Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

May 2015

In this issue

First Coast's Web tools give denied claims the boot

Kristin Gunn is an experienced veteran in managing Medicare billing having done so for more than 27 years. With that extensive experience, Gunn says "SPOT is the greatest thing ever."

SPOT, secure provider online tool, is First Coast Service Options' free online portal for medical providers to handle multiple aspects of Medicare billing.

The tool allows providers to check Medicare beneficiary eligibility and claim status. Providers also can reopen claims where clerical errors can be corrected as well as submit supporting documentation for claim redeterminations.

> **"The SPOT is the way to go. No more filling out forms and then having to fax or mail them in. I have used SPOT to get several claims re-opened. I cannot believe how easy it is."**
>
> — *Kristin Gunn,* South Florida Revenue Cycle Specialists

After 27 years of working for larger medical billing companies, Gunn started her own business in January 2015, the South Florida Revenue Cycle Specialists, LLC. She currently manages the billing for three physician practices. She says SPOT will put her in a good position to grow her business.

"The SPOT is the way to go. No more filling out forms and then having to fax or mail them in. I have used SPOT to get several claims re-opened. I cannot believe how easy it is. By using SPOT we also received those payments quicker than if we had faxed or mailed the request," Gunn said.

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Medicare signature requirements

The Medicare requirement to authenticate the medical record is to ensure the services rendered have been thoroughly documented and authenticated by the author of the medical record entry. *Click here* for information on Medicare's signature requirements and how adhering to these requirements can prevent impacts to your claims.

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

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Recently she used SPOT to quickly handle an overpayment request involving a Medicare beneficiary who was reported deceased.

"SPOT made it so easy to resolve the issue. We checked the physician's records to see if we billed an incorrect patient number among other things. Then I checked the eligibility tab on SPOT, checked the date of death and compared the date of service. I made a screen print from SPOT and sent it through the secure mail. You hit 'send.' Boom. There it goes. No visits to the post office."

> **"SPOT made it so easy to resolve the issue. We checked the physician's records to see if we billed an incorrect patient number among other things. Then I checked the eligibility tab on SPOT, checked the date of death and compared the date of service. I made a screen print from SPOT and sent it through the secure mail. You hit 'send.' Boom. There it goes. No visits to the post office."**
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Gunn uses three SPOT tools primarily. She says she is particularly fond of the claim status window. "The claim status check is my favorite thing on SPOT. I go in with the ICN number. I can do a reopening if I need to make a change to a modifier or other field. I don't have to dial the phone to reopen the claim." With SPOT, Part B providers may change a date of service, diagnosis code, procedure code, modifier, or units billed through a clerical reopening of a claim.

Before starting her own business, Gunn worked for a large medical billing company that used other software products to handle Medicare claims. When one billing company merged with her employer, she decided to become her own boss. "I knew about SPOT, but had not used it until I started on my own business."

Gunn says she has signed up for several of the online learning classes to gain continuing education credits. She also plans to use First Coast's learning center to brush up on many of the features available through SPOT.

General Information

Clarification of ordering and certifying documentation maintenance requirements

Provider action needed

This *MLN Matters*® article is based on change request (CR) 9112 which clarifies the term "access to documentation" in Chapter 15, Section 15.18 of the *Program Integrity Manual (PIM)*. Make sure that your billing staffs are aware of this change.

Background

Under *42 CFR § 424.516(f)(1)*, a provider or supplier that furnishes covered ordered DMEPOS items, clinical laboratory services, imaging services, or covered ordered/certified home health services is required to:

- Maintain documentation for seven years from the date of service, and
- Upon the request of CMS or a Medicare contractor, provide access to that documentation.

The documentation to be maintained includes written and electronic documents (including the national provider identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician - or, when permitted, other eligible professional - who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for DMEPOS items and clinical laboratory, imaging, and home health services.

Key points in CR 9112

Maintaining and providing access to documentation

CMS or a Medicare contractor may request access to documentation as described in 42 CFR § 424.516(f). The term "access to documentation" means that the documentation is actually provided or made available in the manner requested by CMS or a Medicare contractor.

All providers and suppliers who either furnish, order, or certify DMEPOS items, clinical laboratory services, imaging services, or covered ordered/certified home health services are subject to this requirement and are individually responsible for maintaining these records and providing them upon request.

CMS recognizes that providers and suppliers often rely upon an employer or another entity to maintain these records on their behalf.

However, it remains the responsibility of the individual or entity upon whom/which the request has been made

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to provide documentation. All individuals and entities subject to this documentation requirement are responsible for ensuring that documents are provided upon request and may ultimately be subject to the revocation basis associated with not complying with the documentation request.

Examples

To illustrate, if a Medicare contractor requests copies of all orders for wheelchairs from an ordering physician for all beneficiaries with dates of service from November 1, 2014, through November 10, 2014, the ordering physician must provide the copies, in full, according to the specific request. If copies cannot be provided because the physician or eligible professional did not personally maintain the records or can only be partially provided, then the requirement to maintain this documentation and provide access to it will not have been met and the provider, supplier, physician, or eligible professional may be subject to the revocation basis set forth in 42 CFR § 424.535(a)(10).

Table 1: Examples of sufficient and deficient access

Sufficient access	Deficient access
All documentation requested	Providing none of the requested documentation
Documentation specific to the order(s) or certification(s), as requested	Providing only a portion of the requested documentation
Documentation for the dates of service or billing periods requested	Providing similar documentation that does not contain the order or certification requested
	Providing other documents **not** requested by CMS or a Medicare contractor and/or not specifically directing attention to the requested documentation

Additional information

The official instruction, CR 9112 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R587PI.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: MM9112
Related CR Release Date: April 17, 2015
Related Transmittal #: R587PI
Change Request (CR) #: CR 9112
Implementation Date: July 20, 2015
Effective Date: July 20, 2015

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Section 504: Implement national Medicare summary notices in alternate formats

Provider types affected

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

What you need to know

Change request (CR) 9153 alerts providers that the Centers for Medicare & Medicaid Services (CMS) has designated the MACs as responsible for printing requests for large print Medicare summary notices (MSNs) that are sent to beneficiaries in alternate formats, and to have a third party contractor responsible for requests for braille, CD-ROM, and audio alternate formats. MACs are required to produce large print MSNs for beneficiaries in their respective jurisdictions who prefer large print MSNs.

Background

CMS has an obligation to provide the MSN in alternate formats for beneficiaries who elect one of the formats as a preference. CMS has been working on the alternate format project for several years. Most recently, CMS has directed MACs to provide MSNs to a subset of beneficiaries through a manual process. CR 9153 implements the MAC requirements to produce large print MSNs for beneficiaries with that preference in their respective jurisdictions.

Section 504 of the Rehabilitation Act of 1973 (Section 504), 29 U.S.C. 794 forbids executive agencies and recipients of federal financial assistance from excluding individuals with disabilities or denying them an equal opportunity to receive program benefits and services.

Additional information

The official instruction, CR 9153, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1499OTN.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: MM9153
Related Change Request (CR) #: CR 9153
Related CR Release Date: May 8, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R1499OTN
Implementation Date: October 5, 2015

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OMB approves CMS-855 forms for IPP billers and hospitals

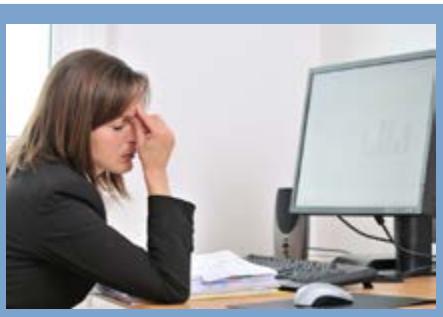
The Office of Management and Budget (OMB) has approved two new Centers for Medicare & Medicaid Services (CMS) 855 forms.

The new forms are CMS-855C and CMS-855POH. Form CMS-855C is used by indirect payment plan (IPP) billers for Medicare registration and form CMS-855POH is used by physician-owned hospitals for reporting hospital ownership and investment interest.

For more information about these forms, please refer to the transmittal released by CMS:

- Change request (CR) 9120 – *Update of CMS-855A, Physician-Owned Hospital Reporting Via the CMS-855POH and Indirect Payment Procedure Registration Via the CMS-855C in Chapter 15 of Pub. 100-08*

When the forms are released by CMS, they may be obtained by accessing the *CMS Forms List page* or the *Provider Enrollment section* on the First Coast Medicare provider website.



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*

General Coverage

Transcatheter mitral valve repair national coverage determination

Note: This article was revised April 26, 2015, due to the release of an updated change request (CR). That CR removed the text concerning billing TMVR for MR with modifier -62 (and from the *Coding requirements/claim processing requirements* section). The CR release date, transmittal number, and link to the transmittal was also changed. This information was previously published in the *January 2015 Medicare A Connection, Page 7*.

Provider types affected

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

Provider action needed

Effective for claims with dates of service furnished on or after August 7, 2014, the Centers for Medicare & Medicaid Services (CMS) will reimburse claims for TMVR for mitral regurgitation (MR) when furnished under coverage with evidence development (CED).

Background

TMVR is a new technology for use in treating MR. MR occurs when the leaflets of the mitral valve do not close properly and blood flows from the left ventricle back into the left atrium, causing the heart to work harder to pump. This, in turn, causes enlargement of the left ventricle and can lead to potential heart failure.

Abbott's MitraClip, the only U.S. Food and Drug Administration (FDA)-approved TMVR device, involves clipping together a portion of the mitral valve leaflets. This is performed under general anesthesia, with delivery of the device typically through a percutaneous transvenous approach, via echocardiographic and fluoroscopic guidance.

The procedure is performed in a cardiac catheterization laboratory or hybrid operating room/cardiac catheterization laboratory with advanced quality imaging. TMVR is covered for uses not listed as an FDA-approved indication when performed in approved clinical studies which meet certain study question requirements. The TMVR procedure must be performed by an interventional cardiologist or cardiac surgeon, or they may jointly participate in the intraoperative technical aspects, as appropriate.

On August 7, 2014, CMS issued a final decision memorandum covering TMVR for MR under CED for the treatment of MR when furnished for an FDA-approved

indication with an FDA-approved device as follows:

- Treatment of significant, symptomatic, degenerative MR when furnished according to an FDA-approved indication, and all CMS coverage criteria are met; and
- TMVR for MR uses not expressly listed as FDA-approved indications but only within the context of an FDA-approved, randomized clinical trial that meets all CMS coverage criteria.

CED requires that each patient be entered into a qualified national registry. In addition, prior to receiving TMVR, face-to-face examinations of the patient are required by a cardiac surgeon and a cardiologist experienced in mitral valve surgery to evaluate the patient's suitability for TMVR and determination of prohibitive risk, with documentation of their rationale.

The NCD lists the criteria that must be met prior to beginning a TMVR program and after a TMVR program is established. No NCD existed for TMVR for MR prior to August 7, 2014, and TMVR is non-covered outside CED or for non-MR indications. The Web address for accessing the NCD transmittal is available in the *Additional information* section at the end of this article.

CR 9002 revises the *Medicare Claims Processing Manual*, Chapter 32, Section 340 (Transcatheter Mitral Valve Repair (TMVR)), and the *National Coverage Determinations (NCD) Manual*, Chapter 20, Section 20.33 (Transcatheter Mitral Valve Repair (TMVR) which are included in CR 9002.

Based on the NCD, TMVR must be furnished in a hospital with the appropriate infrastructure that includes but is not limited to:

- On-site active valvular heart disease surgical program

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with >2 hospital-based cardiothoracic surgeons experienced in valvular surgery;

- Cardiac catheterization lab or hybrid operating room/ catheterization lab equipped with a fixed radiographic imaging system with flat-panel fluoroscopy, offering catheterization laboratory-quality imaging;
- Non-invasive imaging expertise including transthoracic/transesophageal/3D echocardiography, vascular studies, and cardiac CT studies;
- Sufficient space, in a sterile environment, to accommodate necessary equipment for cases with and without complications;
- Post-procedure intensive care facility with personnel experienced in managing patients who have undergone open-heart valve procedures;
- Adequate outpatient clinical care facilities; and
- Appropriate volume requirements per the applicable qualifications below.

There are institutional and operator requirements for performing TMVR. The hospital must have the following:

- A surgical program that performs ≥25 total mitral valve surgical procedures for severe MR per year of which at least 10 must be mitral valve repairs;
- An interventional cardiology program that performs ≥1000 catheterizations per year, including ≥400 percutaneous coronary interventions (PCIs) per year, with acceptable outcomes for conventional procedures compared to National Cardiovascular Data Registry (NCDR) benchmarks;
- The heart team must include:
  1. An interventional cardiologist(s) who:
     - Performs ≥50 structural procedures per year including atrial septal defects ASD), patent foramen ovale (PFO) and trans-septal punctures; and,
     - Must receive prior suitable training on the devices to be used; and
     - Must be board-certified in interventional cardiology or board-certified/eligible in pediatric cardiology or similar boards from outside the United States.
  2. Additional members of the heart team, including cardiac echocardiographers, other cardiac imaging specialists, heart valve and heart failure specialists, electrophysiologists, cardiac anesthesiologists, intensivists, nurses, nurse practitioners, physician assistants, data/research coordinators, and a dedicated administrator.
- All cases must be submitted to a single national database;
- Ongoing continuing medical education (or the nursing/ technologist equivalent) of 10 hours per year of relevant material; and
- The cardiothoracic surgeon(s) must be board-certified in thoracic surgery or similar foreign equivalent.
- The heart team's interventional cardiologist or a cardiothoracic surgeon must perform the TMVR. Interventional cardiologist(s) and cardiothoracic surgeon(s) may jointly participate in the intra-operative technical aspects of TMVR as appropriate.

