* (inclusive of any published Errata documents) and must use valid claim status category codes and claim status codes when sending 277 responses.

Additional information

The official instruction, CR 8735 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3043CP.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: MM8735
Related Change Request (CR) #: CR 8735
Related CR Release Date: August 22, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3043CP
Implementation Date: January 5, 2015

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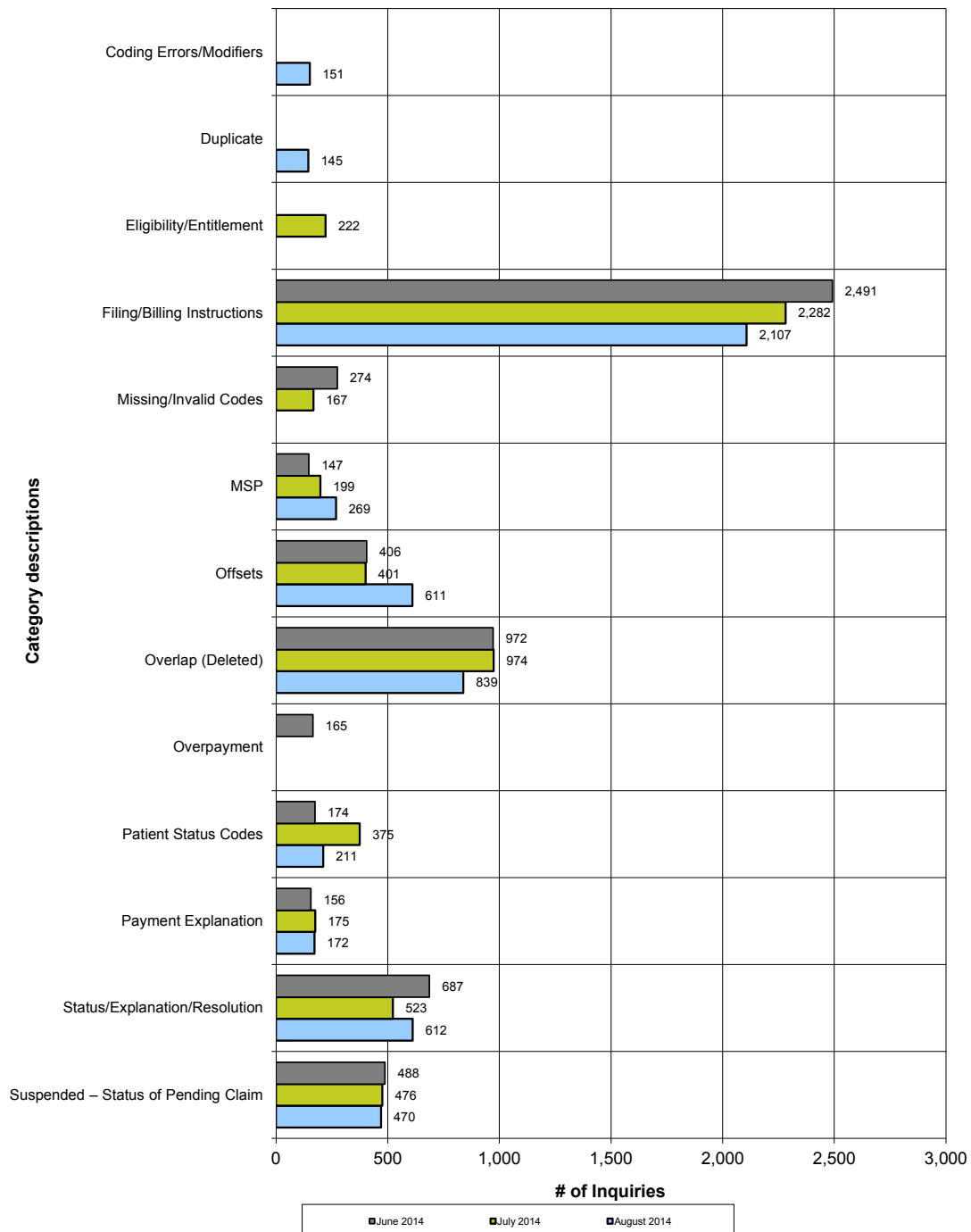
Claims and Inquiry Summary Data

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 June 2014 through August 2014.

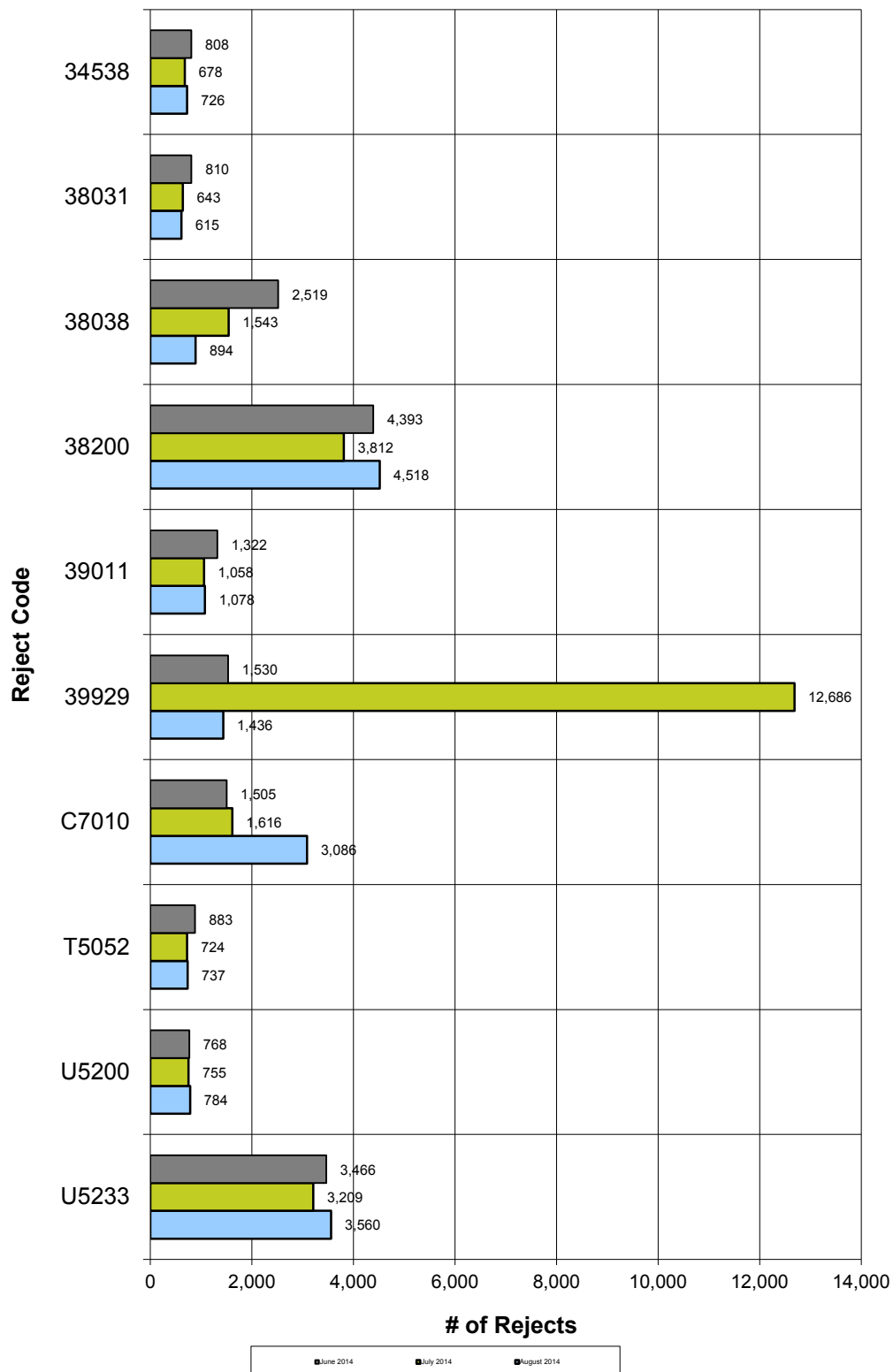
For tips and resources to help providers to avoid or reduce the amount of time spent on many of these issues, refer to the *Inquiries and Denials* section of our website at http://medicare.fcso.com/Inquiries_and_denials/index.asp.

