Medicare A Connection

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A Newsletter for MAC Jurisdiction N Providers

June 2015

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Family practice physicians readied for ICD-10 using First Coast Web Tools

Barring any last minute delays, medical providers across the United States will begin using ICD-10 codes for all claims October 1, 2015. For some office and practice managers, the experience of preparing for this large change might be coded as F43.02, "reaction to severe stress."

But for Najwa Liscombe and her team of medical coders at the Department of Community Health and Family Medicine at the College of Medicine, University of Florida, no code is needed. They are ready.

"Our IT people have us well-prepared for ICD-10. We've already loaded ICD-10 codes and we have it cross-mapped to ICD-9 codes so we can train our residents on what they will see when the change to ICD-10 happens," Liscombe said.

Liscombe is a coding and reimbursement analyst. The Department educates medical students in family medicine.

For the soon-to-be physicians, Liscombe plays an important role getting them ready for the next era in medical coding. What she teaches could be the difference in whether doctors get paid for providing medical care. And, according to Liscombe, *First Coast Service Options' Web tools* play a critical role in training doctors for the future.

"I want every resident to know how to document appropriately and code to the documentation. But most importantly, I want them to understand medical necessity," Liscombe said. "The E/M worksheet is an excellent audit tool for all providers to use in their coding. If I were to hire additional staff, the *E/M worksheet* would be an important part of their orientation."

Liscombe added: "I work with the residents to review their charts. We walk through a chart together. I'll ask them

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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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TOOLS

From front page

what their documentation shows. Did they code it appropriately based on the documentation? And then, we will look and see if anything is missing."

> "The E/M worksheet is an excellent audit tool for all providers to use in their coding. If I were to hire additional staff, the E/M worksheet would be an important part of their orientation."
>
> — *Najwa Liscombe, Department of Community Health and Family Medicine University of Florida, College of Medicine*

She has a number of home-grown tools like the ICD-10 cross-map at her disposal to help train UF residents. "As we transition to ICD-10, I will show the resident this is how the coding works in ICD-9 and this is how it will look in ICD-10," Liscombe said. "Our residents code for themselves.

After they complete a chart, I will go over it with them using a chart review tool and the (First Coast) evaluation and management worksheet. I will use it to see what evaluation level was chosen by the provider and compare it with the results on the E/M worksheet. It is very effective."

Liscombe uses a full array of tools in addition to those provided by First Coast Service Options and the UF technology team.

"I track the coding patterns and the Medicare standards for their type of practice. We will work with the E/M bell-curve for primary care in reviewing their charts," she said. "If they are consistently off 10 percent or higher, then we will bring the resident back for more education in coding."

At this point in the resident training process, Liscombe also turns to First Coast's *local coverage determination (LCD) lookup* and *fee schedule tools*.

She reviews a LCD with the resident to show documentation requirements and possible diagnosis codes associated with a procedure or treatment. Liscombe says the fee schedule look-up tool helps identify what the costs are to the practice when there's a variance between what is documented and what is coded on the chart.

"The review is critical. Using the tools like the fee schedule look up, we can see the potential costs to our facility and to Medicare if they undercode or overcode," Liscombe says.

In explaining her role with educating the residents, Liscombe is as thorough as any patient would want their doctor to be in providing medical care.

"I subscribe to all of the listserves from CMS and First Coast. I keep tabs on all of the changes in Medicare," Liscombe said, adding that the information is critical for her to do her job well.

Medicare billing certificate programs

The programs are designed to provide education on Part A and Part B of the Medicare program.

They each include required Web-based training courses, readings, and a list of helpful resources. Upon successful completion of each of the programs, you will receive a certificate in Medicare billing from CMS.

To participate in either the Part A or Part B provider type program, visit *http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html* and select "Web-Based Training (WBT) Courses."

From the list of courses, select the Medicare billing certificate program for your provider type.

Login (return user) or Register (new user) by clicking on the links at the top of the Course screen.

On the next screen choose 'Web-Based Training Courses' and reselect your course. Click the "Take Course" button and you are ready to begin.

Your feedback matters

Your opinion is important to us. If you haven't already completed the MAC Satisfaction Indicator (MSI) survey, please take a moment to complete it now. Share your experience with the services we provide. It will take about 10 minutes. You can access the survey by clicking here.

Inpatient psychiatric facility (IPF) services

The comprehensive error rate testing (CERT) contractor and First Coast Service Options (First Coast) recently completed a review of records submitted by inpatient psychiatric facilities which found a lack of the required documentation that supported coverage for inpatient psychiatric services provided to Medicare beneficiaries. The review found specific deficiencies related to certification and recertification requirements for facilities.