The heart team and hospital must be participating in a prospective, national, audited registry that: 1) consecutively enrolls TMVR patients; 2) accepts all manufactured devices; 3) follows the patient for at least one year; and, 4) complies with relevant regulations relating to protecting human research subjects, including *45 Code of Federal Regulations* (CFR) Part 46 and 21 CFR Parts 50 & 56.

For complete details on the outcomes that must be tracked by the registry and the data that must be provided to the registry, see the CR 9002 NCD transmittal. The Web address for that transmittal is in the *Additional information* section at the end of this article.

Coding requirements/claim processing requirements

Coding requirements for TMVR for MR claims furnished on or After August 7, 2014

The *Current Procedural Terminology* (*CPT*®) codes for TMVR for MR claims are:

- *0343T*: *Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; initial prosthesis.*

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- (**Note**: *0343T* will be replaced by *CPT*® code 33418 effective January 1, 2015.)
- *0344T*: *Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure).* (**Note**: *0344T* will be replaced by *CPT*® code 33419 effective January 1, 2015.)
- *0345T*: *Transcatheter mitral valve repair percutaneous approach via the coronary sinus*
- *33418*: *Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis.* (**Note**: *CPT*® code *33418* is effective January 1, 2015.)
- *33419*: *Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session. (List separately in addition to code for primary procedure.)* (**Note**: *CPT*® code *33419* is effective January 1, 2015.)

ICD-9/ICD-10 codes for TMVR for MR claims

The ICD-9 (and upon ICD-10 implementation)/ ICD-10 codes are:

- ICD-9 procedure code - 35.97 - Percutaneous mitral valve repair with implant - and ICD-10 procedure code is 02UG3JZ – Supplement mitral valve with synthetic substitute, percutaneous approach and
- ICD-9 diagnosis code for TMVR for MR claims is - 424.0 – mitral valve disorder and ICD-10 diagnosis codes are I34.0 – nonrheumatic mitral (valve) insufficiency or I34.8 – other nonrheumatic mitral valve disorders.

Professional claims place of service (POS) codes for TMVR for MR claims

Effective for claims with dates of service on and after August 7, 2014, place of service (POS) code 21 is valid for use for TMVR for MR services. All other POS codes will be denied. MACs will supply the following messages when MACs denying TMVR for MR claims for invalid POS:

- **Claim adjustment reason code (CARC) 58**: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **Group code CO (contractual obligation)** assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed advance beneficiary notice (ABN) is on file.)

Professional claim modifiers for TMVR for MR claims

Effective for claims with dates of service on or after August 7, 2014, MACs will pay claim lines for TMVR for MR billed with *CPT*® codes *0343T, 0344T*, and *0345T* in a clinical trial when billed with modifier Q0. (Effective January 1, 2015, *CPT*® codes *33418* and *33419* replace *CPT*® codes *0343T* and *0344T*, respectively.) TMVR for MR claim lines in a clinical trial billed without modifier Q0 will be returned as unprocessable. MACs will supply the following messages when returning TMVR for MR claim lines in a clinical trial billed without modifier Q0 as unprocessable:

- **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."
- **Group code**: CO

Professional clinical trial diagnostic coding for TMVR for MR claims

Effective for claims with dates of service on or after August 7, 2014, MACs will pay claim lines for TMVR for MR billed with *CPT*® codes *0343T, 0344T*, and *0345T* in a clinical trial when billed with ICD-9 diagnosis code 424.0 (ICD-10 I34.0 or I34.8) and secondary ICD-9 diagnosis code V70.7 (ICD-10=Z00.6). (Effective January 1, 2015, *CPT*® codes *33418* and *33419* replace *CPT*® codes *0343T* and *0344T*, respectively.) TMVR for MR claim lines in a clinical trial billed without ICD-9 diagnosis code 424.0 (ICD-10 I34.0 or I34.8) and secondary ICD-9 diagnosis code V70.7 (ICD-10=Z00.6) will be denied.

MACs will supply the following messages when denying TMVR for MR claim lines in a clinical trial billed without secondary ICD-9 diagnosis code V70.7(ICD-10=Z00.6) as unprocessable:

- **CARC 50**: "These are non-covered services because this is not deemed a "medical necessity" by the payer."
- **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 *http://www.cms.hhs.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor

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to request a copy of the NCD."

- **Group code**: CO

Mandatory national clinical trial (NCT) number for TMVR for MR claims

Effective for claims with dates of service on or after August 7, 2014, contractors shall pay TMVR for MR claim lines billed with *CPT*® codes *0343T*, *0344T*, and *0345T* in a clinical trial only when billed with an eight-digit national clinical trial (NCT) number. (Effective January 1, 2015, *CPT*® codes *33418* and *33419* replace *CPT*® codes *0343T* and *0344T*, respectively.)

MACs shall accept the numeric, eight-digit NCT number preceded by the two alpha characters of "CT" when placed in Field 19 of paper Form CMS-1500, or when entered WITHOUT the "CT" prefix in the electronic 837P in Loop 2300 REF02 (REF01=P4). NOTE: The "CT" prefix is required on a paper claim, but it is not required on an electronic claim.

TMVR for MR claim lines in a clinical trial billed without an eight-digit NCT number shall be returned as unprocessable. MACs will supply the following messages when returning TMVR for MR claim lines as unprocessable when billed without an 8-digit NCT number:

- **CARC 16**: "Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)"
- **RARC MA50**: "Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services."
- **Group code**: CO

Claims processing requirements for TMVR for MR on inpatient hospital claims

Inpatient hospitals shall bill for TMVR for MR on a 11x type of bill (TOB) effective for discharges on or after August 7, 2014. In addition to the ICD-9/10 procedure and diagnosis codes mentioned above, inpatient hospital discharges for TMVR for MR shall be covered when billed with the following clinical trial coding:

- Secondary ICD-9 diagnosis code V70.7/ICD-10 diagnosis code Z00.6;
- Condition code 30; and
- An eight-digit NCT Number assigned by the National Library of Medicine (NLM) and displayed at *https://clinicaltrials.gov/*.

Inpatient hospital discharges for TMVR for MR will be rejected when billed without the ICD-9/ICD-10 diagnosis and procedure codes and clinical trial coding mentioned above. Claims that do not include these required codes shall be rejected with the following messages:

- **CARC 50**: "These are non-covered services because this is not deemed a "medical necessity" by the payer."
- **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 *http://www.cms.hhs.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- **Group code**: Contractual obligation (CO)

Additional information

The official instruction, CR 9002 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3241CP.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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Patient eligibility requirements for home health services

***Note**: This article was revised April 22, 2015, to reflect an updated change request (CR). That CR revised the effective date from May 11, 2015, to January 1, 2015. The CR release date, transmittal numbers and links to the transmittals also changed. All other information remains the same. This information was previously published in the April 2015 Medicare A Connection, Page 6.*

Provider types affected

This *MLN Matters*® article is intended for physicians, non-physician practitioners (NPPs), and home health agencies (HHAs) that submit claims to Medicare administrative contractors (MACs), including home health & hospice (HH&H) MACs for services provided to Medicare beneficiaries.

Provider action needed

CR 9119 manualizes policies discussed in the 2015 home health prospective payment system (HH PPS) final rule published November 6, 2014. CR 9119 instructs MACs to be aware of the revisions to the requirements for physician certification and recertification of patient eligibility for Medicare home health services.

MACs are also instructed to be aware of the revised timeframe for therapy functional reassessments. Make sure that your billing staffs are aware of these changes.

Background

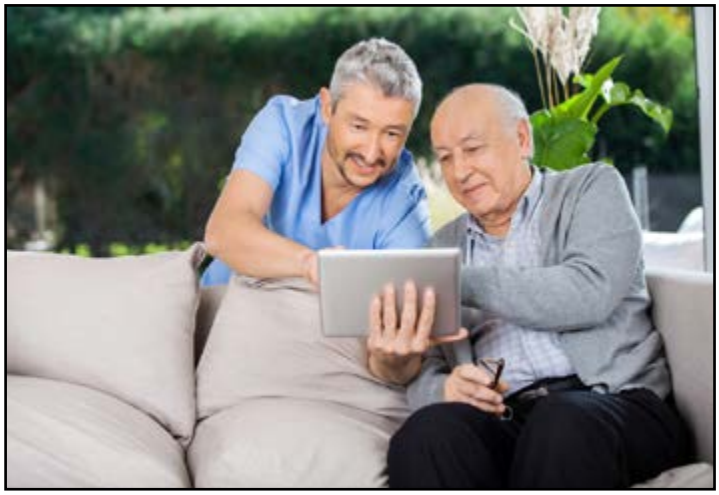
The Centers for Medicare & Medicaid Services (CMS) finalized clarifications and revisions to policies regarding physician certification and recertification of patient eligibility for Medicare home health services in the 2015 HH PPS final rule which was published November 6, 2014 (see *http://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26057.pdf*). In the final rule, CMS also finalized revisions to the timeframe required for therapy functional reassessments.

Face-to-face encounter requirements

The Affordable Care Act requires that the certifying physician or allowed NPP must have a face-to-face encounter with the beneficiary before they certify the beneficiary's eligibility for the home health benefit.

CMS is implementing the following three changes to the face-to-face encounter requirements for episodes beginning on or after January 1, 2015. These changes will reduce administrative burden and provide HHAs with additional flexibilities in developing individual agency procedures for obtaining documentation supporting patient eligibility for Medicare home health care.

- CMS is eliminating the narrative requirement. The certifying physician is still required to certify (attest) that a face-to-face patient encounter occurred and document the date of the encounter as part of the certification of eligibility. For medical review purposes, Medicare requires documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) to be used as the basis for certification of patient eligibility.



- If a HHA claim is denied, the corresponding physician claim for certifying/re-certifying patient eligibility for Medicare-covered home health services is considered non-covered as well because there is no longer a corresponding claim for Medicare-covered home health services.
- CMS is clarifying that a face-to-face encounter is required for certifications, rather than initial episodes; and that a certification (versus a re-certification) is generally considered to be any time a new start of care assessment is completed to initiate care.

Therapy reassessments

CMS has eliminated the 13th and 19th visit therapy reassessment requirements. For episodes beginning on or after January 1, 2015; at least every 30 calendar days a qualified therapist (instead of an assistant) must provide the needed therapy service and functionally reassess the patient. This policy change will lessen HHAs' burden of counting visits.

This change will reduce the risk of non-covered visits so that therapists can focus more on providing quality care for their patients, while still promoting therapist involvement and quality treatment for all beneficiaries regardless of the level of therapy provided.

Additional information

The official instruction, CR 9119, consists of two transmittals. The first updates the *Medicare General*

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'Medicare Claims Processing Manual' - Chapter 15, Section 40, ambulance - medical conditions list

Provider types affected

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

What you need to know

Change request (CR) 9142 informs you that the Centers for Medicare & Medicaid Services (CMS) has moved the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Medical Conditions List and transportation indicators list in Chapter 15, Section 40 of the *Medicare Claims Processing Manual*. Make sure your billing staffs are aware of this change.

Background

CMS issued the ICD-9-CM medical conditions list as guidance via a manual revision as a result of interest expressed in the ambulance industry for this tool.

In addition to the ICD-9-CM medical conditions list, CMS provided information on the appropriate use of transportation indicators.

CMS has decided to move this information from the *Medicare Claims Processing Manual*. The *Ambulance Services Center* is available at *http://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html*.

There are no policy changes as a result of moving this information to the CMS website.

Additional information

The official instruction, CR 9142, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3240CP.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: MM9142 *Revised*
Related Change Request (CR) #: CR 9142
Related CR Release Date: April 24, 2015
Effective Date: July 27, 2015
Related CR Transmittal #: R3240CP
Implementation Date: July 27, 2015

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Information, Enrollment and Entitlement Manual and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R92GI.pdf*.

The second transmittal updates the *Medicare Benefit Policy Manual* and is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R208BP.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 Change Request (CR) #: CR 9119
Related CR Release Date: April 22, 2015
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Implementation Date: May 11, 2015

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July 2015 update to drug/biological code changes

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9167 and informs Medicare providers about the updating of specific drug and biological HCPCS codes that occur quarterly. It alerts providers that the July file includes new HCPCS codes.

CR 9167 also updates Chapter 17, Section 20.1.2 (Average Sales Price (ASP) Payment Methodology) in the *Claims Processing Manual* to address the use of a compounded drug not otherwise classified (NOC) code on claims for compounded drugs. Make sure that your billing staffs are aware of these changes.

Summary of new HCPCS codes in CR 9167

CR 9167 adds the following HCPCS codes with the effective dates noted.

Note: The Medicare physician fee schedule status indicator for all four codes in Table 1 is "E."

CR 9167 also updates Section 20.1.2 Average Sales Price (ASP) Payment Methodology in Chapter 17 of the *Medicare Claims Processing Manual* to show that, beginning in July 2015, claims for compounded drugs should be submitted using a compounded drug, NOC HCPCS code.