Top inquiries for June-August 2014



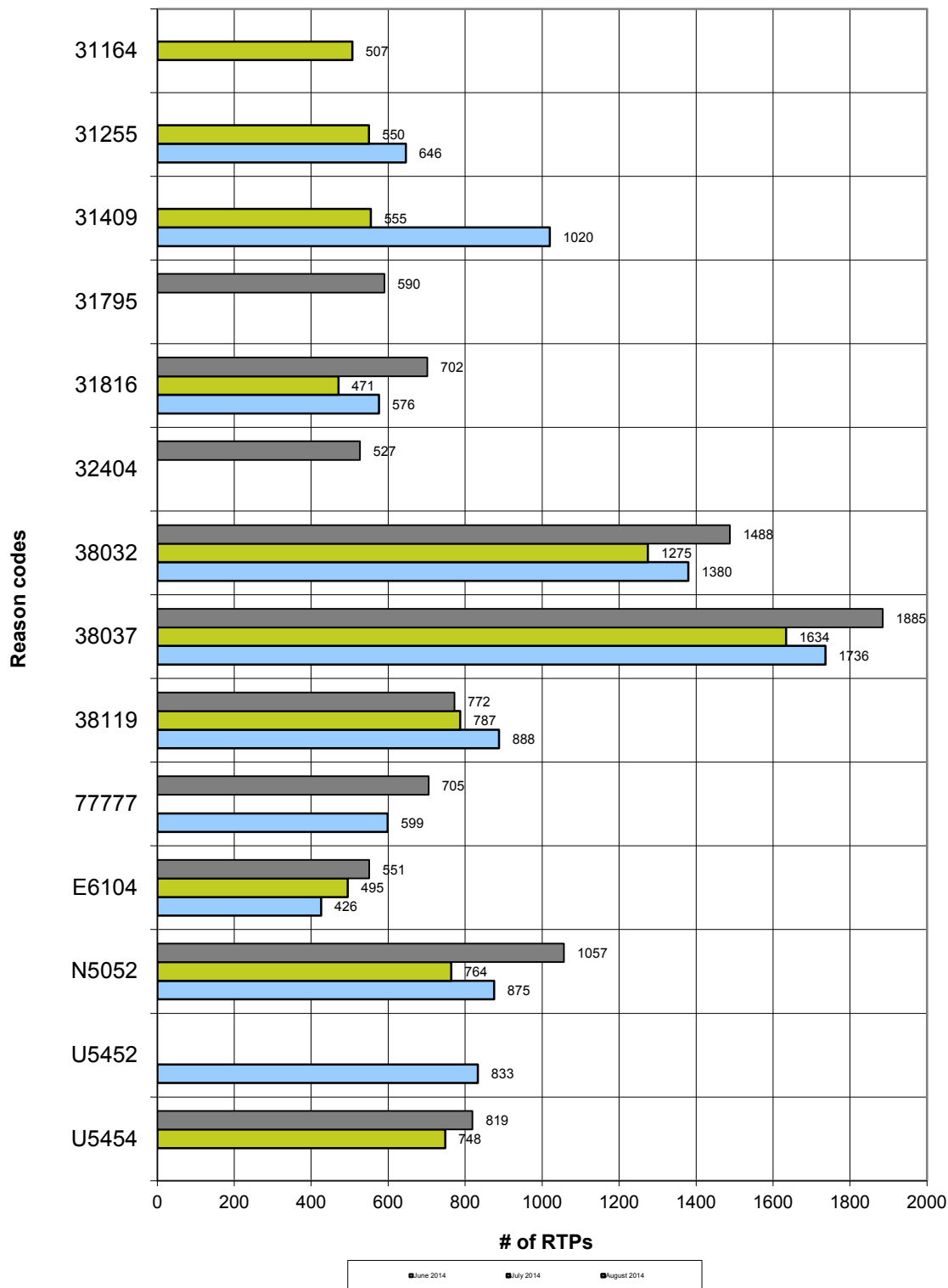
Part A top rejects for June 2014 through August 2014

Top rejects for June-August 2014



Part A top return to providers (RTPs) for June 2014 through August 2014

Top RTPs for June-August 2014



Reimbursement

Sample collection fee adjustment for clinical laboratory fee schedule and laboratory services

Provider types affected

This *MLN Matters*® article is intended for independent clinical laboratories, skilled nursing facilities (SNFs) and home health agencies (HHAs) submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

What you need to know

Change request (CR) 8837 provides instructions to MACs for adjusting payment for a sample collected by a laboratory from an individual in a skilled nursing facility (SNF) or on behalf of a HHA. Make sure your billing staffs are aware of these changes.

Background

CR 8837 applies to Section 1833(h)(3)(A) of the Social Security Act, as amended by Section 216 of the Protecting Access to Medicare Act (PAMA) (P.L. 113-93), and the *Medicare Claims Processing Manual*, Chapter 16, Section 60.1, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf>.

When a sample is collected by a laboratory from an individual in a SNF or from an individual on behalf of a HHA, the Healthcare Common Procedure Coding System (HCPCS) code, G0471 "Collection of venous blood by venipuncture or urine sample by catheterization from an individual in a SNF or by a laboratory on behalf of a HHA," is used.

Effective April 1, 2014, the nominal fee is increased by \$2, from \$3 to \$5, in accordance with the Protecting Access to Medicare Act (PAMA).

The "sample collection fee" is raised from \$3.00 to \$5.00 ONLY when the following statements apply:

- The sample is being collected by a laboratory technician that is employed by the laboratory that is performing the test, and
- The sample is from an individual in either a SNF or a HHA.

MACs will not search their files to adjust claims already processed. However, they will adjust such claims that you bring to their attention.

Additional information

The official instruction, CR 8837 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3056CP.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: MM8837
Related Change Request (CR) #: CR 8837
Related CR Release Date: August 29, 2014
Effective Date: April 1, 2014
Related CR Transmittal #: R3056CP
Implementation Date: December 1, 2014

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Adjustment of some home health claims

Certain home health claims for episodes beginning October 1, 2013, and after, which were subject to the payment shift between the Part A and Part B trust funds, have not been paid correctly.

There was no payment going to the provider, and the entire payment was being reported under value code 17. The system problem has been corrected, and the affected claims will be adjusted. No provider action is needed.

October 2014 physician fee schedule database 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 home health & hospice (HH&H) MACs, for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 8888 informs MACs about changes to payment files that were originally issued to contractors based upon the 2014 Medicare physician fee schedule (MPFS) final rule. This change request amends those payment files, effective October 1, 2014. Make sure that your billing staffs are aware of these changes.

Background

Payment files were issued to MACs based upon rates in the *2014 Medicare Physician Fee Schedule (MPFS) Final Rule*, published in the *Federal Register* on December 10, 2013, which is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html> on the Centers for Medicare & Medicaid Services (CMS) website, as modified by Section 101 of the "Pathway for SGR Reform Act of 2013" to be effective for services furnished between January 1, 2014, and March 31, 2014. On April 1, 2014, the President signed the "Protecting Access to Medicare Act of 2014," which extends those rates through December 31, 2014.

In order to reflect appropriate payment policy as included in the *2014 MPFS Final Rule*, the Medicare physician fee schedule database (MPFSDB) has been updated with October changes. These rates are effective through December 31, 2014.

The table below summarizes the addition of federally qualifying health centers (FQHCs) Healthcare Common Procedure Coding System (HCPCS) codes G0466, G0467, G0468, G0469, and G0470.

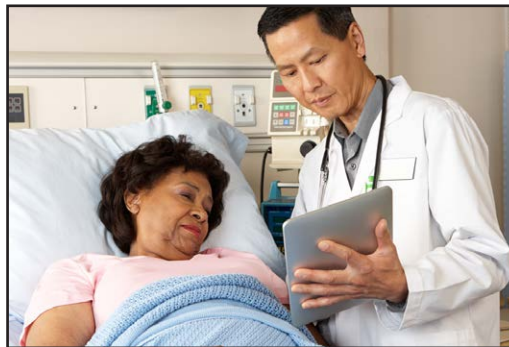
HCPCS	Short descriptor	Procedure status
G0466	FQHC visit, new patient	X
G0467	FQHC visit, estab pt	X
G0468	FQHC visit, IPPE or AWV	X
G0469	FQHC visit, MH new pt	X
G0470	FQHC visit, MH estab pt	X

In addition, note the following changes:

- For HCPCS Codes 55970 and 55980, CMS will

change their procedure status codes from "N"= "Noncovered service by Medicare" to "C"= "Carrier priced", and their global surgery codes from "XXX" to "YYY", effective May 30, 2014 (All other indicators should remain the same.)

- For HCPCS code A9586, CMS will change its procedure status code changed from "N"= "Noncovered service by Medicare" to "C"= "Carrier priced", and its global surgery code from "XXX" to "YYY", effective September 27, 2013 (All other indicators should remain the same. See CR 8526.)
- HCPCS code G0471 "Ven blood coll SNF/HHA" is added to the MPFS with a procedure status code of X, effective April 1, 2014.



- HCPCS code 0275T "Perq lamot/lam lumbar" is revised to the 2014 physician fee schedule with a procedure status code of "R"= "Restricted", effective January 9, 2014 (See CR 8757).

- CMS is changing the short descriptor for G9361 to read "Med Ind for induction," effective January 1, 2014.