In accordance with *42 CFR 424.14* all inpatient psychiatric facilities (IPF), distinct part units of acute care hospitals and critical access hospitals, are required to meet requirements including the certification and recertification requirements.

For all IPFs, an admitting diagnosis must be made on every patient at the time of admission and must include the diagnosis of comorbid disease as well as the psychiatric diagnosis. Psychiatric hospitals are required to be primarily engaged in providing or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of a mentally ill person.

The medical records maintained by the IPF must include the progress notes and treatment plan, must be legible and complete, and should be promptly signed and dated by the person who is responsible for ordering, providing or evaluating the services furnished.

The record must stress the psychiatric components including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized. The reason for the admission must be clearly documented and the social service records must include reports of interviews with patients, family members and other, must provide an assessment of home plans and family attitudes, and community resource contact as well as social history.

A physician, or a qualified medical staff member that is knowledgeable of the case, must provide initial certification at the time of admission or as soon thereafter as is reasonable and practicable, that the inpatient psychiatric hospitalization is reasonable and medically necessary. The physician's certification statement should reflect that the admission was medically necessary for either:

- Treatment which would reasonably expect to improve the patient's condition, or
- Diagnostic study

A physician must provide the first re-certification as of the 12th day of hospitalization; and subsequent re-certifications at intervals established by the utilization review committee (on a case-by-case basis), but no less than every 30 days that the patient continues to need, on a daily basis, active inpatient treatment furnished directly by or requiring the supervision of IPF personnel.

The physician's recertification should state:

- That inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either:
- Treatment which could reasonably be expected to improve the patient's condition;
- Diagnostic study;
- The hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services, and
- Effective July 1, 2006, physicians will also be required to include a statement recertifying that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel.

The period covered by the physician's certification and recertification is referred to as a period during which the patient was receiving active treatment. For services to be designated as active treatment, they must:

- Be provided under an individualized treatment or diagnostic plan;
- Reasonably expected to improve the patient's condition or for the purpose of diagnosis; and
- Supervised and evaluated by a physician.

This period should include all days on which inpatient psychiatric facility services were provided because of the individual's needs for active treatment. The fact that a patient is under the supervision of a physician does not necessarily mean the patient is getting active treatment.

Where the period of "active treatment" ends, the physician is to indicate the ending date in making his/her recertification. If "active treatment" thereafter resumes, the

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Coverage of Microvolt T-wave Alternans (MTWA)

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers submitting claims to Medicare administrative contractors (MACs) for Microvolt T-wave Alternans (MTWA) diagnostic testing services provided to Medicare beneficiaries.

What you need to know

This article is based on change request (CR) 9162 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) states that effective January 13, 2015, your local MAC will determine, at their discretion, Medicare coverage of MTWA using a modified moving average (MMA) method of analysis and methods of analysis other than spectral analysis (SA) for the evaluation of patients at risk for sudden cardiac death (SCD) from ventricular arrhythmias.

No national coverage determination (NCD) is appropriate at this time for MTWA testing using the MMA method for the evaluation of patients at risk for SCD. As a result, national non-coverage of the MMA method was removed.

Background

CMS was asked to reconsider the NCD on MTWA diagnostic testing to extend coverage to the MMA method of analysis.

CMS currently covers MTWA nationally only when it is performed using the SA method for the evaluation of patients at risk for SCD from ventricular arrhythmias, and patients who may be candidates for Medicare coverage of the placement of an implantable cardiac defibrillator (ICD).

Key points of CR 9162

- MACs will accept the inclusion of the -KX modifier on the claim line(s) along with *Current Procedural Technology CPT*® code *93025* (MTWA for assessment of ventricular arrhythmias, short descriptor: microvolt t-wave assess) as an attestation by the practitioner and/or provider of the service that documentation is on file verifying the MTWA was performed using a method of analysis other than SA for the evaluation of patients at risk for SCD from ventricular arrhythmias and that all other NCD criteria were met.
- Claims for MTWA using the SA method of analysis do not require the –KX modifier and will continue to be processed as they are currently.

  See CR 4351 for instructions for processing MTWA claims using the SA method of analysis at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R894CP.pdf or see MM4351 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM4351.pdf.
- Effective for claims with dates of service on and after January 13, 2015, MACs will determine coverage at

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physician should indicate, in making his recertification, the date on which it resumed.

Additionally, data analysis has identified instances where the facility discharged the patient to home (discharge status code 01) but the patient was actually transferred to an acute care facility (discharge status code 02). First Coast would like to remind providers that claims with discharge status code of 02 are paid differently from a claim were the patient is discharged to home.