Additional information

The official instruction, CR 9167 issued to your MAC

regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3254CP.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: MM9167
Related Change Request (CR) #: CR 9167
Related CR Release Date: May 8, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3254CP
Implementation Date: July 6, 2015

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Table 1 – New HCPCS codes in CR 9167

Effective for claims with dates of service on or after:	HCPCS code	Long description	Short description	Type of service (TOS)
March 6, 2015	Q5101	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	Inj filgrastim g-csf biosim	1, P
July 1, 2015	Q9976	Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron	Inj Ferric Pyrophosphate Cit	1,L
July 1, 2015	Q9978	Netupitant 300 mg and Palonosetron 0.5 mg, oral	Netupitant Palonosetron oral	1
July 1, 2015	Q9977	Compounded Drug, Not Otherwise Classified	Compounded Drug NOC	1, P

Chronic care management services FAQs

Provider types affected

This *MLN Matters*® special edition is intended for physicians and non-physician practitioners such as certified nurse midwives (CNMs), clinical nurse specialists (CNSs), nurse practitioners (NPs), and physician assistants (PAs) who bill the Medicare fee-for-service program (original Medicare) for the new chronic care management (CCM) services provided to Medicare beneficiaries.

Provider action needed

This article alerts providers that the Centers for Medicare & Medicaid Services (CMS) revised the *Medicare Learning Network*® fact sheet on CCM services (ICN 909188, released in March 2015) to clarify Medicare's requirement for 24/7 access by individuals furnishing CCM services to the electronic care plan rather than the entire medical record. Also, CMS released a set of frequently asked questions (FAQs) and answers to address requests received from practitioners and providers for additional guidance in specific areas such as claims submission, intersection with transitional care management services, and the provision of CCM services in facility settings. Those FAQs appear later in this article.

Key points

The revised fact sheet is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf*. The CCM Services fact sheet is a resource that succinctly identifies the newly payable CCM service, identifies eligible providers and patients, and details the Medicare physician fee schedule (PFS) billing requirements.

Background

CMS recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending. Beginning January 1, 2015 Medicare pays separately under the physician fee schedule (PFS) under American Medical Association *Current Procedural Terminology* (*CPT*®) *99490*, for non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions.

Frequently asked questions about billing Medicare for chronic care management services

This document answers frequently asked questions about billing CCM services to the PFS and hospital outpatient prospective payment system (OPPS) under *CPT*® code *99490*.

Physician fee schedule

1. ***CPT*® *99490* requires at least 20 minutes of time per calendar month by "clinical staff" in order to bill the code. Who qualifies as "clinical staff"? If the billing physician (or other appropriate practitioner) furnishes services directly, does their time count towards the required minimum 20 minutes of time?**

   In most cases, we believe clinical staff will provide CCM services incident to the services of the billing physician (or other appropriate practitioner who can be a physician assistant, nurse practitioner, clinical nurse specialist or certified nurse midwife). Practitioners should consult the *CPT*® definition of the term "clinical staff." In addition, time spent by clinical staff may only be counted if Medicare's "incident to" rules are met such as supervision, applicable state law, licensure and scope of practice. If the billing physician (or other appropriate billing practitioner) provides CCM services directly, that time counts towards the 20 minute minimum time. Of course, other staff may help facilitate CCM services, but only time spent by clinical staff may be counted towards the 20 minute minimum time.

2. **Can CCM services be subcontracted out to a case management company? What if the clinical staff employed by the case-management company are located outside of the United States?**

   A billing physician (or other appropriate practitioner) may arrange to have CCM services provided by clinical staff external to the practice (for example, in a case management company) if all of the "incident to" and other rules for billing CCM to the PFS are met. Because there is a regulatory prohibition against payment for non-emergency Medicare services

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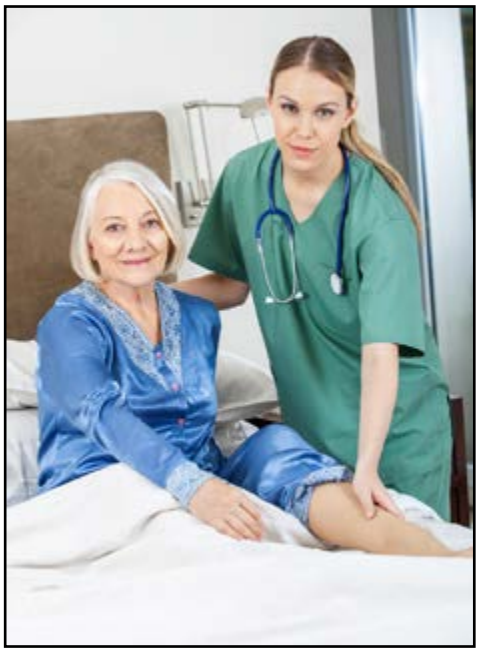
furnished outside of the United States (42 CFR 411.9), CCM services cannot be billed if they are provided to patients or by individuals located outside of the United States.

3. **Does the billing practice have to furnish every scope of service element in a given service period, even those that may not apply to an individual patient?**

   It is our expectation that all of the scope of service elements will be routinely provided in a given service period, unless a particular service is not medically indicated or necessary (for example, the beneficiary has no hospital admissions that month so there is no management of a transition after hospital discharge).



4. **What date of service should be used on the physician claim and when should the claim be submitted?**

   The service period for *CPT® 99490* is one calendar month, and CMS expects the billing practitioner to continue furnishing services during a given month as applicable after the 20 minute time threshold to bill the service is met (see #3 above). However, practitioners may bill the PFS at the conclusion of the service period or after completion of at least 20 minutes of qualifying services for the service period. When the 20 minute threshold to bill is met, the practitioner may choose that date as the date of service, and need not hold the claim until the end of the month.

5. **What place of service (POS) should be reported on the physician claim?**

   Practitioners must report the POS for the billing location (i.e., where the billing practitioner would furnish a face-to-face office visit with the patient). Accordingly, practitioners who furnish CCM in the hospital outpatient setting, including provider-based locations, must report the appropriate POS for the hospital outpatient setting). Payment for CCM furnished and billed by a practitioner in a facility setting will trigger PFS payment at the facility rate.

6. ***CPT® code 99490* is payable to hospital outpatient departments (provider-based locations) under the hospital OPPS. Can physicians practicing in these departments or in locations that are hospital-owned (but not provider-based) also bill this code to the PFS? What if the patient is a hospital or SNF inpatient or is otherwise in a Medicare "facility" or "institution?"**

   If the patient resides in a community setting and the CCM service is provided by or "incident to" services of the billing physician (or other appropriate billing practitioner) working in or employed by a hospital, *CPT® 99490* can be billed to the PFS and payment is made at the facility rate (if all other billing requirements are met). We discuss this further under the section below addressing billing for CCM furnished in the hospital outpatient department setting.

   As we discussed in the 2014 PFS final rule, the resources required to provide care management services to patients in facility settings significantly overlap with care management activities by facility staff that are included in the associated facility payment. Therefore, *CPT® 99490* cannot be billed to the PFS for patients who reside in a facility (that receives payment from Medicare for care of that beneficiary, see 78 FR 74423) regardless of the location of the billing practitioner, because the payment made to the facility under other payment systems includes care management and coordination. For example, *CPT® 99490* cannot be billed to the PFS for services provided to SNF inpatients or hospital inpatients, because the facility is being paid for extensive care planning and care coordination services. However if the patient is not an inpatient the entire month, time that is spent furnishing CCM services to the patient while they are not inpatient can be counted towards the minimum 20 minutes of service time that is required to bill for that month.

   Billing practitioners in hospital-owned outpatient practices that are not provider-based departments are working in a non-facility setting, and may therefore bill *CPT® 99490* and be paid under the PFS at the non-facility rate. However, *CPT® 99490* can only be billed for CCM services furnished to a patient who is not a hospital or SNF inpatient and does not reside in a facility that receives payment from Medicare for that beneficiary.

7. **Is a new patient consent form required each calendar month or annually?**

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No, as provided in the 2014 PFS final rule (78 FR 74424), a new consent is only required if the patient changes billing practitioners, in which case a new consent must be obtained and documented by the new billing practitioner prior to furnishing the service.

8. **Is Medicare now paying separately under the PFS for remote patient monitoring services described by *CPT*® code *99091* or similar *CPT*® *codes*?**

CPT® *99091* continues to be bundled with other services for payment under the PFS. As per *CPT*® guidance, *CPT*® codes *99090*, *99091*, and other codes cannot be billed during the same service period as *CPT*® *99490*. However as discussed in the 2015 PFS final rule (79 FR 67727), analysis of patient-generated health data and other activities described by *CPT*® *99091* or similar codes may be within the scope of CCM services, in which case these activities would count towards the minimum 20 minutes of qualifying care per month that are required to bill *CPT*® *99490*. But in order to bill *CPT*® *99490*, such activity cannot be the only work that is done—all other requirements for billing *CPT*® *99490* must be met in order to bill the code, and time counted towards billing *CPT*® *99490* cannot also be counted towards billing other codes.

9. **If a physician arranges to furnish CCM services to his/her patients "incident to" using a case management entity outside the billing practice, does the billing physician need to ever see the patient face-to-face?**

Yes, as provided in the 2014 final rule (78 FR 74425), CCM must be initiated by the billing practitioner during a comprehensive evaluation & management (E/M) visit, annual wellness visit (AWV) or initial preventive physical exam (IPPE). This face-to-face visit is not part of the CCM service and can be separately billed to the PFS, but is required before CCM services can be provided directly or under other arrangements. The billing practitioner must discuss CCM with the patient at this visit. While informed patient consent does not have to be obtained during this visit, it is an opportunity to obtain the required consent. The face-to-face visit included in transitional care management (TCM) services (*CPT*® *99495* and *99496*) qualifies as a comprehensive visit for CCM initiation. *CPT*® codes that do not involve a face-to-face visit by the billing practitioner or are not payable by Medicare (such as *CPT*® *99211*, anticoagulant management, online services, telephone and other E/M services) do not meet the requirement for the visit that must occur before CCM services are furnished. If the practitioner

furnishes a comprehensive E/M, AWV, or IPPE and does not discuss CCM with the patient at that visit, that visit cannot count as the initiating visit for CCM.

10. **Do face-to-face activities count as billable time?**

CPT® *99490* describes activities that are not typically or ordinarily furnished face-to-face, such as telephone communication, review of medical records and test results, and consultation and exchange of health information with other providers. If these activities are occasionally provided by clinical staff face-to-face with the patient but would ordinarily be furnished non-face-to-face, the time may be counted towards the 20 minute minimum to bill *CPT*® *99490*. However, see #11 below regarding care coordination services furnished on the same day as an E/M visit.

11. **Medicare and *CPT*® allow billing of E/M visits during the same service period as *CPT*® *99490*. If an E/M visit or other E/M service is furnished the same day as CCM services, how do I allocate the total time between *CPT*® *99490* and the other E/M code(s)?**

Under longstanding Medicare guidance, only one E/M service can be billed per day unless the conditions are met for use of modifier 25. Time cannot be counted twice, whether it is face-to-face or non-face-to-face time, and Medicare and *CPT*® specify certain codes that cannot be billed for the same service period as *CPT*® *99490* (see 12, 13 below). Face-to-face time that would otherwise be considered part of the E/M service that was furnished cannot be counted towards *CPT*® *99490*. Time spent by clinical staff providing non-face-to-face services within the scope of the CCM service can be counted towards *CPT*® *99490*. If both an E/M and the CCM code are billed on the same day, modifier 25 must be reported on the CCM claim.

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12. Medicare and *CPT*® specify that CCM and TCM cannot be billed during the same month. Does this mean that if the 30-day TCM service period ends during a given calendar month and 20 minutes of qualifying CCM services are subsequently provided on the remaining days of that calendar month, *CPT*® code *99490* cannot be billed that month to the PFS?

CPT® *99490* could be billed to the PFS during the same calendar month as TCM, if the TCM service period ends before the end of a given calendar month and at least 20 minutes of qualifying CCM services are subsequently provided during that month. However we expect that the majority of the time, CCM and TCM will not be billed during the same calendar month.

13. Are there any other services that cannot be billed under the PFS during the same calendar month as *CPT*® *99490*?

Yes, Medicare does not allow *CPT*® *99490* to be billed during the same service period as home health care supervision (HCPCS G0181), hospice care supervision (HCPCS G0182) or certain ESRD services (*CPT*® *90951-90970*) because care management is an integral part of all of these services.

Also see *CPT*® coding guidance for a list of additional codes that cannot be billed during the same month as *CPT*® *99490*. There may be additional restrictions on billing for practitioners participating in a CMS model or demonstration program; if you participate in one of these separate initiatives, please consult the CMS staff responsible for these initiatives with any questions on potentially duplicative billing.

14. Can I bill *CPT*® *99490* if the beneficiary dies during the service period?

CPT® *99490* can be billed if the beneficiary dies during the service period, as long as at least 20 minutes of qualifying services were furnished during that calendar month and all other billing requirements are met.

15. Will practitioners be able to use an acceptably certified electronic health record (EHR) technology for which certification expires mid-year in order to bill for CCM? For example, can they use technology certified to the 2011 edition to fulfill the scope of services required to bill *CPT*® *99490* in 2015 once this technology no longer bears a "2011 Edition certified" mark?

Yes. Under the CCM scope of services, practitioners must use technology certified to the edition(s) of certification criteria that is acceptable for the EHR incentive programs as of December 31st of the year preceding each CCM payment year. In certain years, this may mean that practitioners can fulfill the scope of services requirement using multiple Editions of certification criteria.