Note that MACs need not search their files to either retract payment for claims already paid or to retroactively pay claims and which were impacted by the above changes. However, they will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 8888 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3064CP.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: MM8888 Revised
Related Change Request (CR) #: CR 8888
Related CR Release Date: September 10, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R3064CP
Implementation Date: October 6, 2014

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Influenza vaccine payment allowances annual update

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8890, which informs MACs about the availability of payment allowances for seasonal influenza virus vaccines. These payment allowances are updated on an annual basis effective August 1st of each year. Make sure that your billing staffs are aware of these changes.

Background

This recurring update notification provides the payment allowances for the following seasonal influenza virus vaccines, when payment is based on 95 percent of the average wholesale price (AWP).

CPT® 90655: payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90656: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90657: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90661: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90685: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90686: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90687: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90688: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

HCPCS Q2035: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

HCPCS Q2036: Payment allowance is pending. Effective dates: August 1, 2014 – July 31, 2015

HCPCS Q2037: Payment allowance is pending. Effective dates: August 1, 2014 – July 31, 2015

HCPCS Q2038: Payment allowance is pending. Effective dates: August 1, 2014 – July 31, 2015

Payment for the following **CPT®** or **HCPCS** codes may be made if your MAC determines its use is reasonable and necessary for the beneficiary:

CPT® 90654: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90662: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015



CPT® 90672: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

CPT® 90673: Payment allowance is pending; effective dates: August 1, 2014 – July 31, 2015

HCPCS Q2039: flu vaccine adult – not otherwise classified payment allowance is to be determined by the local claims processing contractor with effective dates of August 1, 2014 – July 31, 2015.

Payment allowances for codes for products that have not yet been approved will be provided when the products have been approved and pricing information becomes available to CMS.

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the quarterly average sales price (ASP) drug pricing files.

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC).

Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Note: MACs will not search their files either to retract payment for claims already paid or to retroactively pay claims prior to the implementation date of CR 8890. However, they will adjust claims brought to their attention.

Additional information

See **FLU**, next page

Ambulance inflation factor and productivity adjustment

Provider types affected

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

Provider action needed

Change request (CR) 8895 furnishes the 2015 ambulance inflation factor (AIF) for determining the payment limit for ambulance services. Make sure that your billing staffs are aware of the change.

Background

CR 8895 furnishes the 2015 ambulance inflation factor (AIF) for determining the payment limit for ambulance services required by Section 1834(l)(3)(B) of the Social Security Act (the Act).

Section 1834(l)(3)(B) of the Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity (MFP) beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

The MFP for 2015 is 0.70 percent and the CPI-U for 2015 is 2.10 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results

in a negative AIF update. Therefore, the AIF for 2015 is 1.40 percent.

Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule. The 2015 ambulance fee schedule file will be available to MACs in November 2014. It may be updated with each quarterly common working file (CWF) update.

Additional information

The official instruction, CR 8895 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3057CP.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: MM8895
Related Change Request (CR) #: CR 8895
Related CR Release Date: August 29, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3057CP
Implementation Date: January 5, 2015

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FLU

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The official instruction, CR 8890, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3059CP.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: MM8890
Related Change Request (CR) #: CR 8890

Related CR Release Date: September 3, 2014
Effective Date: August 1, 2014
Related CR Transmittal #: R3059CP
Implementation Date: No later than November 24, 2014

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Inpatient rehabilitation facility annual update: prospective payment system pricer changes for 2015

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8788 which provides updated rates used to correctly pay IRF PPS claims for fiscal year (FY) 2015. A new IRF pricer software package will be released prior to October 1, 2014, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2014, through September 30, 2015. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) published a final rule in the *Federal Register* (see <http://www.gpo.gov/fdsys/pkg/FR-2001-08-07/pdf/01-19313.pdf>), that established the IRF PPS, as authorized under the Social Security Act (Section 1886(j)); see http://www.ssa.gov/OP_Home/ssact/title18/1886.htm). In that final rule, CMS set forth per discharge federal rates for FY 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002. Annual updates to the IRF PPS rates are required by the Social Security Act (Section 1886(j)(3)(C)).

Additionally, Section 1886(j)(7)(A)(i) of the Social Security Act requires application of a 2 percentage point reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements which CMS implemented for FY 2014 IRF PPS payments. The updates for FY 2015 are in the following table.

Pricer updates for IRF PPS FY 2015	October 1, 2014 – September 30, 2015
Standard federal rate	\$15,198
Adjusted standard federal rate	\$14,901
Fixed loss amount	\$8,848
Labor-related share	0.69294
Non-labor related share	0.30706
Urban national average cost-to-charge ratio (CCR)	0.443
Rural national average CCR	0.569
Low income patient (lip) adjustment	0.3177
Teaching adjustment	1.0163
Rural adjustment	1.149

The Social Security Act (Section 1886(j)(7)(A)(i)) requires application of a 2 percentage point reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements.

FY 2015 is the second year that the mandated reduction will be applied for IRFs that failed to comply with the data submission requirements during the data collection period January 1, 2013, through December 31, 2013.

In compliance with Section 1886(j)(7)(A)(i) of the Social Security Act, CMS will apply a 2 percentage point reduction to the applicable FY 2015 market basket increase factor (2.2 percent) in calculating an adjusted FY 2015 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements.

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

The adjusted FY 2015 standard payment conversion factor that will be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the period from January 1, 2013, through December 31, 2013, will be \$14,901.

Additional information

The official instruction, CR 8788 issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3039CP.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: MM8788
 Related Change Request (CR) #: CR 8788
 Related CR Release Date: August 22, 2014
 Effective Date: October 1, 2014
 Related CR Transmittal #: R3039CP
 Implementation Date: October 6, 2014

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Inpatient psychiatric facilities PPS update for 2015

Provider types affected

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

Provider action needed

Change request (CR) 8889 identifies changes that are required as part of the annual IPF PPS update from the fiscal year (FY) 2015 IPF PPS Final Rule displayed on August 1, 2014. These changes are applicable to IPF discharges occurring October 1, 2014, through September 30, 2015. Make sure your billing staffs are aware of these IPF PPS changes for FY 2015.

Background

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

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

CR 8889 identifies changes that are required as part of the annual IPF PPS update from the IPF PPS FY 2015 final rule. These changes are applicable to IPF discharges occurring during the FY October 1, 2014, through September 30, 2015.

Inpatient psychiatric facilities quality reporting program (IPFQR)

Section 1886(s)(4) of the Social Security Act (The Act) requires the establishment of a quality data reporting program for the IPF PPS beginning in FY 2014.

CMS finalized new requirements for quality reporting for IPFs in the *Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates* final rule (August 31, 2012) (77 FR 53258, 53644 through 53360). Section 1886(s)(4)(A)(i) of the Act requires that, for FY 2014 and each subsequent fiscal year, the Secretary of Health and Human Services shall reduce any annual update to a standard federal rate for discharges occurring during the FY by two percentage points for any IPF that does not comply with the quality data submission

requirements with respect to an applicable year. Therefore, CMS is applying a 2 percentage point reduction to the federal per diem base rate and the electroconvulsive therapy (ECT) base rate as follows:

- For IPFs that fail to submit quality reporting data under the IPF quality reporting program, CMS is applying a 0.1 percent annual update (that is 2.1 percent reduced by two percentage points in accordance with section 1886(s)(4)(A)(ii) of the Act) and the wage index budget neutrality factor of 1.0002 to the FY 2014 federal per diem base rate of \$713.19, yielding a Federal per diem base rate of \$714.05 for FY 2015.
- Similarly, CMS is applying the 0.1 percent annual update and the 1.0002 wage index budget neutrality factor to the FY 2014 electroconvulsive therapy (ECT) base rate of \$307.04, yielding an ECT base rate of \$307.41 for FY 2015.

Market basket update

For FY 2015, CMS used the FY 2008-based rehabilitation, psychiatric, and long term care (RPL) market basket to update the IPF PPS payment rates (that is the Federal per diem and ECT base rates).

The Social Security Act (Section 1886(s)(2)(A)(ii); see http://www.ssa.gov/OP_Home/ssact/title18/1886.htm on the Internet), requires the application of an "Other Adjustment" that reduces any update to the IPF PPS base rate by percentages specified in the Social Security Act (Section 1886(s)(3)) for rate year (RY) beginning in 2010 through the FY beginning in 2019. For the FY beginning in 2014 (that is, FY 2015), the Act (Section 1886(s)(3)(B)) requires the reduction to be 0.3 percentage point. CMS is implementing that provision in the *FY 2015 Final Rule*.

In addition, the Act Section 1886(s)(2)(A)(i) requires the application of the productivity adjustment described in the Act (Section 1886(b)(3)(B)(xi)(II)) to the IPF PPS for the RY beginning in 2012 (that is, a RY that coincides with a FY), and each subsequent FY. For the FY beginning in 2014 (that is FY 2015), the reduction is 0.5 percentage point. CMS is implementing that provision in the *FY 2015 Final Rule*.