If the patient disposition is miscoded the claim may be paid incorrectly. For additional information see the Centers for Medicare & Medicaid Services (CMS) publication, *100-04 Medicare Claims Processing Manual, Chapter 3*, Sections 2.1.2.4 and 40.2.4.

Sources:

Medicare Learning Network Inpatient Psychiatric Facility Prospective Payment System Fact Sheet Series

CMS Publication 100-02, Chapter 2 -- Inpatient Psychiatric Hospital Services

CMS Publication 100-04, Chapter 4, Section 10.9 -- Inpatient Psychiatric Facility Services Certification and Recertification

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their discretion of MTWA diagnostic testing for the evaluation of patients at risk for SCD using analysis methods other than SA.

- Effective for dates of service on and after January 13, 2015, MACs will process claims for MTWA diagnostic testing for the evaluation of patients at risk for SCD when methods of analysis other than SA are used.
- If MACs determine that a claim for MTWA with methods of analysis other than SA are billed without the -KX modifier, MACs will deny the claim using the following messages:
  - Claim adjustment reason code (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."
  - Remittance advice remarks code (RARC) N657 - This should be billed with the appropriate code for these services.
  - Group Code of CO (contractual obligation) assigning financial liability to the provider.
- The following diagnosis code list/translation was approved by CMS. There are duplicate codes because the ICD-9 and ICD-10 tables can be read as a side-by-side translation for ICD-10 purposes and not all translations are 1-to-1 translations.

  It may or may not be a complete list of covered indications/diagnosis codes that are covered but should serve as a finite starting point. Individual MACs within their respective jurisdictions have the discretion to make coverage determinations they deem reasonable and necessary under section 1862(a)1)(A) of the Social Security Act. Therefore, MACs may have additional covered diagnosis codes in their individual policies where MAC discretion is appropriate.

ICD-9 codes

Code	Descriptor
410.11	Acute myocardial infarction of other anterior wall, initial episode of care
410.11	Acute myocardial infarction of other anterior wall, initial episode of care
410.01	Acute myocardial infarction of anterolateral wall, initial episode of care
410.11	Acute myocardial infarction of other anterior wall, initial episode of care

Code	Descriptor
410.31	Acute myocardial infarction of inferoposterior wall, initial episode of care
410.21	Acute myocardial infarction of inferolateral wall, initial episode of care
410.41	Acute myocardial infarction of other inferior wall, initial episode of care
410.81	Acute myocardial infarction of other specified sites, initial episode of care
410.51	Acute myocardial infarction of other lateral wall, initial episode of care
410.61	True posterior wall infarction, initial episode of care
410.81	Acute myocardial infarction of other specified sites, initial episode of care
410.91	Acute myocardial infarction of unspecified site, initial episode of care
410.71	Subendocardial infarction, initial episode of care
410.01	Acute myocardial infarction of anterolateral wall, initial episode of care
410.11	Acute myocardial infarction of other anterior wall, initial episode of care
410.21	Acute myocardial infarction of inferolateral wall, initial episode of care
410.31	Acute myocardial infarction of inferoposterior wall, initial episode of care
410.41	Acute myocardial infarction of other inferior wall, initial episode of care
410.71	Subendocardial infarction, initial episode of care

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Code	Descriptor
410.51	Acute myocardial infarction of other lateral wall, initial episode of care
410.61	True posterior wall infarction, initial episode of care
410.81	Acute myocardial infarction of other specified sites, initial episode of care
410.91	Acute myocardial infarction of unspecified site, initial episode of care
411.89	Other acute and subacute forms of ischemic heart disease, other
411.89	Other acute and subacute forms of ischemic heart disease, other
427.1	Paroxysmal ventricular tachycardia
427.1	Paroxysmal ventricular tachycardia
427.41	Ventricular fibrillation
427.42	Ventricular flutter
780.2	Syncope and collapse
V45.89	Other postprocedural status

ICD- 10 codes (upon implementation of ICD-10)

Code	Descriptor
I21.01	ST elevation (STEMI) myocardial infarction involving left main coronary artery
I21.02	ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery
I21.09	ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall
I21.09	ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall
I21.11	ST elevation (STEMI) myocardial infarction involving right coronary artery
I21.19	ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall
I21.19	ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall
I21.21	ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery
I21.29	ST elevation (STEMI) myocardial infarction involving other sites