For instance, for payment in 2015, practitioners may use technology certified to either the 2011 or 2014 edition of certification criteria to meet the EHR scope of service requirements, as both editions could be used to meet the requirements of the EHR incentive programs as of December 31, 2014. This remains true for a given PFS payment year even after ONC-Authorized Certification Bodies (ONC-ACBs) have removed the certifications issued to technology certified to a given acceptable edition (e.g., the 2011 Edition for CCM payment in 2015) as a result of the relevant criteria being removed from the *Code of Federal Regulations*.

Thus, practitioners using an acceptable EHR technology that loses its certification mid-year may still use that technology to fulfill the certified EHR criteria for billing *CPT*® *99490* during the applicable payment year.

16. Does the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) affect the billing rules for CCM services?

No, Section 103 of the MACRA codifies payment broadly for chronic care management services under the PFS, authorizing PFS payment after January 1, 2015, for CCM services furnished by physicians and the non-physician practitioners that Medicare generally recognizes to furnish and bill for E/M services (physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives). It does not impact the current billing and payment rules for *CPT*® *99490*. It provides that provision of an AWV or IPPE in advance shall not be a condition of payment for CCM services, which is consistent with our current policy. It also provides that payment shall not be duplicative of other Medicare payments, consistent

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with the rules we have implemented to date regarding duplicative payment for *CPT® 99490*.

17. Where can I find more guidance on CCM billing requirements?

A fact sheet on CCM is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf*. The scope of service elements and other requirements for billing CCM to the PFS are also laid out in the 2014 and 2015 PFS final rules (CMS-1600-FC, CMS-1612-FC and CMS-1612-F2, available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*).

Most of the requirements were finalized in the 2014 PFS final rule, effective 2015. The 2015 final rule with comment period and correction notice address supervision and other "incident to" rules, electronic health record and other electronic technology requirements, valuation, and intersection with CMS' care coordination models and demonstrations. Regarding the intersection with CMS' care coordination models and demonstrations, please consult the CMS staff responsible for those projects. You may also direct questions to your Medicare administrative contractor.

Hospital outpatient prospective payment system

18. Are hospital outpatient departments (HOPDs) eligible to bill *CPT®* code *99490* under the OPPS?

Yes, *CPT®* code *99490* is payable under the OPPS when certain requirements are met (see details in question #19 on billing requirements). As *CPT®* code *99490* is defined as a physician-directed service, the OPPS provides payment to the HOPD when the hospital's clinical staff furnishes the service at the direction of the physician (or other appropriate practitioner). Payment under the OPPS represents only payment for the facility portion of the service. Payment for the physician's (or other appropriate practitioner's) time directing CCM services in the HOPD setting is made under the PFS at the facility rate.

19. What are the requirements to bill CCM under the OPPS?

CPT® 99490 is a physician-directed service that is only payable under the OPPS when the hospital's clinical staff furnishes the service at the direction

of the physician (or other appropriate practitioner). The billing physician or practitioner directing the CCM services must meet the requirements to bill CCM services under the PFS, when the CCM service is furnished in the physician office or the hospital outpatient department. A fact sheet on CCM including requirements to bill CCM services to the PFS is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf*. Specifically, a hospital outpatient department may bill and be paid for CCM services furnished to eligible hospital outpatients under the OPPS if the hospital's clinical staff furnishes at least 20 minutes of care management services under the direction of the physician (or other appropriate practitioner) during the calendar month and the billing physician or practitioner directing the CCM services satisfies the billing requirements for *CPT®* code *99490* under the PFS including the following requirements:

- **Patient eligibility**: Patient has multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
- **Patient agreement**: Patient consent to receive CCM services has been obtained by the practitioner and documented in the medical record.
- CCM scope of service elements including structured data reporting, care plan, access to care, and care management of the patient are furnished by the hospital. The full listing of required CCM scope of service elements is located in the

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2014 and 2015 PFS final rules (CMS-1600-FC, CMS-1612-FC and CMS-1612-F2, available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html*).

- Hospital furnished the CCM services using a version of certified EHR that is acceptable under the EHR incentive programs as of December 31st of the calendar year preceding each Medicare PFS payment year (**referred to as "CCM certified technology"**). The hospital must also meet the requirements to use electronic technology in providing CCM services, such as 24/7 access to the care plan, and electronic sharing of the care plan and clinical summaries (other than by fax), specified in the 2014 and 2015 PFS final rules.

20. How does CMS define a "hospital outpatient" for whom a hospital may bill CCM services (*CPT® 99490*)?

Per section 20.2 of publication 100-04 of the *Medicare Claims Processing Manual*, a hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital.

Since *CPT® 99490* will ordinarily be performed non face-to-face (see # 10 above), the patient will typically not be a registered outpatient when receiving the service. In order to bill for the service, the hospital's clinical staff must provide at least 20 minutes of CCM services under the direction of the billing physician or practitioner.

Because the beneficiary has a direct relationship with the billing physician or practitioner directing the CCM service, we would expect a beneficiary to be informed that the hospital would be performing care management services under their physician or other practitioner's direction.

21. When CCM services are furnished by a physician in a hospital outpatient department, can the physician and the hospital both bill Medicare for the CCM service?

Yes, when certain conditions are met. Specifically, when CCM services are furnished by a physician in a hospital outpatient department to an eligible patient, the physician may bill Medicare for *CPT® 99490* under the PFS reporting place of service (POS) 22 (outpatient hospital), which will indicate that PFS payment should be made at the facility rate, and the hospital may bill for *CPT® 99490* under the OPPS.

22. Can more than one hospital bill and be paid for furnishing CCM services if the patient has been a registered hospital outpatient at more than one hospital over a 12-month span? If only one hospital can bill and receive payment for CCM services, which hospital is allowed to bill?

CPT® 99490 is only payable under the OPPS when the hospital's clinical staff furnishes the CCM service at the direction of a qualified physician (or other appropriate practitioner). As only one physician or practitioner is allowed to bill under the PFS for *CPT® 99490* during a calendar month service period, accordingly, only one hospital is allowed to bill and be paid for *CPT® 99490* for a particular beneficiary during a calendar month service period.We would expect the hospital billing for *CPT® 99490* under physician direction to have access to the patient's consent to receive CCM services documented in the patient's medical record.

The patient may choose a different practitioner to furnish CCM at the conclusion of the service period, at which time the practitioner assuming the provision of CCM services will be required to have the patient consent of CCM services documented in the patient's medical record. New patient consent is only required if the patient chooses a new practitioner to furnish CCM services, in which case a new consent must be documented in the patient's medical record prior to furnishing the service.

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23. Is *CPT® 99490* payable to provider-based hospital outpatient departments under the hospital OPPS? May a hospital-owned practice that is not provider-based bill the OPPS for CCM services?

A provider-based outpatient department of a hospital is part of the hospital and therefore may bill for CCM services furnished to eligible patients, provided that it meets all applicable requirements. A hospital-owned practice that is not provider-based to a hospital is not part of the hospital and, therefore, not eligible to bill for services under the OPPS; but the physician (or other qualifying practitioner) practicing in the hospital-owned practice may bill under the PFS for CCM services furnished to eligible patients, provided all PFS billing requirements are met.

24. What is the supervision level for CCM services furnished in the hospital setting?

CPT® 99490 is assigned a general supervision level under the OPPS when furnished in the hospital setting.

General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually perform the procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Additional information

To review the provisions included in the 2015 PFS proposed rule go to: *http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-07-03-1.html* and scroll down to read the section titled: primary care and complex chronic care management.

To review the revisions to payment policies under the PFS, clinical laboratory fee schedule and other revisions to Part B for 2014 (CMS-1600-FC) go to page 186: *CMS-1600-FC (PDF version*).

Page ten of the CCM services fact sheet outlines a comprehensive list of resources with Web addresses for additional information on CCM services.

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Online Medicare refreshers

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

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

Click here to explore the wide away of training opportunities.

Local Coverage Determinations

This section of *Medicare A Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.

These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

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

Effective and notice dates

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

More information

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

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

Advance beneficiary notice

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

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

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

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

New LCDs

Amniotic membrane: suture-less placement on the ocular surface – new LCD

LCD ID number: L35935
(Florida, Puerto Rico/U.S. Virgin Islands)

Data analysis identified an increase in utilization of placement of amniotic membrane on the ocular surface; without sutures, *Current Procedural Terminology*® (*CPT*®) code *65778*.

The Medicare Part B Extraction Summary System (BESS) statistical medical data obtained for dates of service January 1, 2014, through June 30, 2014, indicated a carrier to nation ratio for Florida at *2.79 for procedure code *65778* (150 percent above the national average).

(**Note**: data for Puerto Rico and the U.S. Virgin Islands was below the national average for the applicable code). Reimbursement for *CPT*® code *65778* from Medicare physician and non-physician practitioner fee schedule (MPFS) for non-facility participating (Non-Fac Par) in Florida location 99 (Rest of Florida) is $1338.50.

Due to the risk for a high dollar claim payment error and lack of quality evidence for many proposed indications in available published literature, the LCD has been created to address indications for this service.

This LCD outlines indications and limitations of coverage and/or medical necessity, *CPT*® code, ICD-9-CM diagnosis codes, documentation guidelines, and utilization guidelines for amniotic membrane- sutureless placement on the ocular surface. In addition, coding guidelines were created and attached to the LCD to provide instructions on coding and billing.

Effective date

This LCD is effective for **services rendered on or after June 29, 2015**.

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 “Attachments” in the “Section Navigation” drop-down menu at the top of the LCD page.

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

Cardiology non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, cardiac PET– new LCD

LCD ID number: L35933
(Florida, Puerto Rico/U.S. Virgin Islands)

This new local coverage determination (LCD) has been developed to outline indications and limitations of coverage and/or medical necessity, *CPT*® codes, ICD-9-CM diagnosis codes, documentation guidelines, and utilization guidelines for noninvasive testing for obstructive coronary artery disease in the outpatient setting.

The diagnosis and management of patients with suspected and documented coronary artery disease in the office setting is supported by several validated tests including treadmill stress test, stress echocardiography, myocardial perfusion imaging (MPI) through both single photon emission computed tomography (SPECT) and positron emission tomography (PET).

Historically, in the course of the contractor’s standard policy development process that includes routine data analysis for Jurisdiction N, several LCDs were implemented addressing office based diagnostic testing.

Physicians have requested reconsideration of several of these LCDs that share similar indications for many clinical situations. This new LCD updates and consolidates several existing policies and serves to align indications and utilization guidelines in the office setting for patients in a non-emergency situation.

The following existing policies will be retired with implementation of this policy.

- Cardiovascular stress testing
- Stress echocardiography
- Cardiovascular nuclear imaging studies(Part B)/ Myocardial perfusion imaging (Part A)
- Myocardial imaging, positron emission tomography (PET) scan

Effective date

This new LCD is effective for **services rendered on or after June 29, 2015**. 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 “Attachments” in the “Section Navigation” drop-down menu at the top of the LCD page.

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

Humanitarian use device (HUD) and humanitarian device exemption process (HDE) – new LCD

LCD ID number: L35931
(Florida, Puerto Rico/U.S. Virgin Islands)

Humanitarian Use Device (HUD), as defined by the Food and Drug Administration (FDA), is a device intended to benefit patients by treating or diagnosing a disease or condition that affects or is manifested in fewer than 4,000 individuals per year in the United States.

When the manufacturer submits a humanitarian device exemption (HDE) application to the FDA, it must provide sufficient information for the FDA to determine that the device does not pose an unreasonable or significant risk of illness or injury to the patient and that the probable benefits to health outweigh the risk of injury or illness from its use. The manufacturer is not required to provide the results of scientifically valid clinical investigations demonstrating that the device is effective for its intended purpose prior to marketing (see FDA regulations [21 CFR 814.124]). This FDA regulation was developed to provide an incentive for the development of devices for use in the treatment or diagnosis of diseases affecting limited populations. Such devices may only be used in institutions where an institutional review board (IRB) has approved the use of the device to treat or diagnose the specific rare disease.

This policy clarifies that a device classified by the FDA as an HUD is not addressed by the Medicare Administrative Contractor (MAC) Jurisdiction N (JN) Investigational Device Exemption (IDE) study approval process.

An HDE-designated device may only be considered for coverage at the claim level (pre or post payment review). On audit, the medical record must support that the device meets the Medicare reasonable and necessary (R&N) threshold for coverage assuming all other applicable requirements of the program are met. The device is specifically not covered if noted as such by national or local coverage determination or used off-label per the FDA indications. Claims for a device generally (with some exceptions) incorporate physician services billed to multi-carrier system (MCS) and hospital facility services billed to fiscal intermediary standard system (FISS).

Effective date

This LCD is effective **on or after 06/29/2015**.

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 “Attachments” in the “Section Navigation” drop-down menu at the top of the LCD page.

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

Revised LCDs

Colorectal cancer screening – revision to the Part A LCD

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

Based on the Centers for Medicare and Medicaid Services (CMS) change request (CR) 8874, two modifiers may be used to identify anesthesia services rendered in conjunction with a screening service.

- Modifier 33 – Preventive Services: when the primary purpose of the service is the delivery of an evidence based service in accordance with United States Preventive Task Force A or B rating in effect and other preventive services Appending the 33 modifier will waive patient’s deductible and co-insurance.
- Modifier PT – Colorectal cancer screening test; converted to diagnostic test or other procedure. Appending the PT modifier will waive the patient’s deductible. Co-insurance will still apply.

The local coverage determination (LCD) for colorectal cancer screening has been revised to reflect the addition of Modifiers 33 and PT.

Effective date

This LCD revision is effective for **services rendered on or after January 1, 2015**.

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 “Attachments” in the “Section Navigation” drop-down menu at the top of the LCD page.