Specifically, CMS has updated - the IPF PPS base rate for FY 2015 by applying the adjusted market basket update of 2.1 percent (which includes the RPL market basket increase of 2.9 percent, an ACA required 0.3 percent reduction to the market basket update, and an ACA required productivity adjustment reduction of 0.5 percent) and the wage index budget neutrality factor of 1.0002 to the FY 2014 federal per diem base rate of \$713.19 yields a federal per diem base rate of \$728.31 for FY 2015. Similarly, applying the adjusted market basket update of

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2.1 percent and the wage index budget neutrality factor of 1.0002 to the FY 2014 ECT rate of \$307.04 yields an ECT rate of \$313.55 for FY 2015.

Pricer updates for FY 2015

- The federal per diem base rate is \$728.31;
- The federal per diem base rate is \$714.05 (when applying the two percentage point reduction.);
- The fixed dollar loss threshold amount is \$8,755;
- The IPF PPS will use the FY 2014 unadjusted pre-floor, pre-reclassified hospital wage index;
- The labor-related share is 69.294 percent;
- The non-labor related share is 30.706 percent;
- The ECT rate is \$313.55; and
- The ECT rate is \$307.41 (when applying the two percentage point reduction).

Cost-to-charge ratio (CCR) for the IPF prospective payment system FY 2015

Cost to Charge Ratio	Median	Ceiling
Urban	0.4710	1.6582
Rural	0.6220	1.8590

CMS is applying the national CCRs to the following situations:

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

MS-DRG Update

- The code set and adjustment factors are unchanged for IPF PPS FY 2015.

FY 2014 Pre-floor, pre-reclassified hospital wage index

- CMS is using the updated wage index and the wage index budget neutrality factor of 1.0002.

COLA Adjustment for the IPF PPS FY 2015

The Office of Personal Management (OPM) began transitioning from cost of living adjustment (COLA) factors to a locality payment rate in FY 2010. The 2009 COLA factors were frozen in order to allow this transition.

In the FY 2013 IPPS/LTCH final rule (77 FR 53700 through 53701), CMS established a new methodology to update the COLA factors for Alaska and Hawaii.

In this FY 2015 IPF PPS update, CMS adopted this new COLA update methodology and is updating the COLA rates (as published in FY 2014 IPPS/LTCH final rule (78 FR 50986), using the new methodology). The COLAs for Alaska and Hawaii are shown in the following tables:

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

Hawaii	Cost of living adjustment factor
City and County of Honolulu	1.25
County of Hawaii	1.19
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Additional Information

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Annual clotting factor furnishing fee update 2015

Provider types affected

This *MLN Matters*® article is intended for physicians and other providers billing Medicare administrative contractors (MACs) for services related to the administration of clotting factors to Medicare beneficiaries.

Provider action needed

Change request (CR) 8891 announces that for 2015 the clotting factor furnishing fee of \$0.197 per unit is included in the published payment limit for clotting factors. For dates of service of January 1, 2015, through December 31, 2015, the clotting factor furnishing fee of \$0.197 per unit is added to the payment when no payment limit for the clotting factor is included in the average sales price (ASP) or not otherwise classified (NOC) drug pricing files. Please be sure your billing staffs are aware of this fee update.

Background

The Medicare Modernization Act section 303(e)(1) added Section 1842(o)(5)(C) of the Social Security Act which requires that a furnishing fee will be paid for items and services associated with clotting factor.

The Centers for Medicare & Medicaid Services (CMS) includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. When the national payment limit for a clotting factor is not included on the ASP Medicare Part B drug pricing file or the NOC pricing file, your MAC must make payment for the clotting factor as well as make payment for the furnishing fee.

Additional information

The official instruction, CR 8891, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3055CP.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: MM8891
 Related Change Request (CR) #: CR 8891
 Related CR Release Date: August 29, 2014
 Effective Date: January 1, 2015
 Related CR Transmittal #: R3055CP
 Implementation Date: January 5, 2015

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Additional Information

The official instruction, CR 8889 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3034CP.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: MM8889

Related Change Request (CR) #: CR 8889
 Related CR Release Date: August 22, 2014
 Effective Date: October 1, 2014
 Related CR Transmittal #: R3034CP
 Implementation October 6, 2014

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Annual update of HCPCS codes used for home health consolidated billing enforcement

Provider types affected

This *MLN Matters*® article is intended for home health agencies (HHAs) and other providers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

Provider action needed

Change request (CR) 8893, from which this article is taken, provides annual home health (HH) consolidated billing updates, effective January 1, 2015. It announces that Healthcare Common Procedure Coding System (HCPCS) code A4459 (Manual pump enema system, includes balloon, catheter and all accessories, reusable, any type) is added to the HH consolidated billing non-routine supply code list. You should make sure that your billing personnel are aware of this update.

Background

The HH consolidated billing code list is updated annually, to reflect the annual changes to the HCPCS code set itself, and additional updates may occur as often as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. These updates are required by changes to the coding system itself, not because the services subject to HH consolidated billing are being redefined. Therefore you should note that the new codes identified in each update describe the same services that were used to determine the applicable HH PPS payment rates; and that the updates do not add any additional services.

With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that

have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings are not subject to HH consolidated billing.

CR 8893 provides annual home health (HH) consolidated billing updates, effective January 1, 2015. It announces that HCPCS code A4459 (Manual pump enema system, includes balloon, catheter and all accessories, reusable, any type) is added to the HH consolidated billing non-routine supply code list. Code A4459 is added because of its similarity to code A4458, which has been subject to HH consolidated billing since 2003.

There are no changes to the HH consolidated billing therapy code list in this update.

Additional information

The official instruction, CR 8893 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3035CP.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: MM8893
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Related CR Release Date: August 22, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3035CP
Implementation Date: January 5, 2015

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2015 payment and policy changes for Medicare skilled nursing facilities

On July 31, 2014, the Centers for Medicare & Medicaid Services (CMS) issued a final rule outlining fiscal year (FY) 2015 Medicare payment rates for skilled nursing facilities (SNFs). The FY 2015 SNF payment rates and other issues discussed in the final rule are summarized at <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-07-31-4.html>.

The wage index for each provider will consist of a blend of

50 percent of the FY 2015 wage index using the current the Office of Management and Budget (OMB) delineations and 50 percent of the FY 2015 wage index using the revised OMB delineations.

CMS is implementing these changes by providing a one-year transition with a blended wage index for all providers. As a result, several counties have been *assigned new core-based statistical area (CBSA) numbers*.

Billing for cost-based payment for certified registered nurse anesthetists in rural hospitals

Provider types affected

This *MLN Matters*® article is intended for rural hospitals submitting claims to Medicare administrative contractors (MACs) for certified registered nurse anesthetist (CRNA) services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 8897 manualizes instructions previously implemented in CR 2325 (Transmittal A-02-109, dated October 25, 2002) that allows small rural hospitals subject to the outpatient prospective payment system (OPPS) that qualify for cost-based CRNA services to bill and be properly paid for those services. This article is for informational purposes and does not convey any new policy.

Background

Payment of outpatient services of CRNAs furnished by small rural hospitals subject to OPPS (that qualify for cost based payment under 42 CFR 412.113(c)) are made through biweekly interim payments that are calculated based on retrospective adjustments from a settled cost report. See 42 CFR 412.113(c) at <http://www.ecfr.gov/cgi-bin/text-idx?SID=afdd6f10630598719f65d974fdc7b019&nde=42:2.0.1.2.12.8.50.3&rgn=div8>.

The Centers for Medicare & Medicaid Services (CMS) issued CR 2325 (Transmittal A-02-109, dated October 25, 2002) to provide instructions that allow these small rural hospitals that qualify for cost-based CRNA services to bill and be properly paid for these services.

See CR 2325 (Transmittal A-02-109) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/A02109.pdf>. In CR 8897, CMS is updating the *Medicare Claims Processing Manual* to include the requirements of CR 2325.

As a reminder, in order for interim payments to be made to small rural hospitals subject to OPPS, a number of changes were required in the reporting and acceptance of

revenue code 0964 “Anesthetists (CRNA).” Those changes are as follows:

- (1) Hospitals that qualify for cost based CRNA services must report these services under revenue code 0964;
- (2) Medicare claims systems are required to accept revenue code 0964 on type of bill 013x for these hospitals; and (3) Reporting and acceptance of revenue code 0964 from other OPPS hospitals (without a CRNA pass-through exemption) may not be allowed.

Reminder: Value code 05 “Professional Component Included In Charges and Also Billed Separately to B/MACs,” should not be reported with revenue code 0964.