Code	Descriptor
I21.29	ST elevation (STEMI) myocardial infarction involving other sites
I21.29	ST elevation (STEMI) myocardial infarction involving other sites
I21.3	ST elevation (STEMI) myocardial infarction of unspecified site
I21.4	Non-ST elevation (NSTEMI) myocardial infarction
I22.0	Subsequent ST elevation (STEMI) myocardial infarction of anterior wall
I22.0	Subsequent ST elevation (STEMI) myocardial infarction of anterior wall
I22.1	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall
I22.1	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall
I22.1	Subsequent ST elevation (STEMI) myocardial infarction of inferior wall
I22.2	Subsequent non-ST elevation (NSTEMI) myocardial infarction
I22.8	Subsequent ST elevation (STEMI) myocardial infarction of other sites
I22.8	Subsequent ST elevation (STEMI) myocardial infarction of other sites
I22.8	Subsequent ST elevation (STEMI) myocardial infarction of other sites
I22.9	Subsequent ST elevation (STEMI) myocardial infarction of unspecified site
I24.8	Other forms of acute ischemic heart disease
I24.9	Acute ischemic heart disease, unspecified

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Code	Descriptor
I47.0	Re-entry ventricular arrhythmia
I47.2	Ventricular tachycardia
I49.01	Ventricular fibrillation
I49.02	Ventricular flutter
R55	Syncope and collapse
Z98.89	Other specified postprocedural states

- Your MAC shall not search for and adjust any claims for MTWA for the evaluation of patients at risk for SCD when methods of analysis other than SA are used, with dates of service January 13, 2015, through the implementation date of CR 9162. However, they may adjust claims meeting their coverage criteria when brought to their attention by the provider within the timely filing period if appropriate.

Additional information

The official instruction, CR 9162, was issued to your MAC in two transmittals. The first updates the *Medicare National Coverage Determinations Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R182NCD.pdf.*

The second updates the *Medicare Claims Processing Manual* and it is at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3265CP.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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Transcatheter aortic valve replacement hospital program volume requirements

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) established Medicare coverage criteria for individual hospitals that want to perform transcatheter aortic valve replacement (TAVR).

Before a TAVR procedure is eligible for Medicare coverage individual hospitals must meet the volume requirements specified in the TAVR national coverage determination (NCD).

Hospitals that do not meet these volume requirements are not eligible for waivers or exceptions. This special edition article is being provided by CMS to remind providers of the hospital volume requirements for TAVR programs.

Background

TAVR, also known as transcatheter aortic valve implantation (TAVI), is a technology for use in treating aortic stenosis. A bioprosthetic valve is inserted intravascularly using a catheter and implanted in the orifice of the native aortic valve.

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

The interventional cardiologist and cardiothoracic surgeon jointly participate in the intra-operative technical aspects of TAVR. Effective May 1, 2012, Medicare covers TAVR procedures under coverage with evidence development (CED) for the treatment of symptomatic aortic stenosis when:

- Furnished according to a Food and Drug Administration (FDA) approved indication; and
- Certain conditions are met including requirements for individual hospitals in which TAVR procedures are performed.

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Hospital volume requirements

CMS established specific volume requirements pertaining to various procedures that hospitals, with and without TAVR experience, must meet in order for a hospital to perform TAVR procedures in compliance with the NCD for TAVR (NCD 20.32) and be eligible for Medicare coverage, the individual hospital must meet these volume requirements.

The hospital TAVR program volume requirements are specific to each individual hospital site where TAVR procedures are performed, and they are as follows:

1. To begin a TAVR program, the hospital (without TAVR experience) must have:
    - = 50 total aortic valve replacements (AVRs) in the previous year prior to TAVR, including = 10 high-risk patients; and
    - = two physicians with cardiac surgery privileges; and
    - = 1000 catheterizations per year, including = 400 percutaneous coronary interventions (PCIs) per year.
2. To continue a TAVR program, the hospital (with TAVR experience) must maintain:
    - = 20 AVRs per year or = 40 AVRs every two years; and
    - = two physicians with cardiac surgery privileges; and
    - = 1000 catheterizations per year, including = 400 percutaneous coronary interventions (PCIs) per year.

It is important to note that there are also requirements for heart team members and these volume requirements may include procedures performed at different facilities, but the hospital volume requirements are specific to the site where TAVR procedures are performed. Hospitals that do not meet these volume requirements are not eligible for waivers or exceptions. In addition, hospital systems comprised of multiple individual sites (that may or may not be in close proximity to each other) may not combine procedural experiences at multiple sites to meet these volume requirements.

Additional information

You can review the complete NCD for TAVR which details all requirements that must be met for Medicare coverage at http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=355.

The Medicare approved TAVR registry and Medicare approved clinical trials which were reviewed and determined to meet the requirements of Medicare coverage are available at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/TAVR.html.

You can review the *MLN Matters*® article MM8168 titled National Coverage Determination (NCD): Transcatheter Aortic Valve Replacement (TAVR) Coding Update/Policy Clarification at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8168.pdf.