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

Bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications – revision to the Part A LCD

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

The local coverage determination (LCD) for bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications was revised to add a new Food and Drug Administration (FDA) approved indication for Xgeva®. The "Indications and Limitations of Coverage and/or Medical Necessity" and "ICD-9 Codes that Support Medical Necessity" sections of the LCD were updated.

Additionally, pamidronate (Aredia®) has been added to this LCD. The following sections of the LCD were revised: "Indications and Limitations of Coverage and/or Medical Necessity", "*CPT*®/HCPCS codes", "ICD-9 Codes That Support Medical Necessity", "Documentation Requirements", "Utilization Guidelines", and "Sources of Information and Basis for Decision."

Effective date

The LCD revision related to Xgeva® is effective for claims processed on or after May 14, 2015, for services rendered on or after December 14, 2014.

The LCD revision related to the addition of pamidronate (Aredia®) is effective for services rendered on or after May 14, 2015.

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 "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Non-covered services – revision to the Part A LCD

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

The Medical Policy & Procedures Department evaluated the following services and determined that they are not considered medically reasonable and necessary at this time based on current available published evidence (e.g., peer-reviewed medical literature, and published studies).

Therefore, the following procedure codes have been added to the non-covered services local coverage determination (LCD). The comment period for the addition of these services was from February 14, 2015, to March 30, 2015.

After a LCD becomes effective/active, any stakeholder may request a revision to the LCD, by following the reconsideration process as outlined on our website.

- C9737 – *Laparoscopy, surgical, esophageal sphincter augmentation with device (eg, magnetic band)*
- *0378T – 0379T* - Visual field assessment, with concurrent real time data analysis and accessible data storage with patient initiated data transmitted to a remote surveillance center for up to 30 days
- *0380T - Computer-aided animation and analysis of time series retinal images for the monitoring of disease progression, unilateral or bilateral, with interpretation and report*
- *0381T – 0382T* – External heart rate and 3-axis accelerometer data recording up to 14 days to assess changes in heart rate and to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events
- *0383T – 0384T* – External heart rate and 3-axis accelerometer data recording from 15 to 30 days to assess changes in heart rate to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events
- *0385T – 0386T* – External heart rate and 3-axis accelerometer data recording more than 30 days to assess changes in heart rate to monitor motion analysis for the purposes of diagnosing nocturnal epilepsy seizure events
- *0387T- Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular*
- *0388T - Transcatheter removal of permanent leadless pacemaker, ventricular*
- *0389T - Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report, leadless pacemaker system*
- *0390T - Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure or test with analysis*,

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review and report, leadless pacemaker system

- *0391T - Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, leadless pacemaker system*

*Covered if beneficiary is enrolled in a MAC approved category B investigational device exemption (IDE) study.

In determining if a service or procedure reaches the threshold for coverage, this contractor addresses the quality of the evidence per the *Program Integrity Manual*.

When addressing the articles and related information in the public domain, the jurisdiction N (JN) Medicare administrative contractor (MAC) reached the determination that available evidence was of moderate to low quality, consisting of small case series, retrospective studies, and review articles reporting limited safety and efficacy data for these procedures.

Due to the unavailability of high quality evidence, the JN MAC reiterates that there is insufficient scientific evidence to support these procedures, and therefore they are not considered reasonable and necessary under Section 1862(a)(1)(a) of the Social Security Act.

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.

An interested stakeholder can request a reconsideration of an LCD after the draft is finalized, the notice period has ended, and the draft becomes active. In the case of the non-covered services LCD, the stakeholder may request the list of the articles and related information in the public domain that were considered by the Medical Policy department in making the non-coverage decision.

If the stakeholder has new information based on the evaluation of the list of articles and related information, an LCD reconsideration can be initiated.

It is the responsibility of the interested stakeholder to request the evidentiary list from the contractor and 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.

Also, any interested party could request CMS to consider developing a national coverage determination (NCD). Of note, if the evidence is not adequate for coverage under section 1862(a)(1)(A), an item or service may be considered for coverage under the CMS Coverage with Evidence Development (CED) policy in which "reasonable and necessary" is established under 1862(a)(1)(E) of the Act.

Under the authority of Section 1862(a)(1)(E), the NCD process may result in coverage if the item or service is covered only when provided within a setting in which there is a pre-specified process for gathering additional data, and in which that process provides additional protections and safety measures for beneficiaries, such as those present in certain clinical trials.

Effective date

This LCD revision is effective for **services rendered on or after June 29, 2015**. 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 "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Retired LCD information

Pamidronate (Aredia®, APD) – Part A LCD retired

LCD ID number: L28944 (Florida)
LCD ID number: L28965
(Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pamidronate (Aredia®) has been retired. Pamidronate (Aredia®) has been incorporated into the bisphosphonates (intravenous [IV]) and monoclonal antibodies in the treatment of osteoporosis and their other indications LCD.

Effective date

This LCD retirement is effective for **services rendered on or after May 14, 2015**.

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 "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Multiple Part A local coverage determinations being retired

LCD ID number: L28756, L28795, L28888 (Florida)
LCD ID number: L28757, L28800, L28910 (Puerto Rico/U.S. Virgin Islands)

Based on data analysis and a review of the local coverage determinations (LCDs), it was determined that the following LCDs are no longer required and, therefore, were retired.

- Accelerated partial breast irradiation (APBI)
- Ceredase/cerezyme
- Ibritumomab tiuxetan (Zevalin®) therapy

Effective date

This retirement of these LCDs is effective for **services rendered on or after May 13, 2015**.

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 "Attachments" in the "Section Navigation" drop-down menu at the top of the LCD page.

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

Additional LCD Information

Claims for Venofer® and Ferrlecit® denied in error between February 24-May 4, 2015

Venofer® is covered for the Food and Drug Administration (FDA) approved indication as a first line treatment of iron deficiency anemia in patients undergoing chronic hemodialysis as well as for the treatment of iron deficiency anemia in non-dialysis dependent chronic kidney disease patients.

Ferrlecit® is covered for the FDA approved indication as a first line treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental erythropoietin therapy.

Claims submitted for HCPCS codes J1756 and J2916 (Injection,) between February 24, 2015, and May 6, 2015, may have been denied incorrectly with the following denial message: "Service is not medically necessary based on Medicare guidelines."

This error was corrected on May 6, 2015.

Providers whose claims were incorrectly denied due to this error do not need to take any action.

First Coast Service Options Inc. will perform adjustments to correct the error on all the affected claims. We apologize for any inconvenience this may have caused.

Viscosupplementation therapy for knee – Part A LCD

LCD ID number: L29005 (Florida)
LCD ID number: L29037
(Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for viscosupplementation therapy for knee contains the following language related to the non-coverage of imaging procedures (e.g., *20611*, *77012*, *77021*, *76881*, *76882* or *76942*).

Imaging procedures performed routinely for the purpose of visualization of the knee to provide guidance for needle placement will not be covered.

Fluoroscopy may be medically necessary and allowed if documentation supports that the presentation of the patient's affected knee on the day of the procedure makes needle insertion problematic.

No other imaging modality for the purpose of needle guidance and placement will be covered. Therefore, these services will be denied.

Instructions for reopening claims electronically

Note: *This article was revised May 7, 2015, to make changes to keep the information consistent with the related article, MM8581. The table on page 4 was added, and the effective date and implementation date were also changed. The change request (CR) release date, transmittal number and link to the CR also changed to the revised CR for MM8581. All other information remains the same. This article was previously published in the September 2014 edition of Medicare A Connection, Page 27.*

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, reopenings are written requests for corrections that include supporting documentation. However, a standard process across all A/MACs has not been available. In an effort to streamline and standardize the process for providers to request reopenings, CMS petitioned the National Uniform Billing Committee (NUBC) for a "new" bill type frequency code to be used by providers indicating a request for reopening and a series of condition codes that can be utilized to identify the type of Reopening being requested.

These institutional reopenings must be submitted with a "Q" frequency code to identify them as a reopening. The NUBC adopted these new codes and bill type frequency change effective with claims received on or after January 1, 2016 (based on an October 1, 2015 implementation of ICD-10, see bold below).

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.

Reopenings are different from adjustment bills in that adjustment bills are subject to normal claims processing timely filing requirements (that is, filed within one year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (for example, claim determinations may be reopened within one year of the date of the initial determination for any reason, or within one to four years of the date of the initial determination upon a showing of good cause).

Note that while the reopening period associated with ARC R1 is one year from the RA date, providers must submit an adjustment bill (TOB xxx7) when the claim correction is submitted within the claims timely filing period (that is, within one year of the date of service or claim through date). The reopening request (TOB xxxQ) should only be utilized when the submission falls outside of the period to submit an adjustment bill.

Table 1 on the next page presents some scenarios of reopening and adjustment timeline scenarios. Note that there is a special congressionally mandated time frame for adjustments/reopenings that are for higher weighted DRGs.

These must be filed within 60 days from the initial claim determination. Note that clerical errors or minor errors are

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limited to errors in form and content, and that omissions do not include failure to bill for certain items or services (for example, late charges).

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

Decisions to allow reopenings are discretionary actions on the part of your A/MAC. An A/MAC's decision to reopen a claim determination or refusal to reopen a claim determination is not an initial determination and is therefore not appealable. Requesting a reopening does not guarantee that request will be accepted and the claim determination will be revised, and does not extend the timeframe to request an appeal.

If an A/MAC decides not to reopen an initial determination, the A/MAC will return to provider (RTP) the reopening request indicating that the A/MAC is not allowing this discretionary action. In this situation, the original initial determination stands as a binding decision, and appeal rights are retained on the original initial determination. New appeal rights are not triggered by the refusal to reopen, and the filing timeframes to request an appeal (which are based on the original initial determination on the RA) are not extended and do not "reset" 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 (TOB xxx7) or reopening requests (TOB xxxQ) 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.

Also, due to ICD-10 implementation, currently scheduled for October 2015, the NUBC is going to delay implementation of the new bill type and condition codes until January 1, 2016. CMS will implement system changes in October, as scheduled, but will not allow the front end edits to accept these coding changes until January 2016. If there is a change in the ICD-10 implementation dates, we will re-issue this communication and provide the acceptance of the reopenings as scheduled with system changes in October 2015.

Finally, clarification was requested regarding the congressional exception to the adjustment and reopening process. As is currently the situation with adjustment and reopening processes, a provider cannot use the automation of the reopening process to reopen a claim to a higher weighted DRG after 60 days from the initial claim processing. The automation of the reopening process does not change this long standing congressional exception.

Table 1 - Scenarios for reopenings and timeline adjustments

Claim "through" date	Remittance advice date	Adjustment period (based on "through" date)	Reopening period – adjustment reason code (ARC)= R1 (based on RA date after adjustment period has lapsed)	Reopening period – ARC=R2 (based on RA date)	Reopening period – ARC=R3 (based on RA date)
Timely filing period – Use TOB xxx7			Beyond timely filing period – Use TOB xxxQ		
10-01-2014	11-01-2014	10-01-2014 Thru 09-30-2015	10-01-2015 thru 10-31-2015	11-01-2015 thru 10-31-2018	11-01-2018 and beyond
10-01-2014	03-31-2015	04-01-2015 thru 09-30-2015	10-01-2015 thru 03-30-2016	3-31-2016 thru 3-30-2019	3-31-2019 and beyond
10-01-2014	9-30-2015	N/A – timely filing period has lapsed	10-01-2015 thru 09-30-2016	10-1-2016 thru 9-29-2019	09-30-2019 and beyond

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Definitions:

Timely filing = 12 calendar months from the date of service
(IOM 100-04, Chapter 1, Section 70.1 - Determining Start Date of Timely Filing Period -- Date of Service)
"For institutional claims (Form CMS-1450, the UB-04 and now the 837 I or its paper equivalent) that include span dates of service (that is, a "From" and "Through" date span on the claim), the "Through" date on the claim is used for determining the date of service for claims filing timeliness."

Initial claim determinations = the date of the initial determination via an electronic or paper remittance advice (RA) (that is, A.K.A. the date on the 835) – see CFR 42 §405.921.

Additional information

The related CR 8581 may be viewed at *http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3060CP.pdf*.

To assist providers with claims coding a request for reopening, the following attachment was prepared with condition codes that may be used and scenarios using adjustment reason codes, R1, R2 and R3.

Attachment

Coding requirements

1. (1) Type of bill xxxQ
2. (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 consider a 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=Duplicate of an original bill. When a provider uses this code they are attesting that they are reopening a bill already sent to the Medicare program and that there is no Appeal in Process. A provider cannot reopen a bill and appeal the same bill simultaneously.
5. (For DDE claims only) An "adjustment reason code" from the reopening subset below on claim page 3 (MAP1713) R1 = < 1 yr initial determination (from remittance advice date) r2 = 1 - 4 yr initial determination (from remittance advice date) R3 = > 4 yr initial determination (from remittance advice date)
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…

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

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

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

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

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

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

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

GOOD CAUSE- C-A HCPCS

GOOD CAUSE- C-A HIPPS

GOOD CAUSE- C-A OTHER BECAUSE…

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

GOOD CAUSE- F-E (FAULTY EVIDENCE) BECAUSE…

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

Reopening request scenarios

(Examples are not all-inclusive)

Scenario A – Adjustment reason code R1

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

TOB	xxxQ	
Reopening condition code	R1	Mathematical or computational mistakes
Adjustment condition code	D9	Other
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE Only)	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	
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
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE Only)	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 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	
Reopening condition code	R3	**Misapplication of a fee schedule**
Adjustment condition code	D9	Other
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE Only)	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 – (that is, Provider had wrong code or units hardcoded/loaded in their charge master or billing software)

TOB	xxxQ	
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
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

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

TOB	xxxQ	
Reopening condition code	R5	Incorrectly identified duplicate
Adjustment condition code	D9	Other
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE only)	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 (that is, incorrect data items such as discharge status, modifier or date of service.)