Additional Information

The official instruction, CR 8897, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3065CP.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: MM8897
Related Change Request (CR) #: CR 8897
Related CR Release Date: September 12, 2014
Effective Date: April 1, 2003
Related CR Transmittal #: R3065CP
Implementation Date: December 15, 2014

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Mass adjustments to IPF claims with teaching adjustment amounts being duplicated

Due to a software issue in the second release of the FY 2014 inpatient psychiatric facility (IPF) pricer, the teaching adjustment amounts on IPF claims have been duplicated.

Medicare administrative contractors will complete mass adjustments to all IPF claims with a teaching adjustment, for discharge dates in FY 2014 by December 1, 2014.

2015 inpatient prospective payment system and long term care hospital PPS changes

Provider types affected

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

Provider action needed

Change request (CR) 8900 provides FY 2015 updates to the acute care hospital IPPS and the LTCH PPS. All items covered in CR 8900 are effective for hospital discharges occurring on or after October 1, 2014, unless otherwise noted. Make sure your billing staff are aware of these changes.

Background

The policy changes for FY 2015 were published in the *Federal Register* on August 22, 2014. You can find the home page for the *FY 2015 Hospital Inpatient PPS final rule* at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Proposed-Rule-Home-Page.html>.

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

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

Files related to the Long term care PPS can be found at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html>.

Key points of CR 8900

IPPS updates

Medicare severity diagnosis related group (MS-DRG) grouper and Medicare code editor changes

The grouper contractor, 3M Health Information Systems (3M-HIS), developed the new Medicare severity diagnosis related group (MS-DRG) grouper, Version 32.0, software package effective for discharges on or after October 1, 2014. The Medicare code editor (MCE) selects the proper internal code edit tables based on discharge date. Note that the MCE version continues to match the grouper.

The Centers for Medicare & Medicaid Services (CMS) created the following new MS-DRGs for endovascular cardiac valve replacements:

- MS-DRG 266 (Endovascular Cardiac Valve Replacement w MCC); and
- MS-DRG 267 (Endovascular Cardiac Valve Replacement w/o MCC).



CMS deleted:

- MS-DRG 490 (Back & Neck Procedures except Spinal Fusion with CC/MCC or Disc Device/Neurostimulator); and
- MS-DRG 491 (Back & Neck Procedures except Spinal Fusion without CC/MCC).

CMS created the following three new MS-DRGs to account for a separate CC severity level:

- MS-DRG 518 (Back & Neck Procedure Except Spinal Fusion w MCC or Disc Device/Neurostimulator);
- MS-DRG 519 (Back & Neck Procedure Except Spinal Fusion w CC); and
- MS-DRG 520 (Back & Neck Procedure Except Spinal Fusion w/o CC/MCC).

Lastly, CMS modified MS-DRG 483 (Major Joint/Limb Reattachment Procedure of Upper Extremities with CC/MCC) by deleting MS-DRG 484 (Major Joint/Limb Reattachment Procedure of Upper Extremities without CC/MCC) and revising the title for MS-DRG 483 (Major Joint/Limb Reattachment Procedure of Upper Extremities) to create one base DRG.

Post-acute transfer and special payment policy

As a result of changes to MS-DRGs for FY 2015 the following MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy and special payment policy:

- 266, 267 (Endovascular Cardiac Valve Replacement with and without MCC, respectively); and
- 518, 519, and 520 (Back & Neck Procedure except Spinal Fusion with MCC or Disc Device/Neurostimulator, with CC, and without MCC/CC, respectively).

MS-DRG 483 (Major Joint/Limb Reattachment Procedure of Upper Extremities) will be removed from the list of MS-

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DRGs subject to the post-acute care transfer policy.

See table five of the FY 2015 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs at the end of this article or visit <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>. At that page, click on the link on the left side of the screen titled, "FY 2015 IPPS Final Rule Home Page" or "Acute Inpatient – Files for Download."

New technology add-on

The following items will continue to be eligible for new-technology add-on payments in FY 2015:

- **Zenith Fenestrated Graft**—Cases involving the Zenith Fenestrated Graft that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 39.78. The maximum add-on payment for a case involving the Zenith Fenestrated Graft is \$8,171.50. (For your information the ICD-10-CM procedure codes are: 04U03JZ - Supplement Abdominal Aorta with Synthetic Substitute, Percutaneous Approach; 04U04JZ - Supplement Abdominal Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach; 04V03DZ - Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Approach or 04V04DZ - Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Endoscopic Approach.)
- **Voraxaze**—Cases involving Voraxaze that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 00.95. The maximum add-on payment for a case involving the Voraxaze is \$45,000. (For your information the ICD-10-CM procedure codes are: 3E033GQ - Introduction of Glucarpidase into Peripheral Vein, Percutaneous Approach or 3E043GQ - Introduction of Glucarpidase into Central Vein, Percutaneous Approach.)
- **Argus**—Cases involving the Argus®II System that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 14.81. The maximum add-on payment for a case involving the Argus®II System is \$72,028.75. (For your information the ICD-10-CM procedure codes are: 08H005Z - Insertion of Epiretinal Visual Prosthesis into Right Eye, Open Approach or 08H105Z - Insertion of Epiretinal Visual Prosthesis into Left Eye, Open Approach.)
- **Kcentra**—Cases involving Kcentra that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 00.96. The maximum add-on payment for a case of Kcentra™ is \$1,587.50. DO NOT MAKE THIS NEW TECH PAYMENT IF ANY OF THE FOLLOWING DIAGNOSIS CODES ARE ON THE CLAIM: 286.0, 286.1, 286.2, 286.3, 286.4, 286.5, 286.7, 286.52, 286.53, or 286.59. (For your information the ICD-10-CM procedure codes are:



30280B1 - Transfusion of Nonautologous 4-Factor Prothrombin Complex Concentrate into Vein, Open Approach or 30283B1 - Transfusion of Nonautologous 4-Factor Prothrombin Complex and the ICD-10-CM diagnosis codes are: D66, D67, D68.1, D68.2, D68.0, D68.311, D68.312, D68.318, D68.32, and D68.4.)

- **Zilver**—Cases involving the Zilver® PTX® that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 00.60. The maximum add-on payment for a case of the Zilver® PTX® is, \$1,705.25. (For your information the ICD-10-CM procedure codes are: 047K04Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Open Approach; 047K34Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Approach; 047K44Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach; 047L04Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Open Approach; 047L34Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Approach or 047L44Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach.)

The following items will be eligible for new-technology add-on payments in FY 2015:

- **CardioMEMS™ HF Monitoring System** – Cases involving the CardioMEMS™ HF Monitoring System that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 38.26. The maximum add-on payment is \$8,875. (For your information the ICD-10-CM procedure code is: 02HQ30Z - Insertion of Pressure Sensor Monitoring Device into Right Pulmonary Artery, Percutaneous Approach.)
- **MitraClip® System** – Cases involving the MitraClip® System that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 35.97. The maximum add-on payment is

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\$15,000. (For your information, the ICD-10-CM procedure code is: 02UG3JZ Supplement Mitral Valve with Synthetic Substitute, Percutaneous Approach.)

- **RNS® System** – Cases involving the RNS® System that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 01.20 in combination with 02.93. The maximum add-on payment is \$18,475. (The ICD-10-CM procedure codes are: 0NH00NZ-Insertion of Neurostimulator Generator into Skull, Open Approach in combination with 00H00MZ-Insertion of Neurostimulator Lead into Brain, Open Approach.)

Cost of living adjustment update for IPPS

The IPPS incorporates a cost of living adjustment (COLA) for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2015, and are the same COLAs established for FY 2014. For reference, a table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2014, is in the FY 2015 IPPS/LTCH PPS final rule and is also displayed in the following table:

FY 2015 COLA factors: Alaska and Hawaii hospitals

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

FY 2015 wage index changes and issues

Effective October 1, 2014, CMS is revising the labor market areas used for the wage index based on the most recent labor market area delineations issued by the Office of Management and Budget (OMB) using 2010 census data.

MACs will update the actual geographic location core-

based statistical area (CBSA) field in the provider specific file (PSF) (data element 35) effective October 1, 2014, to reflect the new CBSA delineations.

CMS is adopting a one-year transition for FY 2015 for hospitals that are experiencing a decrease in their wage index exclusively due to the implementation of the new OMB delineations. This mitigates potential negative payment impacts due to the adoption of the new OMB delineations.

Under the new OMB delineations for the few hospitals that have been located in an urban county prior to October 1, 2014, that are becoming rural effective October 1, 2014, CMS is assigning a hold-harmless urban wage index value of the labor market area in which they are physically located for FY 2014 for three years beginning in FY 2015.

That is, for FYs 2015, 2016, and 2017, assuming no other form of wage index reclassification or re-designation is granted, these hospitals are assigned the area wage index value of the urban CBSA in which they were geographically located in FY 2014.