You can find the Medicare "*National Coverage Determinations Manual*" (Publication 100-03; Chapter 1, Part 1, Section 20.32 (Transcatheter Aortic Valve Replacement (TAVR)) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf.

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CMS issues reminder on Medicare secondary payer claims involving Veterans Affairs services

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 and coding reminders for billing Medicare when the Department of Veterans Affairs (VA) is involved for a portion of the services.

This article is based on change request (CR) 8198 (*http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1213OTN.pdf*) which informs MACs about clarification to procedures for institutional claims related to the Department of Veterans Affairs (VA). Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) sent the MACs a letter (Technical Direction Letter #12002), entitled "Clarification to Procedures Related to the Department of Veterans Affairs (VA)". This communication advised MACs to no longer accept VA information entered on claims as the basis for assuming that Medicare should pay secondary.

The coordination of benefits contractor (COBC) also disabled the creation of VA Medicare secondary payer (MSP) records when an action to create such records was requested via the electronic correspondence referral system (ECRS).

CMS took these actions based on the following language found in §1862(a) (3) of the Social Security Act (the Act): Medicare is precluded from making payment for services or items that are paid for directly or indirectly by another government entity. VA claims, therefore, represents a Medicare program exclusion rather than an indication of MSP.

Billing instructions

For inpatient claims where the VA is the payer, the covered VA services are exclusions to the Medicare program per Section 1862 of the Social Security Act. If the VA doesn't approve all the services, any Medicare covered services not considered by the VA may be billed to the Medicare program. VA approved services (that is, Medicare excluded services) may be submitted on a separate non-covered claim to Medicare.

Only Medicare covered services should be billed to the Medicare program. Medicare should not be billed as the secondary payer to VA using the value code "42". (See the *Medicare Claims Processing Manual*, Chapter 1, Section 60 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf* for billing instructions).

For outpatient claims where the VA is the Payer, the covered VA services are exclusions to the Medicare program per Section 1862 of the Social Security Act.

If the VA doesn't approve all the services, any Medicare covered services can be billed to Medicare. Medicare should not be billed as the secondary payer to VA using the Value Code "42".

(See the *Medicare Claims Processing Manual*, Chapter 1, Section 60 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf* for billing instructions).

Additional information

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

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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

Bone mineral density studies – revision to the Part A LCD

LCD ID number: L28766 (Florida)
LCD ID number: L28767 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bone mineral density studies was revised based on change request (CR) 9087 related to ICD-9-CM updates to national coverage determination (NCD) 150.3 and *Current Procedural Terminology* (*CPT*®) code *77085*.

The "Indications", "Limitations" and "*CPT*®/HCPCS Codes" sections of the LCD were updated.

Effective date

This LCD revision is effective for **services rendered on or after July 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*.

Carboplatin, (Paraplatin®, Paraplatin-AQ®) – revision to the Part A LCD

LCD ID number: L28791 (Florida)
LCD ID number: L28796 (Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for carboplatin (Paraplatin®, Paraplatin-AQ®)) was revised to include the off-label indication of malignant poorly differentiated neuroendocrine carcinoma. The "Indications and Limitations of Coverage and /or Medical Necessity" section of the LCD was revised to include this off-label indication, and the "ICD-9 Codes that Support Medical Necessity" section was updated to add the correlating diagnosis code 209.30. In addition, the "Sources of Information and Basis of Decision" section was updated.

Effective date

The LCD revision is effective for **services rendered on or after June 11, 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*.

Viscosupplementation therapy for knee – revision to the 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 has been revised. In the "Limitations" section of the LCD, the following language has been added: "Per the Food and Drug Administration (FDA) package insert, the effectiveness of Monovisc™ has not been established for more than one course of treatment."

Also, a list of the imaging procedures that are not covered when performed routinely for the purpose of visualization of the knee to provide guidance for needle placement have been added.

Additionally, in the "Utilization Guidelines" section of the LCD, the "Duration of Treatment" has been revised to reflect, "One time/single injection (the effectiveness of Monovisc™ has not been established for more than one course of treatment)."

Effective date

This LCD revision is effective for **claims processed on or after June 11, 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*.

Implement operating rules - phase III ERA EFT: CORE 360 uniform use of CARC and RARC codes

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9138 which instructs MACs and Medicare's shared system maintainers (SSMs) to update their systems based on the Council for Affordable Quality Healthcare (CAQH) 360 Uniform Use of CARC and RARC (835) rule set. These system updates are based on the committee on operating rules for information exchange (CORE) code combination list to be published on or about June 1, 2015. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE electronic funds transfer (EFT) & electronic remittance advice (ERA) operating rule set that was under the Affordable Care Act.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security by adding Part C— Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of Health and Human Services to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

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

CR 9138 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) rule.