TOB	xxxQ	
Reopening condition code	R6	Incorrect data entry (used wrong code completely)

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TOB	xxxQ	
Adjustment condition code	D0 D1 D2 D4 D9 E0	Changes in service date Changes to charges Changes in revenue code/HCPCS/HIPPS rate codes Change in clinical codes (ICD) for diagnosis and/or procedure codes Change in condition codes, occurrence codes, occurrence span codes, or modifiers Change in patient status
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE Only)	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 (that is, incorrect data items such as modifier or clinical information.)

TOB	xxxQ	
Reopening condition code	R6	**Incorrect data entry (left off the code from billing)**
Adjustment condition code	D2 D4 D9	Changes in revenue code/ HCPCS/HIPPS rate codes Change in clinical codes (ICD) for diagnosis and/or procedure codes Change in condition codes, occurrence codes, occurrence span codes, or modifiers
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE only)	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 (that is, off-site provider zip code, condition code, occurrence code, occurrence span code, value code, modifier)

TOB	xxxQ	
Reopening condition code	R7	Computer system omission
Adjustment condition code	D2 D4 D9	Changes in revenue code/ HCPCS/HIPPS rate codes Change in clinical codes (ICD) for diagnosis and/or procedure codes Change in condition codes, occurrence codes, occurrence span codes, value codes or modifiers
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE only)	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 8: Corrections other than clerical errors – New and material evidence (subsequent test results, new documentation has become available since the initial determination)

TOB	xxxQ	
Reopening condition code	R8	**New and material evidence**
Adjustment condition code	D9	Other
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE Only)	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	
Reopening condition code	R9	Faulty evidence
Adjustment condition code	D9	Other
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE only)	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 I/OCE, revised NCD edits, revised MUE edits

TOB	xxxQ	
Reopening condition code	R1	Mathematical or computational mistakes
Adjustment condition code	D9	Other
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE only)	R2	1 -4 yrs from initial determination
Remarks – (good cause)	Yes	

Claim 2: Clerical error – Minor Error – Keying Error

TOB	xxxQ	
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
Duplicate bill condition code	W2	Duplicate of an original bill

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TOB	xxxQ	
Adjustment reason code (For DDE only)	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	
Reopening condition code	R3	Misapplication of a fee schedule
Adjustment condition code	D9	Other
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE only)	R2	1 -4 yrs from initial determination
Remarks – (good cause)	Yes	

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

TOB	xxxQ	
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
Duplicate bill condition code	W2	Duplicate of an original bill

TOB	xxxQ	
Adjustment reason code (For DDE only)	R2	1 -4 yrs from Initial Determination
Remarks – (good cause)	Yes	

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

TOB	xxxQ	
Reopening condition code	R5	Incorrectly identified duplicate
Adjustment condition code	D9	Other
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE only)	R2	1 -4 yrs from initial determination
Remarks – (good cause)	Yes	

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

TOB	xxxQ	
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

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TOB	xxxQ	
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE Only)	R2	1 -4 yrs from initial determination
Remarks – (Good Cause)	Yes	

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

TOB	xxxQ	
Reopening condition code	R6	Incorrect data entry (left off the code from billing)
Adjustment condition code	D2 D4 D9	Changes in revenue code/ HCPCS/HIPPS rate codes Change in clinical codes (icd) for diagnosis and/or procedure codes Change in condition codes, occurrence codes, occurrence span codes, or modifiers
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE Only)	R2	1 -4 yrs from initial determination
Remarks – (Good Cause)	Yes	

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

TOB	xxxQ	
Reopening condition code	R7	Computer system omission
Adjustment condition code	D2 D4 D9	Changes in revenue code/ HCPCS/HIPPS rate codes Change in clinical codes (ICD) for diagnosis and/or procedure codes Change in condition codes, occurrence codes, occurrence span codes, value codes or modifiers
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE only)	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	
Reopening condition code	R8	New and material evidence
Adjustment condition code	D9	Other
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code (For DDE only)	R2	1 -4 yrs from initial determination
Remarks – (good cause)	Yes	

Claim 9: Corrections other than clerical errors – faulty evidence

TOB	xxxQ	
Reopening condition code	R9	Faulty Evidence
Adjustment condition code	D9	Other
Duplicate bill condition code	W2	Duplicate of an original bill

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TOB	xxxQ	
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	
Reopening condition code	R8	New and material evidence
Adjustment condition code	D9	Other
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code	R3	>4 yrs from initial determination
Remarks – (good cause)	Yes	

Claim 2: Corrections other than clerical errors – faulty evidence

TOB	xxxQ	
Reopening condition code	R9	Faulty evidence
Adjustment condition code	D9	Other
Duplicate bill condition code	W2	Duplicate of an original bill
Adjustment reason code	R3	>4 yrs from initial determination
Remarks – (good cause)	Yes	

MLN Matters® Number: SE1426 *Revised*
Related Change Request (CR) #: CR 8581
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Effective Date: Claims received on or after January 1, 2016
Related CR Transmittal #: R3219CP
Implementation Date: January 1, 2016

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CMS issues notification of FY 2017 wage index preliminary PUF availability and timeline

For fiscal year (FY) 2017, the Centers for Medicare & Medicaid Services (CMS) have changed the wage index development timetable.

The wage index development process now starts in May with the posting of the preliminary worksheet S-3 PUF.

- *FY 2017 Hospital Wage Index Development Timetable*
- *Letter to hospitals on the "Availability of the Preliminary Federal Fiscal Year (FY) 2017 Wage Index Public Use Files (PUF), Deadline for Requesting Revisions to the Preliminary FY 2017 Wage Index Data, and FY 2017 Wage Index Development Timetable."*
- *Preliminary Wage Index PUFs external link*

Got a success story using First Coast Web tools?

With its *Tools Center*, First Coast Service Options offers medical providers an abundance of self-service tools to improve Medicare billing practices.

Provider profiles - *Click here* to read how providers are making innovative use of Web tools to grow their bottom line.

Success story? - If you have a success story to share with First Coast, let us know by *clicking here*. Check the "Success Story" button on the form and let us know how First Coast's Tools Center is helping to improve your practice.

Updates for remittance advice remark and claims adjustment reason codes and Medicare remit easy print

Provider types affected

This *MLN Matters*® article is intended for physicians, 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) 9125, which updates the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists.

It also instructs Medicare system maintainers to update Medicare remit easy print (MREP) and PC print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if they use that software.

Background

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

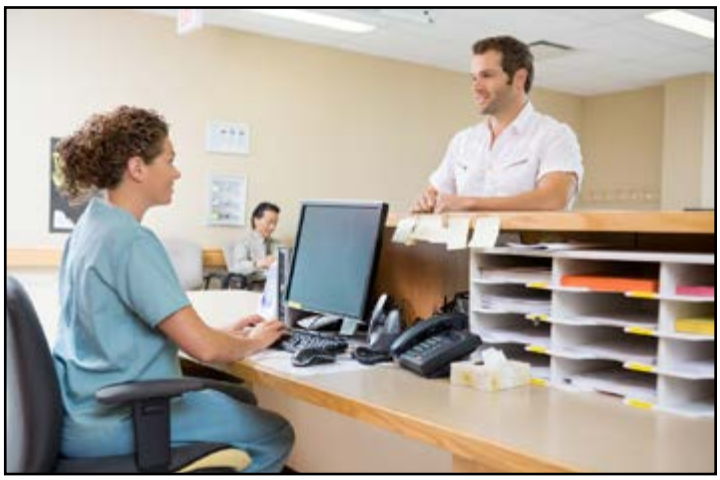
Medicare policy states that CARCs and appropriate RARCs that provide either supplemental explanation for a monetary adjustment or policy information, which generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The CARC and RARC changes that affect Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change.

Medicare contractors and shared system maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification.

If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

SSMs have the responsibility to implement code deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the Washington Publishing Company (WPC) website.



If any new or modified code has an effective date past the implementation date specified in CR 9125, MACs will implement on the date specified on the WPC website. The WPC website is available at *http://www.wpc-edi.com/Reference*.

CR 9125 lists only the changes that have been approved since the last code update CR (CR 9004 issued on January 9, 2015, with a related *MLN Matters*® article available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9004.pdf*), and does not provide a complete list of codes for these two code sets.

The complete list for both CARC and RARC from the WPC website is updated three times a year – around March 1, July 1, and November 1. The WPC website, which has four listings available for both CARC and RARC, is available *at http://www.wpc-edi.com/Reference*.

In case of any discrepancy in the code text as posted on WPC website and as reported in any CR, the WPC version should be implemented.

Note: This recurring code update CR lists only the changes approved since the last recurring code update CR once.

If any modification or deactivation becomes effective at a future date, MACs must make sure that they update on the effective date or the quarterly release date that matches the effective date as posted on the WPC website.

Changes in CARC list since CR 9004

The following tables are changes in the CARC database since the last code update in CR 9004.

New codes – CARC

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Code	Narrative	Effective date
269	Anesthesia not covered for this service/procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	03/01/2015

Modified codes – CARC

Code	Modified narrative	Effective date
45	Charge exceeds fee schedule/maximum allowable or contracted/ legislated fee arrangement. (Use only with group codes PR or CO depending upon liability) This change effective 11/1/2015: Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement. **Note**: this must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with group codes PR or CO depending upon liability)	03/01/2015
55	Procedure/treatment/drug is deemed experimental/ investigational by the payer. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	03/01/2015
133	The disposition of this service line is pending further review. (Use only with group code OA). **Note**: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	03/01/2015

Deactivated codes – CARC

Code	Current narrative	Effective date
A7	Presumptive payment adjustment	07/01/2015

Changes in RARC list since CR 9004

The following tables are changes in the RARC database since the last code update in CR 9004.

New codes – RARC

Code	Narrative	Effective date
N736	Incomplete/invalid sleep study report.	03/01/2015
N737	Missing sleep study report.	03/01/2015
N738	Incomplete/invalid vein study report.	03/01/2015
N739	Missing vein study report.	03/01/2015
N740	The member's consumer spending account does not contain sufficient funds to cover the member's liability for this claim/service.	03/01/2015
N741	This is a site neutral payment.	03/01/2015
N742	Alert: This claim was processed based on one or more ICD-9 codes. The transition to ICD-10 is required by October 1, 2015, for health care providers, health plans, and clearinghouses. More information can be found at *http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html.*	03/01/2015
N743	Adjusted because the services may be related to an employment accident.	03/01/2015

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Code	Narrative	Effective date
N744	Adjusted because the services may be related to an auto accident.	03/01/2015
N745	Missing ambulance report.	03/01/2015
N746	Incomplete/invalid ambulance report.	03/01/2015
N747	This is a misdirected claim/service. Submit the claim to the payer/plan where the patient resides.	03/01/2015
N748	Adjusted because the related hospital charges have not been received.	03/01/2015
N749	Missing blood gas report.	03/01/2015
N750	Incomplete/ invalid blood gas report.	03/01/2015
N751	Adjusted because the drug is covered under a Medicare Part D plan.	03/01/2015
N752	Missing/incomplete/ invalid HIPPS treatment authorization code (TAC).	03/01/2015

Modified codes – RARC

Code	Modified narrative	Effective date
N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/ medical advisor/dental advisor/peer review.	03/01/2015

Deactivated codes – RARC

Code	Current narrative	Effective date
N483	Missing periodontal charts	05/01/2015
N484	Incomplete/invalid periodontal charts.	05/01/2015

Code	Current narrative	Effective date
N29	Missing documentation/ orders/notes/summary/ report/chart	03/01/2016
N225	Incomplete/invalid documentation/orders/notes/ summary/report/chart	03/01/2016

The full CARC and RARC lists must be downloaded from the WPC website available at *http://wpc-edi.com/Reference*.

Additional information

The official instruction, CR 9125, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3242CP.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: MM9125
Related Change Request (CR) #: CR 9125
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Related CR Transmittal #:R3242CP
Implementation Date: July 6, 2015

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CMS releases updated supplemental security income and Medicare data for cost report settlement

Provider types affected

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

What you need to know

Change request (CR) 8835 provides updated supplemental security income (SSI)/Medicare beneficiary data for determining the disproportionate share (DSH) adjustment for IPPS hospitals and the low income patient adjustment for IRFs.

Background

The SSI/Medicare beneficiary data for hospitals are available electronically and contains the:

- Name of the hospital;
- Centers for Medicare & Medicaid Services (CMS) certification number;
- SSI days;
- Total Medicare days; and
- Ratio of Medicare Part A patient days attributable to SSI recipients.

The files are located at the following CMS website addresses:

- **IPPS hospitals**: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html*
- **IRFs**: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/SSIData.html*
- **Long term care hospitals (LTCHs)**: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html*

The data are used for settlement purposes for IPPS hospitals and IRFs with cost reporting periods beginning during FY 2012 (cost reporting periods beginning on or after October 1, 2011 and before October 1, 2012).

The Consolidated Omnibus Budget Reconciliation Act of 1985 (Section 9105) provides that, for discharges occurring on or after May 1, 1986, an additional payment must be made to IPPS hospitals serving a disproportionate share of low income patients.