For FY 2015, for hospitals that are eligible for the three-year hold-harmless transition, it is possible that receiving the FY 2015 wage index of the CBSA where the hospital is geographically located for FY 2014 might still be less than the FY 2015 wage index that the hospital would have received in the absence of the adoption of the new OMB delineations.

The assignment of the three-year transitional wage index is included in the calculation of the FY 2015 portion of the blended wage index for that hospital. After FY 2015, such a hospital will revert to the second year of the three-year transition (assuming no other form of wage index reclassification or re-designation is granted).

Note that for hospitals that are receiving a one-year transition blended wage index or the three-year hold-harmless wage index, these transitions are only for the purpose of the wage index and do not affect a hospital's urban or rural status for any other payment purposes.

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

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

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Treatment of certain urban hospitals reclassified as rural hospitals under 42 CFR 412.103

An urban hospital that reclassifies as a rural hospital under 412.103 is considered rural for all IPPS purposes. Note that hospitals reclassified as rural under 412.103 are not eligible for the capital disproportionate share hospital (DSH) adjustment since these hospitals are considered rural under the capital PPS (see 412.320(a)(1)). Please reference Table 9C of *FY 2015 Final Rule* available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>.

The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. The MDH program is currently effective through March 31, 2015, as provided by Section 106 of the Protecting Access to Medicare Act of 2014. Provider types 14 and 15 continue to be valid through March 31, 2015.

Under current law, beginning in April 1, 2015, all previously qualifying hospitals will no longer have MDH status and will be paid based solely on the federal rate. (CMS notes that the sole community hospital (SCH) policy at section 412.92(b) allows MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program.) Provider types 14 and 15 will no longer be valid beginning April 1, 2015.

Hospital specific rate update for sole community hospitals and medicare-dependent, small rural hospitals

For FY 2015, hospital-specific (HSP) amount in the PSF for SCHs and MDHs will continue to be entered in FY 2012 dollars. Pricer will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2014 of 0.9480 and make all updates to the HSP amount for FY 2013 and beyond. (As noted above, under current law, the MDH program expires March 31, 2015.)

Low-volume hospitals – criteria and payment adjustments for FY 2015

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Section 105 of the Protecting Access to Medicare Act of 2014 extended the temporary changes to the low-volume hospital payment adjustment through March 31, 2015. The regulations implementing the hospital payment adjustment policy are at 412.101.

Beginning with FY 2015 discharges occurring on or after April 1, 2015, the low-volume hospital qualifying criteria and payment adjustment methodology will revert to that which was in effect prior to the amendments made by the Affordable Care Act and subsequent legislation (that is, the

low-volume hospital payment adjustment policy in effect for FYs 2005 through 2010).

Effective October 1, 2014, through March 31, 2015, in order to qualify as a low-volume hospital, a hospital must be located more than 15 road miles from another “subsection (d) hospital” and have less than 1600 Medicare discharges (which includes Medicare Part C discharges) during the fiscal year.

For FY 2015 discharges occurring through March 31, 2015, the applicable low-volume percentage increase is determined using a continuous linear sliding scale equation that results in a low-volume hospital payment adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more Medicare discharges.

For FY 2015 discharges occurring before April 1, 2015, qualifying low-volume hospitals and their payment adjustment are determined using Medicare discharge data from the March 2014 update of the FY 2013 MedPAR file. Table 14 of the FY 2015 IPPS/LTCH PPS final rule (which is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>) lists the “subsection (d)” hospitals with fewer than 1,600 Medicare discharges based on the March 2014 update of the FY 2013 MedPAR file and their low-volume payment adjustment for FY 2015 discharges occurring before April 1, 2015 (if eligible). CMS notes that the list of hospitals with fewer than 1,600 Medicare discharges in Table 14 does not reflect whether or not the hospital meets the mileage criterion (that is, the hospital is located more than 15 road miles from any other subsection (d) hospital, which, in general, is an IPPS hospital).

Effective April 1, 2015, in order to qualify as a low-volume hospital, a hospital must be located more than 25 road miles from another “subsection (d) hospital” and have less than 200 total discharges (including both Medicare and non-Medicare discharges) during the fiscal year. For FY 2015 discharges occurring on or after April 1, 2015, the low-volume hospital adjustment for all qualifying hospitals is 25 percent.

For FY 2015 discharges occurring on or after April 1, 2015, the MAC will make the discharge determination based on the hospital’s number of total discharges, that is, Medicare and non-Medicare discharges as reported on the hospital’s most recently submitted cost report. To meet the mileage criterion to qualify for the low-volume hospital payment adjustment for FY 2015 discharges occurring on or after April 1, 2015, a hospital must be located more than 25 road miles (as defined at § 412.101(a)) from the nearest “subsection (d) hospital” (that is, in general, an IPPS hospital).

A hospital must notify and provide documentation to its MAC that it meets the mileage criterion. The use of a Web-based mapping tool, such as MapQuest, as part of

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documenting that the hospital meets the mileage criterion for low-volume hospitals, is acceptable.

The MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance (in road miles) from the hospital requesting low-volume hospital status, is sufficient to document that it meets the mileage criterion. If not, the MAC will follow up with the hospital to obtain additional necessary information to determine whether or not the hospital meets the low-volume hospital mileage criterion.

To receive a low-volume hospital payment adjustment under 412.101, a hospital must notify and provide documentation to its MAC that it meets the discharge and distance requirements under 412.101(b)(2)(ii) for FY 2015 discharges occurring before April 1, 2015, and 412.101(b)(2)(i) for FY 2015 discharges occurring on or after April 1, 2015, if also applicable.

Specifically, for FY 2015, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2014, in order for the applicable low-volume hospital payment adjustment to be applied to payments for its discharges occurring on or after October 1, 2014, and through March 31, 2015, or through September 30, 2015, for hospitals that also meet the low-volume hospital payment adjustment qualifying criteria for discharges occurring during the second half of FY 2015.

A hospital that qualified for the low-volume payment adjustment in FY 2014 may continue to receive a low-volume payment adjustment for FY 2015 discharges occurring before April 1, 2015, without reapplying if it continues to meet the Medicare discharge criterion established for FY 2015 and the distance criterion.

However, the hospital must send written verification that is received by its MAC no later than September 1, 2014, stating that it continues to be more than 15 miles from any other "Subsection (d)" hospital. If a hospital's written request for low-volume hospital status for FY 2015 is received after September 1, 2014, and if the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital's FY 2015 discharges, effective prospectively within 30 days of the date of its low-volume hospital status determination.

The low-volume hospital payment is based on and in addition to all other IPPS per discharge payments,

including capital, DSH (including the uncompensated care payment), indirect medical education (IME) and outliers. For SCHs and MDHs, the low-volume hospital payment is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Hospital quality initiative

The hospitals that will receive the quality initiative bonus are listed at the following website: www.qualitynet.org. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website.

Electronic health record incentive program

Section 1886(b) (3) (B) of the Social Security Act as amended by Section 4102(b) (1) of the Health Information Technology for Economic and Clinical Health (HITECH) Act requires CMS to apply a reduced annual payment update to the IPPS update for subsection(d) hospitals that are not meaningful electronic health record (EHR) users or have not been granted a hardship exception. The statute also requires payment adjustments for eligible hospitals in states where hospitals are paid under Section 1814(b) (3) of the Act (waiver).

For FY 2015, the applicable percentage increase to the IPPS payment rate is adjusted downward for those eligible hospitals that are not meaningful EHR users for the associated EHR reporting period for a payment year.

This reduction applies to three-quarters of the percentage increase otherwise applicable. The reduction to three-quarters of the applicable update for an eligible hospital that is not a meaningful EHR user is 33 1/3 percent for FY 2015. In other words, for eligible hospitals that are not meaningful EHR users, the percentage increase is reduced for the entire FY by 25 percent (33 1/3 percent of 75 percent) in 2015.

A list of hospitals that will receive the EHR incentive payment reduction for FY 2015 is listed in the official instruction to CR 8900 titled: Hospitals Subject to EHR Payment Incentive Reduction for FY 2015.

Hospital acquired conditions

Section 3008 of the Affordable Care Act establishes a program, beginning in FY 2015, for IPPS hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain HACs. HACs are conditions that patients did not have when they were admitted to the hospital, but which developed

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during the hospital stay. Under the HAC Reduction Program, hospitals that rank in the worst-performing quartile of selected HAC measures will be subject to a reduction of what they would otherwise be paid under the IPPS. The HAC reduction program adjustment amount is calculated after all other IPPS per discharge payments, which includes adjustments for DSH (including the uncompensated care payment), IME, outliers, readmissions, Value-based purchasing (VBP), low-volume hospitals, and capital payments. For SCHs and MDHs, the HAC reduction program adjustment amount applies to either the federal rate payment amount or the hospital-specific rate payment amount, whichever results in a greater operating IPPS payment.

CMS did not make the list of providers subject to the HAC reduction program public in the final rule because they had not completed the review and correction period.