CAQH CORE will publish the next version of the code combination list on or about June 1, 2015. This update is based on March 1, 2015 claim adjustment reason code (CARC) and remittance advice remark code (RARC) updates as posted at the WPC website. Please go to *http://www.wpc-edi.com/reference* for CARC and RARC updates and *http://www.caqh.org/CORECodeCombinations.php* for CAQH CORE defined code combination updates.

Note: Per the Affordable Care Act mandate all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/group code for a minimum set of four business scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE defined business scenarios but for the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional information

The official instruction, *CR 9138* issued to your MAC regarding this change is available on the CMS website.

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: MM9138
Related Change Request (CR) #: CR 9138
Related CR Release Date: May 29, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3270CP
Implementation Date: October 5, 2015

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Claim status category and claim status codes update

Provider types affected

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

Provider action needed

Change request (CR) 9141 informs MACs about the changes to the claim status category and claim status codes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the Accredited Standards Committee (ASC) x12 276/277 health care claim status request and response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at

http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and

http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/.

All code changes approved during the June 2015 committee meeting shall be posted on those sites on or about July 1, 2015.

MACs must complete entry of all applicable code text changes, add new codes, and terminate use of deactivated codes by the implementation date of CR 9141.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC x12 277 transactions issued on and after the date of implementation of CR 9141.

Additional information

The official instruction, CR 9141, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3272CP.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: MM9141
Related Change Request (CR) #: CR 9141
Related CR Release Date: May 29, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3272CP
Implementation Date: October 5, 2015

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Get ready for ICD-10

On October 1, 2015, the health care industry will transition from ICD-9 to ICD-10 codes for diagnoses and inpatient procedures.

This transition is going to change how you do business—from registration and referrals to superbills and software upgrades. But that change doesn't have to be overwhelming.

The Centers for Medicare & Medicaid Services has the following resources to help your practice prepare for the transition.

Online ICD-10 guide

ICD-10 basics for large medical practices

July 2015 integrated outpatient code editor (I/OCE) specifications version 16.2

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9190 which informs MACs about the changes to the I/OCE instructions and specifications for the I/OCE that will be utilized under the OPPS and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the home health prospective payment system or to a hospice patient for the treatment of a non-terminal illness.

Make sure that your billing staffs are aware of these changes. See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

CR 9190 announces that the I/OCE is being updated for July 1, 2015. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, which eliminates the need to update, install, and maintain two separate OCE software packages on a quarterly basis.

The full list of I/OCE specifications can now be found at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html*. There is a summary of the changes for July 2015 in Appendix O of Attachment A of CR 9190 and that summary is captured in the following key points.

Key points

The modifications of the IOCE for the July 2015 release (V16.2) are summarized in the table below. Some IOCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the 'Effective date' column.

Effective date	Edits affected	Modification
7/1/2015	88, 89	Update Appendix M (FQHC) to note edits 88 and 89 are bypassed for FQHC PPS claims when Telehealth originating site services HCPCS code Q3014 is reported and there is no FQHC payment code or qualifying visit code present.
7/1/2015		Assign payment adjustment flag 11 (Appendix G of Attachment A of CR9190) when the OCE reduces service units to one for the following: - Conditionally packaged HCPCS codes (SI = Q1,Q2) that have final status indicator (SI) change to S, T or V (see OPPS special processing conditions, page 8) - FQHC payment HCPCS codes (see Appendix M)
1/1/2015	38	Update the edit logic for edit 38 to include criteria for comprehensive APC procedures codes with SI = J1: - There is a code with status indicator H or U present, but no type S, T, or J1 procedures are present on the same claim.
3/6/2015	67	Implement mid-quarter approval for HCPCS Q5101.
1/1/2015	92	Updates to the device list (see summary of data changes).
1/1/2015		Update packaged laboratory services list (see Summary of Data changes).
1/1/2015		Revise the code effective begin date for HCPCS code G0276 and remove the previous mid-quarter edit requirement for edit 68.

See **I/OCE**, next page

I/OCE

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Effective date	Edits affected	Modification
1/1/2015		Updates to the complexity-adjusted code pairs for comprehensive ambulatory payment classifications (APCs) (see summary of changes).
7/1/2015		Make HCPCS/APC/SI changes as specified by CMS (data change files).
7/1/2015	20, 40	Implement version 21.2 of the NCCI (as modified for applicable institutional providers).
7/1/2015		Update the IOCE PC product *User and Installation Manual* for notification of supported Windows versions.
7/1/2015		Update the federally qualified health center (FQHC) processing information (pages 10-11) for clarification purposes only as there are no new logic changes.
7/1/2015		The IOCE specification document is updated for minor, general formatting changes made to tables and footnotes throughout the document.