The additional payment is determined by multiplying the federal portion of the diagnosis-related group (DRG) payment by the disproportionate share hospital (DSH) adjustment factor, and beginning for discharges occurring on or after October 1, 2014, the additional payment is determined by multiplying the DRG payment by the DSH adjustment factor reduced by 75 percent. See 42 CFR 412.106 at *http://www.ecfr.gov/cgi-bin/text-idx?SID=f1e0dfaa3e10da210951232e91244cb6&node=42:2.0.1.2.12&rgn=div5#42:2.0.1.2.12.7.50.11*.

Under the IRF prospective payment system (PPS), IRFs receive an additional payment amount to account for the cost of furnishing care to low income patients. The additional payment is determined by multiplying the federal prospective payment by the output of the LIP adjustment formula. See 42 CFR 412.624(e)(2) at *http://www.ecfr.gov/cgi-bin/text-idx?SID=f1e0dfaa3e10da210951232e91244cb6&node=42:2.0.1.2.12&rgn=div5#42:2.0.1.2.12.16.59.13*

Under the LTCH PPS, the payment adjustment for short-stay outlier (SSO) cases at 42 CFR 412.529 requires the calculation of an amount comparable to the amount that would otherwise be paid under the IPPS (that is, the "IPPS comparable amount.").

This calculation includes an "IPPS comparable" DSH adjustment, where applicable, that is determined using the best available SSI data at the time of claim payment. See 42 CFR 412.529(d)(4) at *http://www.ecfr.gov/cgi-bin/text-idx?SID=f1e0dfaa3e10da210951232e91244cb6&node=42:2.0.1.2.12&rgn=div5#42:2.0.1.2.12.15.59.14*.

Additional information

The official instruction for CR 8835 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1488OTN.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: MM8835
Related Change Request (CR) #: CR 8835
Related CR Release Date: April 17, 2015
Effective Date: May 18, 2015
Related CR Transmittal #: R1488OTN
Implementation Date: May 18, 2015

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Payments to long term care hospitals not submitting quality data

Provider types affected

This *MLN Matters*® is intended for long term care hospitals (LTCHs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 9105, which informs LTCHs that, for fiscal year (FY) 2014, and each subsequent year, if they do not submit required quality data, their payment rates for the year are reduced by two percentage points for that FY.

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

Every year, the Centers for Medicare & Medicaid Services (CMS) will provide MACs with information identifying LTCHs not meeting the quality data reporting requirements. MACs will use that information to make appropriate payment reductions for those LTCHs. You should make sure that your billing staffs are aware of these changes and that you remain current with quality data reporting and submission requirements.

Background

Section 3004 of the Affordable Care Act amended the Social Security Act (the Act) to authorize a quality reporting program for LTCHs. Section 1886(m)(5)(A)(i) of the Act requires that, beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any LTCH that does not comply with the quality data submission requirements with respect to that FY. Any reduction based on failure to comply with the reporting requirements, as required by Section 1886(m)(5)(B) of the Act, would apply only for the particular FY involved. Any such reduction would not be cumulative or be taken into account in computing the payment amount for subsequent FYs.

Key points in CR 9105

- Beginning with FY 2016 and subsequent years, MACs will notify the LTCHs that they have been identified as not complying with the requirements of submitting quality data and are scheduled to have Medicare payments to their agency reduced by 2 percentage points.
- LTCHs that are identified as non-compliant with regard to LTCH quality reporting will be sent an initial notification letter that indicates they are non-compliant. The letters will be sent no later than 10 business days from the receipt of the report from CMS, identifying the LTCHs that are potentially subject to reductions.
- The notification letter will also inform the LTCH of the process to request a reconsideration of their payment reduction if they disagree with the determination. The reconsideration process will be outlined within the initial notification letter.
- CMS will review all reconsideration requests received and provide a determination to the Medicare contractor typically within a period of two to three months. In its review of the LTCH documentation, CMS will determine whether evidence to support a finding of compliance has been provided by the LTCH. The determination will be made based solely on the documentation provided. If clear evidence to support a finding of compliance is not present, the 2-percent reduction will be upheld. If clear evidence of compliance is present, the reduction will be reversed.
- After the reconsideration process has occurred and prior to October 1 of each FY, CMS will provide the MACs with a final list of LTCHs that failed to comply with the data submission requirements.

Additional information

The official instruction, CR 9105, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R42QRI.pdf.*

More information on Long-Term Care Hospital (LTCH) Quality Reporting (QRP) may be found at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/.*

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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Effective Date: September 2, 2015
Related CR Transmittal #: R42QRI
Implementation Date: September 2, 2015

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Payments to inpatient rehabilitation facilities that do not submit required quality data

Provider types affected

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

Provider action needed

Change request (CR) 9106 advises IRFs that for fiscal year (FY) 2014, and each subsequent year, if you do not submit required quality data, your payment rates for the year are reduced by two percentage points for that fiscal year. Application of the two percent reduction may result in an update that is less than zero for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. In addition, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

Every year, the Centers for Medicare & Medicaid Services (CMS) will provide Medicare MACs with a list of IRFs not meeting the quality data reporting requirements. Make sure that your billing staffs are aware of these changes and that you remain current with quality data requirements and submission.

Background

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

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

Every year, your MAC will send a letter to those IRFs that have been identified as not complying with the requirements of submitting quality data and are scheduled to have Medicare payments to their agency reduced by 2 percentage points. MACs will also inform the IRFs regarding the process to request reconsideration of their payment reduction if they disagree with the determination.

CMS will then review all reconsideration requests received and provide a determination to the MAC typically within a period of two to three months. In its review of the IRF documentation, CMS will determine whether evidence to support a finding of compliance

has been provided by the IRF. The determination will be made based solely on the documentation provided. If clear evidence to support a finding of compliance is not present, the 2 percent reduction will be upheld. If clear evidence of compliance is present, the reduction will be reversed.

Your MAC will then notify each IRF that failed to comply with the quality data submission requirements that it will receive a 2 percentage point reduction in payment. MACs will make this notification via a second letter only to IRFs that request a reconsideration. Additionally, in this second letter the MACs will include information regarding the IRFs right to further appeal the 2 percent reduction via the Provider Reimbursement Review Board (PRRB) appeals process.

Additional information

The official instruction, CR9106, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R44QRI.pdf*. For more information, see Inpatient Rehabilitation Facilities (IRF) Quality Reporting Program (QRP), available at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/*.

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 #: R44QRI
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Practitioners on Part A critical access hospital claims

Provider types affected

This *MLN Matters*® article is intended for critical access hospitals (CAHs), method II providers submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

This is a reminder that CAHs, method II claims submitted to Medicare must contain an attending or rendering physician or non-physician practitioner who has a valid national provider identifier (NPI), is of an eligible specialty, and is enrolled in Medicare in an approved status. Failure to list a physician or non-physician practitioner, in the attending or referring fields that meet the above requirements will result in the rejection of the CAH Methods II claim.

Background

All Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entities (except small health plans), including enrolled Medicare providers and suppliers that are covered entities, are required to obtain an NPI and to use their NPI to identify themselves as "health care providers" in the HIPAA standard transactions that they conduct with Medicare and other covered entities.

Every provider or supplier that submits an enrollment application must furnish its NPI(s) in the applicable section(s) of the Form CMS-855.

The Centers for Medicare & Medicaid Services (CMS) has implemented edits that verify that the NPI reported for physicians or non-physician practitioners in the attending or rendering physician fields on CAH method II claims for payment has a valid NPI and that the provider for that NPI is enrolled in Medicare in an approved status, otherwise the claim will be rejected.

If the physician or non-physician practitioner is not enrolled in Medicare, he/she will need to establish an enrollment record in the Provider Enrollment Chain and Ownership System (PECOS) with a valid NPI.

He/she may submit their enrollment application electronically using Internet-based PECOS located at h*ttps://pecos.cms.hhs.gov/pecos/login.do* or by completing the paper CMS-855I or CMS- 855O application, which is available at *http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html*.

Note that an application fee is not required as part of the physician's or non-physician practitioner's application submission.

Only physicians and certain types of non-physician practitioners are eligible as attending or rendering providers on CAH method II claims. Those providers are as follows:

- Doctor of medicine or osteopathy;
- Dental surgery;
- Podiatric medicine;
- Optometry;
- Chiropractic medicine;
- Physician assistant;
- Certified clinical nurse specialist;
- Nurse practitioner;
- Clinical psychologist;
- Certified nurse midwife;
- Licensed clinical social worker;
- Certified registered nurse anesthetist; and
- Registered dietitian/nutritional professional.

If the attending or rendering provider is listed on the claim, the edits will compare the first four letters of the provider's last name and validate that the physician or non-physician practitioner is enrolled in Medicare with a valid NPI. If the provider's enrollment status cannot be validated the claim will be rejected with the following claim adjustment reason codes:

- N253: Missing/incomplete/invalid attending provider primary identifier, and
- N290: Missing/incomplete/invalid rendering provider primary identifier.

Additional information

To assist providers, CMS provides an attending and rendering file that identifies those physicians and non-physician practitioners who are of a specialty type that is eligible to be listed as an attending or rendering provider on CAH method II claims and is enrolled in Medicare in an approved status.

When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the attending and rendering file available at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html*.

Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the attending/rendering fields.

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April 2015 update of the hospital outpatient prospective payment system

***Note**: This article was revised April 23, 2015, to reflect updated change request (CR) 9097 on April 14, 2015 and April 22, 2015. The first update corrected the payment rate for C9447. There was also a correction made to the copayment rate for HCPCS code C9447. In addition, references to HCPCS codes J0365 and J7180 were removed and the table "Drugs and Biological with Revised Status Indicators" was deleted from attachment in CR 9097. The second update corrected table references. All other information remains the same. This article was previously published in the March 2015 edition of Medicare A Connection, Page 41.*

Provider types affected

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

Provider action needed

CR 9097 describes changes to and billing instructions for various payment policies implemented in the April 2015 outpatient prospective payment system (OPPS) update. Make sure your billing staffs are aware of these changes.

Background

The April 2015 integrated outpatient code editor (I/OCE) and OPPS pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 9097. The April 2015 revisions to I/OCE data files, instructions, and specifications are provided in CR 9107. Upon release of CR 9107, a *MLN Matters*® article related to CR 9107 will be available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9107.pdf*.

The key changes to and billing instructions for various payment policies implemented in the April 2015, OPPS update are as follows:

Changes to device edits for April 2015

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

New device pass-through categories

The Social Security Act (Section 1833(t)(6)(B); see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*) requires

that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than three years. Section 1833(t)(6)(B)(ii)(IV) of the Social Security Act requires that CMS create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

CMS is establishing one new device pass-through category as of April 1, 2015. Table 1 provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

Table 1 – New device pass-through categories

HCPCS	Effective date	SI	Short descriptor	Long descriptor
C2623	04/01/15	H	Cath, translumin, drug-coat	Catheter, transluminal angioplasty, drug-coated, non-laser

a. Device offset from payment

Section 1833(t)(6)(D)(ii) of the Social Security Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the device (70 FR 68627-8).

CMS has determined that a portion of the APC payment amount associated with the cost of C2623 is reflected in procedures assigned to various peripheral transluminal angioplasty codes in APC 0083, APC 0229, and APC 0319. The C2623 device may be billed with various peripheral transluminal balloon angioplasty codes that are assigned to these three APCs for 2015. The device offset

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from payment represents a deduction from pass-through payments for the device in category C2623.

New services

No new services have been assigned for payment under the OPPS effective April 1, 2015.

Drugs, biologicals, and radiopharmaceuticals

a. Drugs and biologicals with payments based on average sales price (ASP) effective April 1, 2015

For 2015, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP+6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical.

In 2015, a single payment of ASP+6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items.

Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2015 and drug price restatements can be found in the April 2015 update of the OPPS Addendum A and Addendum B at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html*.

b. Drugs and biologicals with OPPS pass-through status effective April 1, 2015

Six drugs and biologicals have been granted OPPS pass-through status effective April 1, 2015. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

Table 2 – Drugs and biologicals with OPPS pass-through status effective April 1, 2015

HCPCS code[1]	Short desc.	Long descriptor	APC	Status ind.
C9445	C-1 esterase, Ruconest	Injection, c-1 esterase inhibitor (recombinant), Ruconest, 10 units	9445	G

HCPCS code[1]	Short desc.	Long descriptor	APC	Status ind.
C9448	Oral netupitant palonosetron	Netupitant 300mg and palonosetron 0.5 mg, oral	9448	G
C9449	Inj, blinatumomab	Injection, blinatumomab, 1 mcg	9449	G
C9450[2]	Fluocinolone acetonide implt	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg	9450	G
C9451	Injection, peramivir	Injection, peramivir, 1 mg	9451	G
C9452	Inj, ceftolozane/ tazobactam	Injection, ceftolozane 50 mg and tazobactam 25 mg	9452	G

1. HCPCS codes listed in Table 2 are new codes effective April 1, 2015.
2. HCPCS code C9450 is associated with Iluvien® and should not be used to report any other fluocinolone acetonide intravitreal implant (e.g., Retisert®). Hospitals should note that the dosage descriptor for Iluvien is 0.01 mg. Because each implant is a fixed dose containing 0.19 mg of fluocinlone acetonide, hospitals should report 19 units of C9450 for each implant.

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c. Drugs and biologicals based on ASP methodology with restated payment rates

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html*. Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files.

d. Reassignment of skin substitute products from the low cost group to the high cost group

Two existing skin substitute products have been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. These products are listed in Table 3 below.