Hospital value-based purchasing

Section 3001 of the Affordable Care Act added section 1886(o) to the Social Security Act, establishing the hospital VBP program. This program began adjusting base operating DRG payment amounts for discharges from subsection (d) hospitals, beginning in FY 2013. CMS has continued to exclude Maryland hospitals from the hospital VBP program for the FY 2015 program year. The regulations that implement this provision are in subpart I of 42 CFR part 412 (Sections 412.160 through 412.162).

Under the hospital VBP program, CMS reduces base operating DRG payment amounts for subsection (d) hospitals by the applicable percent defined in statute. The applicable percent for payment reductions for FY 2015 is 1.50 percent, and it gradually increases each fiscal year to 2.0 percent in FY 2017. These payment reductions fund value-based incentive payment to hospitals that meet or exceed performance standards on the measures selected for the program. By law, CMS must base value-based incentive payments on hospitals' performance under the hospital VBP program, and the total amount available for value-based incentive payments must be equal to the amount of payment reductions, as estimated by the Secretary.

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

In the FY 2013 IPPS/LTCH PPS final rule, CMS established the methodology to calculate the hospital value-based incentive payment adjustment factor, the

portion of the IPPS payment that will be used to calculate the value-based incentive payment amount, and review and corrections and appeal processes wherein hospitals can review information used to calculate their TPSs and submit requests for corrections to the information before it is made public.

For FY 2015, CMS will implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2015.

Note that the values listed in Table 16A of the FY 2015 IPPS final rule are "proxy" values. The proxy values are not used to adjust payments. CMS will add Table 16B to display the actual value-based incentive payment adjustment factors, which is expected to be available in October 2014 at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>.

Hospital readmissions reduction program

For FY 2015, the readmissions adjustment factor is the higher of a ratio or 0.97 (-3 percent). The readmissions adjustment factor is applied to a hospital's "base operating DRG payment amount", or the wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable), to determine the amount reduced from a hospital's IPPS payment due to excess readmissions.

Add-on payments for IME, DSH (including the uncompensated care payment), outliers and low-volume hospitals are not adjusted by the readmissions adjustment factor. In addition, for SCHs, the difference between the SCH's operating IPPS payment under the hospital-specific rate and the federal rate is not adjusted by the readmissions adjustment factor.

However, the portion of a MDH's payment reduction due to excess readmissions that is based on 75 percent difference between payment under the hospital-specific rate and payment under the federal rate will be determined at cost report settlement. In determining the claim payment, the pricer will only apply the readmissions adjustment factor to a MDH's wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable) to determine the payment reduction due to excess readmissions.

Hospitals that are not subject to a reduction under the hospital readmissions reduction program (HRR) in FY 2015 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. (Hospitals located in Puerto Rico are not subject to the Hospital Readmissions Reduction Program).

For FY 2015, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.

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The HRR adjustment factors for FY 2015 are proxy values and are available in Table 15 of the FY 2015 IPPS final rule, which is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page-Items/FY2015-Final-Rule-Tables.html>. Claims will be reprocessed if a hospital's HRR adjustment factor changes when the actual factors are available in the near future. CMS will display the final HRR adjustment factors for FY 2015 on the CMS website.

Medicare disproportionate share hospitals (DSH) program

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

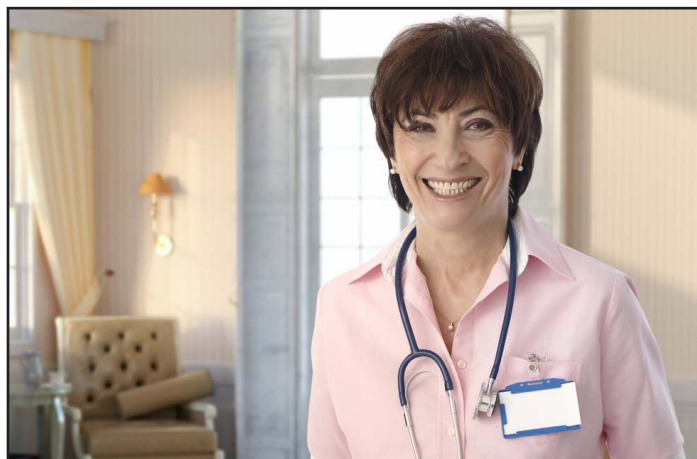
Each Medicare DSH hospital will receive a portion of this uncompensated care pool based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital's share of uncompensated care is based on its share of insured low income days, defined as the sum of Medicare SSI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

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

For FY 2015, the total uncompensated care payment amount to be paid to Medicare DSH hospitals is \$7,647,644,885.18, as calculated as the product of 75 percent of Medicare DSH (estimated CMS Office of the Actuary) and the change in percent of uninsured individuals and an additional statutory adjustment at 76.19 percent.

The total uncompensated care payment amount to be paid to the Medicare DSH hospitals was finalized in the FY 2015 IPPS final rule. The uncompensated care payment will be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2015. The estimated per claim amount is determined by dividing the total uncompensated care payment by the average number of claims from the most recent three years of claims data (FYs 2011-2013).

The hospitals that were located in urban counties that are becoming rural under our adoption of the new OMB delineations, are subject to a transition for their Medicare



DSH payment. For a hospital with more than 99 beds and less than 500 beds that was re-designated from urban to rural, it would be subject to a DSH payment adjustment cap of 12 percent.

Under the transition, per the regulations at 412.102, for the first year after a hospital loses urban status, the hospital will receive an additional payment that equals two-thirds of the difference between DSH payment before its re-designation from urban to rural and the DSH payment otherwise applicable to the hospital subsequent to its re-designation from urban to rural.

In the second year after a hospital loses urban status, the hospital will receive an additional payment that equals one third of the difference between the DSH payments applicable to the hospital before its re-designation from urban to rural and the DSH payments otherwise applicable to the hospital subsequent to its re-designation from urban to rural. This adjustment will be determined at cost report settlement and will apply the DSH payment adjustment based on its urban/rural status according to the re-designation.

Recalled devices

As a reminder, section 2202.4 of the *Provider Reimbursement Manual, Part I* states, "charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient." Accordingly, hospital charges with respect to medical devices must be reasonably related to the cost of the medical device.

If a hospital receives a replacement medical device for free, the hospital should not be charging the patient or Medicare for that device. The hospital should not be including costs on the cost report or charges on the Medicare claim. If that medical device was received at a discount, the charges should also be appropriately reduced.

To review the *Provider Reimbursement Manual – Part 1* visit <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html>.

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LTCH PPS FY 2015 update

FY 2015 LTCH PPS rates and factors are located in the official instruction to CR 8900. The LTCH PPS pricer has been updated with the Version 31.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2014, and on or before September 30, 2015.

LTCH quality reporting (LTCHQR) program

Section 3004(a) of the Affordable Care Act requires the establishment of the long-term care hospital quality reporting (LTCHQR) program. Beginning in FY 2015, the annual update to a standard Federal rate will be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance with the LTCHQR program for that year.

Cost of living adjustment update for LTCH PPS

There are no changes to the COLAs for FY 2015, and are the same COLAs. For reference, a table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2014, can be found in the FY 2015 IPPS/LTCH PPS final rule and is also shown in Table 2 in the Attachment to CR 8900 titled, "FY 2015 Tables."

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

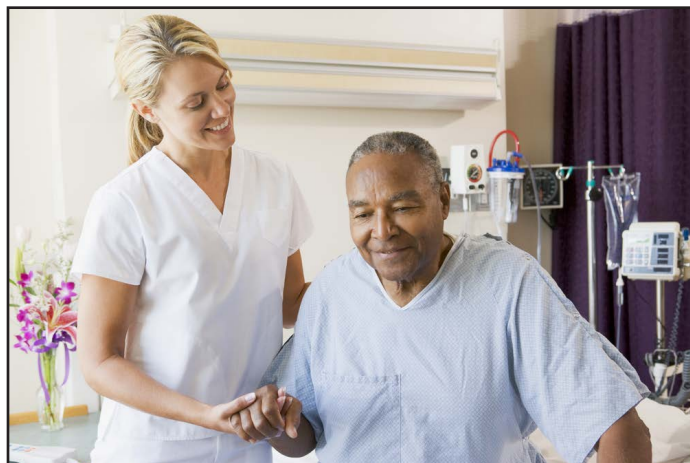
CMS is updating the CBSA based labor market area definitions (and associated CBSA codes) used under the LTCH PPS for FY 2015. These revisions to the LTCH PPS geographic classifications are based on the most recent metropolitan statistical area (MSA) delineations issued by OMB using 2010 census data.

In order to mitigate potential negative payment impacts due to the adoption of the new OMB delineations, CMS adopted a one-year transition for LTCHs that would experience a decrease in their wage index exclusively due to the implementation of the new OMB delineations.