Additional information

The official instruction, CR 9190 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3264CP.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: MM9190
Related Change Request (CR) #: CR 9190
Related CR Release Date: May 22, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3264CP
Implementation Date: July 6, 2015

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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.

Non-specific procedure code description requirement for HIPAA version 5010 claims

Provider types affected

***Note**: This article was revised June 8, 2015, to delete a reference to a Web address for the NOC code set. That code set is no longer available on the CMS website. All other information remains the same. This information was previously published in the January 2012 Medicare A Connection, Pages 30.*

Provider types affected

This *MLN Matters*® special edition article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare administrative contractors (A/B MACs), home health and hospice MACs (HH+H MACs), and durable medical equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

What you need to know

The Office of E-Health Standards and Services (OESS) announced on November 17, 2011, that although the 5010/D.0 compliance date of January 1, 2012 will not change, HIPAA enforcement of compliance with the standards will be deferred until March 31, 2012.

The 5010 versions of the institutional and professional claim implementation guides mandate that when claims use non-specific procedure codes a corresponding description of the service is now required. Please make certain your billing and coding staff follow these requirements for submitting a HIPAA compliant claim when non-specific procedure codes are used. Please ensure these implementation guide requirements are followed when submitting a HIPAA compliant claim for all non-specific procedure codes.

Background

The HIPAA version 5010 implementation guide describes non-specific procedure codes as codes that may include, in their descriptor, terms such as: “not otherwise classified (NOC); unlisted; unspecified; unclassified; other; Miscellaneous; Prescription Drug Generic; or Prescription Drug, Brand Name”. If a procedure code containing any of these descriptor terms is billed, a corresponding description of that procedure is required; otherwise, the claim is not HIPAA compliant. Note that there is no crosswalk of non-specified procedure codes with corresponding descriptions.

Detailed information regarding this new requirement can be found in the 837I and 837P implementation guides (837I – 005010X223A2 and 837P – 005010X222A1). If the corresponding non-specific procedure code description is not submitted, the transaction does not comply with the implementation guide and is not, therefore, HIPAA compliant. Note that the non-specific procedure code’s descriptor terms as listed above do not constitute a description of the procedure, drug, or service. For example, simply using not otherwise classified as the description does not pass editing and the claim will be rejected.

Additional information

For 5010/D.O implementation information and deadlines, refer to *MLN Matters*® special edition article SE1131, which is available at http://www.cms.gov/MLNMattersArticles/downloads/SE1131.pdf.

If you are not ready, consider contacting your Medicare contractor to receive the free version 5010 software (PC-Ace Pro32) and begin testing now. Or, consider contracting with a version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions.

If you are billing Part B and DME claims, you may download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices. This software is available at http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp.

Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines. Part A billers may download the free PC-Print software to view and print a compliant HIPAA 5010 835 remittance advice from their A/B MACs website.

Please note, change request (CR) 7392, “Common Edits and Enhancements Module (CEM) and Receipt, Control, and Balancing Updates,” dated July 21, 2011, established the requirements that all procedures shall comply with the HIPAA 5010 version claim process. CR 7392 was implemented by Medicare contractors on October 1, 2011, and does not override any previous claim processing instructions.

MLN Matters® Number: SE1138 Revised
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

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ICD-10 conversion/coding infrastructure revisions/ICD-9 updates to - second maintenance update

Provider types affected

***Note**: This article was revised May 22, 2015, to reflect a revised change request. That revision changed C8681 to L8681 in spreadsheet NCD 160.18 and added a requirement to change the provider query eligibility screens for bone density to support CWF updates to NCD 150.3. The transmittal number, CR release date and link to the CR also changed. All other information remains the same. This information was previously published in the March 2015 Medicare A Connection, Pages 23-24.*

Provider types affected

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

Provider action needed

This article is based on CR 9087 which is the second maintenance update of ICD-10 conversions and coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR 7818, CR 8109, CR 8197, and CR 8691. Links to related *MLN Matters®* articles MM7818, MM8109, MM8197, and MM8691 are available in the additional information section of this article. Some are the result of revisions required to other NCD-related CRs released separately that also included ICD-10.