Table 3 – Updated skin substitute product assignment to high cost status effective April 1, 2015

HCPCS code	Short descriptor	Status indicator	Low/high cost status
Q4150	Allowrap DS or Dry 1 sq cm	N	High
Q4153	Dermavest 1 square cm	N	High

e. Other changes to 2015 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals

Effective April 1, 2015, HCPCS code Q9975 Factor VIII FC Fusion Recomb, will replace HCPCS code C9136 Factor viii (Eloctate).

The SI will remain G, "Pass-Through Drugs and Biologicals." Table 4 describes the HCPCS code change and effective date.

Table 4 – New HCPCS codes for certain drugs and biologicals effective April 1, 2015

HCPCS code	Short desc	Long desc	Stat ind.	APC	Add date	Term. date
C9136	Factor viii (Eloctate)	Injection, factor viii, fc fusion protein, (recomb't), per i.u.	G	1656	1/1/15	3/31/15
Q9975	Factor VIII FC Fusion Recomb	Injection, factor viii, fc fusion protein, (recomb't), per i.u.	G	1656	4/1/15	

f. Corrected copayment rate for HCPCS code J7315 effective January 1, 2014, through March 31, 2015

The beneficiary copayment for HCPCS code J7315 was erroneously set to 20 percent of the APC payment rate in the OPPS pricer from January 1, 2014, through March 31, 2015.The corrected copayment is listed in Tables 5 through 9 below. For claims impacted with HCPCS J7315, APC 1448, instructions for mass adjusting claims will be provided in future notification.

Table 5 – Corrected copayment rate for HCPCS code J7315 effective January 1, 2014, through March 31, 2014

HCPCS code	Status ind.	APC	Short desc	Pmt rate	Corr'd min. unadj. copay
J7315	G	1448	Opthalmic mitomycin	$379.47	$0

Table 6 – Corrected copayment rate for HCPCS code J7315 Effective April 1, 2014, through June 30, 2014

HCPCS code	Status ind	APC	Short desc	Pmt rate	Corr'd min. unadj. copay
J7315	G	1448	Opthalmic mitomycin	$379.66	$0

Table 7 – Corrected copayment rate for HCPCS code J7315 effective July 1, 2014, through September 30, 2014

HCPCS code	Stat. ind	APC	Short desc.	Pmt rate	Corr'd min. unadj. copay
J7315	G	1448	Opthalmic mitomycin	$379.59	$0

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Table 8 – Corrected copayment rate for HCPCS code J7315 effective October 1, 2014, through December 31, 2014

HCPCS code	Stat. ind.	APC	Short desc.	Pmt. rate	Corr'd min. unadj. copay
J7315	G	1448	Opthalmic mitomycin	$366.88	$0

Table 9 – Corrected copayment rate for HCPCS code J7315 effective January 1, 2015, through March 31, 2015

HCPCS code	Stat. ind	APC	Short desc	Pmt rate	Corr'd min. unadj. copay
J7315	G	1448	Opthalmic mitomycin	$372.80	$0

g. Corrected copayment rate for HCPCS code C9447 effective January 1, 2015, through March 31, 2015

The beneficiary copayment for HCPCS code C9447 was erroneously set to 20 percent of the APC payment rate in the OPPS pricer from January 1, 2015, through March 31, 2015.

The corrected copayment is listed in Table 10 below, and has been installed in the April 2015 OPPS pricer, effective for services furnished on January 1, 2015, through March 31, 2015. The MACs will adjust claims, as appropriate, that is brought to their attention that contain HCPCS code listed in table 10; have dates of service that fall on or after January 1, 2015, through April 1, 2015; and were originally processed prior to the installation of the April 2015 OPPS pricer.

Table 10 – Corrected copayment rate for HCPCS code C9447 effective January 1, 2015, through March 31, 2015

HCPCS code	Stat ind.	APC	Short desc.	Pmt rate	Corr'd min. unadj. copay
C9447	G	1663	Inj, phenylephrine ketorolac	$492.90	$0

h. New vaccine *CPT*® codes

Three new vaccine *CPT*® codes have been established. The following table lists these new vaccine codes, their OPPS status indicator, and effective date.

Table 11 – New vaccine *CPT*® codes

CPT® code	Short desc.	Long desc.	2015 SI	Effective date
90620	Menb rp w/omv vaccine im	*Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use*	E	2/1/2015
90621	Menb rlp vaccine im	*Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use*	E	2/1/2015
90697	Dtap-ipv-hib-hepb vaccine im	*Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenza type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use*	E	1/1/2015

Inpatient only list

CMS is revising billing instructions to allow payment for inpatient only procedures that are provided to a patient in the outpatient setting on the date of the inpatient admission or during the three calendar days (or one calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission to be bundled into billing of the inpatient admission, according to Medicare policy for the payment window for outpatient services treated as inpatient services.

Effective April 1, 2015, inpatient only procedures that are provided to a patient in the outpatient setting on the date of the inpatient admission or during the three calendar days (or one calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission, according to the policy for the payment window for outpatient services treated as inpatient services will be covered by

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CMS and are eligible to be bundled into the billing of the inpatient admission.

CMS is updating the *Medicare Claims Processing Manual*, (Chapter 4, Sections 10.12 and 180.7) to reflect the revised impatient only payment policy. This revised section is included as an attachment to CR 9097.

Reporting of the "PO" HCPCS modifier for outpatient service furnished at an off-campus provider-based department

As stated in the 2015 OPPS final rule, CMS finalized the instructions related to the reporting of the "PO" modifier (the short descriptor "Serv/proc off-campus pbd," and the long descriptor "Services, procedures and/or surgeries furnished at off-campus provider-based outpatient departments."). The "PO" HCPCS modifier is to be reported with every code for outpatient hospital services furnished in an off-campus PBD of a hospital. Reporting of this new modifier will be voluntary for one year (2015), with reporting required beginning on January 1, 2016. The modifier should not be reported for remote locations of a hospital, satellite facilities of a hospital, or for services furnished in an emergency department.

CMS is updating the *Medicare Claims Processing Manual*, (Chapter 4, Section 20.6.11) to include the use of the "PO" HCPCS modifier. The revised manual section is included as an attachment to CR 9097.

Clarification regarding propel and propel mini coding
Hospitals may report C2625 (Stent, non-coronary, temporary, with delivery system) when utilizing the Propel™ and Propel Mini™ drug eluting sinus implants by Intersect ENT. These implants are appropriately described by C2625.

Clarification regarding Cysview® coding

When billing for cystoscopy procedures using Cysview® (hexaminolevulinate hydrochloride), hospitals are reminded to report HCPCS code C9275 (Injection, Hexaminolevulinate Hydrochloride, 100 mg, per study dose) on a separate claim line from the cystoscopy procedure code. Consistently reporting charges for C9275 in addition to the appropriate cystoscopy procedure code will ensure that CMS has accurate claims data for future ratesetting.

Coverage determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under

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

Additional information

The official instruction, CR 9097, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3238CP.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 #: R3238CP
Implementation Date: April 6, 2015

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Educational Events

Provider outreach and educational events – June 2015

Medicare Part A - changes and regulations

When: Tuesday, June 16
Time: 11:30 a.m. - 1:30 p.m. ET – Delivery language: English
Type of Event: Webcast
Location: Jacksonville, Fl
http://medicare.fcso.com/Events/0276339.asp

Internet-based PECOS class

When: Thursday, June 25
Time: 7:30 a.m. -4:30 p.m. ET – Delivery language: English
Type of Event: Conference/Seminar
http://medicare.fcso.com/Events/0293486.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*.

MLN Connects®

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.

MLN Connects® Provider eNews for April 23, 2015

MLN Connects® Provider eNews for April 23, 2015

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In this edition:

Take the time to 'chat' with the website team

You now have the opportunity to save your valuable time by asking your website-related questions online – with First Coast's Live Chat service.

Live chat is available Monday-Friday, from 10 a.m.-2 p.m. ET.

MLN Connects® Provider eNews for April 30, 2015

MLN Connects® Provider eNews for April 30, 2015

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In this edition:

MLN Connects® National Provider Calls

- Medicare Acute Care Quality and Reporting Programs — Register Now
- 2014 Mid-Year QRURs – Save the Date
- New MLN Connects® National Provider Call Video Slideshow, Audio Recordings and Transcripts

CMS Events

- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Special Open Door Forum: Home Health Patient Survey Star Ratings

Announcements

- Proposed FY 2016 Inpatient Rehabilitation Facility Payment and Policy Changes
- Proposed FY 2016 Inpatient Psychiatric Facility Payment and Policy Changes
- Focusing on Women's Health
- Open Payments Physician and Teaching Hospital Review and Dispute Period Ends May 20
- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- 2015 PV-PQRS GPRO Registration is Open
- Participation Continues to Rise in Medicare PQRS and eRx Incentive Program
- Antipsychotic Drug use in Nursing Homes: Trend Update
- Five Facts about ICD-10
- 2014 Mid-Year QRURs Available

Claims, Pricers, and Codes

- April 2015 Outpatient Prospective Payment System Pricer File Update
- Coding for ICD-10-CM: Continue to Report *CPT*®/HCPCS Modifiers for Laterality

Medicare Learning Network® Educational Products

- "Physicians and Non-Physician Practitioners Reported on Part A Critical Access Hospital (CAH) Claims" *MLN Matters*® article — Released
- "Accreditation for Ventilators" *MLN Matters*® Article — Released
- "The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Repairs and Replacements" Fact Sheet — Revised
- New Medicare Learning Network® Provider Compliance Fast Fact
- Subscribe to the Medicare Learning Network® Educational Products and MLN Matters® Electronic Mailing Lists

Expand your knowledge of Medicare

Visit the *Medicare Learning Network*® (MLN) Educational Web Guides Overview page, for educational and informational resources to improve your knowledge of Medicare billing and policies.

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.

Click here to explore educational Web guides.

MLN Connects® Provider eNews for May 7, 2015

MLN Connect® Provider eNews for May 7, 2015

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MLN Connects® National Provider Calls

- Medicare Acute Care Quality and Reporting Programs for Hospitals — Last Chance to Register
- 2014 Mid-Year QRURs — Registration Now Open
- National Partnership to Improve Dementia Care and QAPI — Registration Now Open
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X — Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Final Opportunity to Volunteer for ICD-10 End-to-End Testing in July — Forms Accepted May 11 through 22
- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Webinar for Comparative Billing Report on Transthoracic Echocardiography

Announcements

- Proposed Updates to Hospice Wage Index and Payment Rates
- May is National Osteoporosis Month
- Medicare Coverage for Viral Hepatitis
- New CDC Measles Information and Resources
- HHS Announces $101 Million in Affordable Care Act Funding to 164 New Community Health Centers
- Amendment to Disproportionate Share Hospital Ruling
- Inpatient Hospital Probe and Educate Extension
- Quality Reporting Programs: Updated 2014 eCQMs for 2016 Reporting
- CMS Announces the Physician Quality Reporting Programs Strategic Vision
- ICD-10 Resources for Medicare Providers
- Five More Facts about ICD-10
- Medscape Article for CME Credit: Improving Quality of Care through Care Coordination
- EHR Proposed Rules Available for Comment: Stage 3 Comments Due by May 29
- FY 2016 Inpatient and LTCH PPS Proposed Rule: Comment Period Ends June 16
- CMS is Accepting Suggestions for Potential PQRS Measures

Medicare Learning Network® Educational Products

- "The Medicare Home Health Benefit" Web-Based Training Course — *Released*
- "Resources for Medicare Beneficiaries" Fact Sheet — *Revised*
- "Medicare Part B Immunization Billing" Educational Tool — Reminder
- *Medicare Learning Network®* Products Available In Electronic Publication Format

Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency?

You do – visit the *Tools to improve your billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time.

You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

MLN Connects® Provider eNews for May 14, 2015

MLN Connects® Provider eNews for May 14, 2015

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In this edition:

MLN Connects® National Provider Calls

- 2014 Mid-Year QRURs — Register Now
- Medicare Shared Savings Program ACO: Application Review — Registration Now Open
- National Partnership to Improve Dementia Care and QAPI — Register Now
- Hospice Quality and Hospice Item Set Manual v 1.02 — Save the Date
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X — Register Now

MLN Connects® Videos

- New ICD-10 Videos: Impact on Inpatient Hospital Payment and Medicare Testing Plans

CMS Events

- Final Opportunity to Volunteer for ICD-10 End-to-End Testing in July — Forms Accepted May 11 through 22
- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Special Open Door Forum: Home Health Electronic and Paper Clinical Templates

Announcements

- Depression is Not a Normal Part of Growing Older
- Therapy Caps Exceptions Process Extended through CY 2017
- Questions about Medicare?
- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- Groups: 6 Weeks Left to Register for 2015 PQRS GPRO

Medicare Learning Network® Educational Products

- "Overview of the Repetitive Scheduled Non-emergent Ambulance Prior Authorization Model" MLN Matters® Article — Released
- "Items and Services That Are Not Covered Under the Medicare Program" Booklet — Revised
- Medicare Learning Network® Product 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@fcso.com
855-416-4199

Websites
medicare.fcso.com
medicareespanol.fcso.com

First Coast Service Options Addresses

Claims/correspondence
Florida/ U.S. Virgin Islands

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

Puerto Rico

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

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

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

FOIA requests
Provider audit/reimbursement
(relative to cost reports and audits)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268

General Inquiries

Online Form (Click here)

Email: *AskFloridaA@fcso.com*

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