Under this transition policy, for discharges occurring in FY 2015, affected LTCHs will get a "50/50 blended area wage index" value that is calculated as the sum of 50 percent of the wage index computed under the FY 2014 CBSA designations (from Tables 12C and 12D, as applicable, of the FY 2015 IPPS/LTCH PPS final rule) and 50 percent of the wage index computed under the new OMB delineations for FY 2015 (from Tables 12A and 12B, as applicable, of the FY 2015 IPPS/LTCH PPS final rule).

Additional LTCH PPS policy changes for FY 2015

The statutory moratoria on the full implementation of the "25 percent threshold" payment adjustment originally put in place by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) is extended until the start of LTCH cost reporting periods beginning on either July or October,



2014, as applicable as provided by the Pathway for the Sustainable Growth Rate (SGR) Reform Act.

The new extension generally maintained the same policies that have been in place, except that "grandfathered" LTCH hospitals-within-hospitals (HwH) are totally exempt from the application of the 25 percent threshold. For additional details, refer to the discussion in the FY 2015 IPPS/LTCH PPS final rule.

The FY 2015 IPPS/LTCH final rule also included the removal of the "5 percent" policy adjustment. Therefore, the policy specified at 42 CFR 412.532, Special Payment Provisions for Patients Who are Transferred to Onsite Providers and Readmitted to an LTCH, is no longer in effect beginning October 1, 2014.

Additional information

The official instruction CR 8900 issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3066CP.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: MM8900
Related Change Request (CR) #: CR 8900
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Related CR Transmittal #: R3066CP
Implementation October 6, 2014

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Educational Events

Provider outreach and educational events October-December 2014

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>

Medicare Part A changes and regulations

When: Tuesday, December 9

Time: 10:30 a.m. - 11:30 a.m. ET – Delivery language: English

Type of Event: Webcast

<http://medicare.fcso.com/Events/273901.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 articles link to recent *MLN Connects*™ e-News:

MLN Connects™ Provider eNews for August 28, 2014

MLN Connects™ Provider eNews for August 28, 2014

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In this edition:

MLN Connects™ National Provider Calls

- PQRS: How To Avoid 2016 Negative Payment Adjustments For CMS Medicare Quality Reporting Programs – Register Now
- Overview of the 2013 Quality And Resource Use Reports – Registration Opening Soon
- New MLN Connects™ National Provider Call Video Slideshow, Audio Recording, And Transcript

Announcements

- NIST EHR Randomizer Tool: Provider User Guide Available
- Review New FAQs for the EHR Incentive Programs

Claims, pricers, and codes

- Update to Preventive Services Paid Based on the RHC or FQHC All-inclusive Rate
- Adjustment of Some Home Health Claims
- FY 2014 HH PPS PC Pricer Updated

MLN Educational Products

- “International Classification of Diseases, 10th Revision (ICD-10) Testing – Acknowledgement Testing with

Providers” MLN Matters® Article - Released

- “ICD-10-CM/PCS Billing and Payment Frequently Asked Questions” Fact Sheet – Revised
- “ICD-10-CM/PCS Myths and Facts” Fact Sheet - Revised
- “ICD-10-CM Classification Enhancements” Fact Sheet – Revised
- “General Equivalence Mappings Frequently Asked Questions” Booklet – Revised
- “New Physician Specialty Code for Interventional Cardiology” MLN Matters® Article – Released
- “Scenarios and Coding Instructions for Submitting Requests to Reopen Claims that are Beyond the Claim Filing Timeframes – Companion Information to MM8581: Automation of the Request for Reopening Claims Process” MLN Matters® Article – Released
- “Fingerprint-based Background Check Begins August 6, 2014” MLN Matters® Article – Released
- “Comprehensive Error Rate Testing (CERT): Skilled Nursing Facility (SNF) Certifications and Recertifications” MLN Matters® Article – Released
- “MLN Suite of Products & Resources for Rural Health Providers” Educational Tool – Revised
- New MLN Educational Web Guides Fast Fact
- MLN Products Available in Electronic Publication Format

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The *MLN Educational Web Guides* provides information on evaluation and management (E/M) services; guided pathways to resources and topics of interest; lists of health care management products; as well as easy-to-understand billing and coding products.

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MLN Connects™ Provider eNews for September 4, 2014

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- CMS Offers Settlement to Acute Care Hospitals and CAHs for Resolving Patient Status Denials - Register Now
- PQRS: How to Avoid 2016 Negative Payment Adjustments for CMS Medicare Quality Reporting Programs - Register Now
- New MLN Connects™ National Provider Call Audio Recording and Transcript
- Providers and Suppliers - Browse the MLN Connects™ Call Program Collection of Resources

Announcements

- Get Ready for DMEPOS Competitive Bidding - Get Accredited
- Healthy Aging® Month - Discuss Preventive Services with your Patients

- New CMS Rule Allows Flexibility in Certified EHR Technology for 2014
- Open Payments System Outages

MLN Educational Products

- "Quick Reference Information: Coverage and Billing Requirements for Medicare Ambulance Transports" Educational Tool - Released
- "Intravenous Immune Globulin (IVIG) Demonstration - Implementation" *MLN Matters®* article - Revised
- "Medicare Enrollment and Claim Submission Guidelines" Booklet - Revised
- "Medicare Vision Services" Fact Sheet - Revised
- "Medicare Enrollment Guidelines for Ordering/Referring Providers" Fact Sheet - Revised
- New MLN Provider Compliance Fast Fact
- MLN Products Available in Electronic Publication Format

MLN Connects™ Provider eNews for September 11, 2014

MLN Connects™ Provider eNews for September 11, 2014

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MLN Connects™ National Provider Calls

- PQRS: How to Avoid 2016 Negative Payment Adjustments for CMS Medicare Quality Reporting Programs – Last Chance to Register

Announcements

- Hospitals Appeals Settlement FAQs
- National Cholesterol Education Month – Medicare Preventive Services for Cardiovascular Disease
- New Release of PEPPER for Short-term Acute Care Hospitals
- EHR Incentive Programs: Learn More about Patient Electronic Access Requirements
- EHR Incentive Programs: Exclusions and Hardship Exceptions for Broadband Access Claims, Pricers, and Codes
- Incarcerated Beneficiary Update
- Updated Information on Preventive Services Paid Based on the RHC or FQHC All – Inclusive Rate

- October 2014 Average Sales Price Files Now Available

MLN Educational Products

- "HIPAA Privacy and Security Basics for Providers" Fact Sheet – Released
- "The CMS Physician Quality Reporting System (PQRS) Program: What Medicare Eligible Professionals Need to Know in 2014" Web– Based Training Course – Released
- "The CMS Value– Based Payment Modifier: What Medicare Eligible Professionals Need to Know in 2014" Web– Based Training Course – Released
- "The Medicare and Medicaid EHR Incentive Programs: What Medicare and Medicaid Providers Need to Know in 2014" Web– Based Training Course – Released
- "Examining the Difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN)" *MLN Matters®* Article – Revised
- "Scenarios and Coding Instructions for Submitting Requests to Reopen Claims that are Beyond the Claim Filing Timeframes – Companion Information to MM8581: Automation of the Request for Reopening Claims Process" *MLN Matters®* Article – Revised
- New MLN Topic of the Month

MLN Connects™ Provider eNews for September 18, 2014

MLN Connects™ Provider eNews for September 18, 2014

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In this edition:

MLN Connects™ National Provider Calls

- Hospital Appeals Settlement Update – Registration Opening Soon
- Transitioning to ICD-10 – Registration Now Open
- New MLN Connects™ National Provider Call Audio Recording and Transcript

CMS Events

- ICD-10 Coordination and Maintenance Committee Meeting

Announcements

- New Affordable Care Act Tools and Payment Models Deliver \$372 Million in Savings, Improve Care
- HHS Provides Additional Flexibility for Certification of Electronic Health Record Technology

- Medicare EHR Incentive Program: October 3 Last Day for 1st-year EPs to Begin 2014 Reporting Period

Claims, Pricers, and Codes

- Mass Adjustments to IPF Claims with Teaching Adjustment Amounts Being Duplicated

MLN Educational Products

- “2014-2015 Influenza (Flu) Resources for Health Care Professionals” MLN Matters® Article – Released
- “Internet-based PECOS FAQs” Fact Sheet – Released
- “Safeguard Your Identity and Privacy Using PECOS” Fact Sheet – Released
- “Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs” Fact Sheet – Revised
- “Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs” Fact Sheet – Revised
- MLN Products Available In Electronic Publication Format

FIRST COAST UNIVERSITY

Discover your passport to Medicare training

- Register for live events
- Explore online courses
- Find CEU information
- Download recorded events
- Learn more at *First Coast University*



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@fcsso.com
855-416-4199

Websites

medicare.fcsso.com
medicareespanol.fcsso.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