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly updates. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Make sure that your billing staffs are aware of these spreadsheets attached to CR 9087 for the following 13 NCDs:

NCD	NCD title
20.29	Hyperbaric Oxygen Therapy
20.9.1	Ventricular Assist Devices
50.3	Cochlear Implantation
80.2	Photodynamic Therapy
80.2.1	Ocular Photodynamic Therapy (OPT)
80.3	Photosensitive Drugs
80.3.1	Verteporfin
110.10	Intravenous Iron Therapy
150.3	Bone (Mineral) Density Studies
160.18	Vagus Nerve Stimulation
180.1	Medical Nutrition Therapy
210.2	Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer
250.3	Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases

Background

CR 9087's purpose is to create and update NCD editing, both hard-coded shared system edits as well as local MAC edits, that contain either ICD-9 diagnosis/procedure codes or ICD-10 diagnosis/procedure codes, or both, plus all associated coding infrastructure such as and so forth. The requirements described in CR 9087 reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to the attached Medicare NCD spreadsheets.

Please note that there are 10 spreadsheets attached to CR 9087. These spreadsheets relate to 13 NCDs, and provide pertinent policy/coding information necessary to implement ICD-10. Further, you should be aware that NCD policies may contain specific covered, non-covered and/or discretionary diagnosis coding.

These spreadsheets are designated as such and are based on current NCD policies and their corresponding edits. Nationally covered and non-covered diagnosis code editing is finite and cannot be revised without subsequent discussions with CMS. Discretionary code lists are to be regarded as CMS' compilation of discretionary codes based on current analysis/interpretation. Local MACs may or may not expand discretionary lists based on their individual local authority within their respective jurisdictions. Nothing contained in CR 9087 should be construed as new policy.

Some coding details are as follows:

1. The ICD-10 diagnosis/procedure codes associated with the NCDs attached to CR 9087 are not to be implemented until October 1, 2015, or until ICD-10 is implemented.
2. Your MAC will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages, where appropriate:
   - **Remittance advice remark code (RARC) N386**:

See **CONVERSION**, next page

CONVERSION

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(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), along with claim adjustment reason code (CARC) 50 (These are noncovered services because this is not deemed a "medical necessity" by the payer), CARC 96 (Non-covered charge(s). At least one remark code must be provided [may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT]), and/or CARC 119 (Benefit maximum for this time period or occurrence has been reached).

3. When denying claims associated with the attached NCDs, except where otherwise indicated, your MACs will use:
   - **Group code PR** (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 (Advance Beneficiary Notice), or with occurrence code 32 and a GA modifier (The provider or supplier has provided an Advance Beneficiary Notice (ABN) to the patient), indicating a signed ABN is on file).
   - **Group code CO** (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier (The provider or supplier expects a medical necessity denial; however, did not provide an Advance Beneficiary Notice (ABN) to the patient), indicating no signed ABN is on file).

Note: For modifier GZ, use CARC 50 and MSN 8.81 (If the provider/supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment, you may be entitled to a refund of any amounts you paid. However, if the provider/supplier requests a review of this claim within 30 days, a refund is not required until we complete our review. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your provider/supplier).

Additional information

The official instruction, CR 9087 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1504OTN.pdf*.

The spreadsheet attachments to CR 9087 are available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1478OTN.zip*.

MM7818 is available for review at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7818.pdf*.

MM8109 is available for review at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8109.pdf*.

MM8197 is available for review at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8197.pdf*.

MM8691 is available for review at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8691.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: MM9087 *Revised*
Related Change Request (CR) #: CR 9087
Effective Date: April 6, 2015 - For designated ICD-9 updates and all local system edits (ICD-9 and ICD-10); July 1, 2015 - For all ICD-9 shared system edits; October 1, 2015 - For all ICD-10 shared system edits (or whenever ICD-10 is implemented)
Related CR Release Date: May 20, 2015
Implementation Date: April 6, 2015 - For designated ICD-9 updates and all local system edits; July 6, 2015 - For ICD-9 and ICD-10 shared system edits
Related CR Transmittal #: R1504OTN

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

Note: This article was revised on May 29, 2015, to show that the April I/OCE is available and that it contains ICD-9 and ICD-10 codes. It was previously published in the *December 2014 edition of Medicare A Connection*, *Page 25.*

Provider types affected

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

Provider action needed

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

The HIPAA standard health care claim transactions are among those for which International Classification of Diseases, 10th Edition (ICD-10) codes must be used for dates of service on and after October 1, 2015. Be sure you are ready.

This *MLN Matters*® special edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

Background

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

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

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

Each approach is discussed in more detail below.

CMS internal testing of its claims processing systems

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

- Alpha testing is performed by each FFS claims processing system maintainer for 4 weeks;
- Beta testing is performed by a separate integration contractor for eight weeks; and
- Acceptance testing is performed by each MAC for 4 weeks to ensure that local coverage requirements are met and the systems are functioning as expected.

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

Provider-initiated beta testing tools

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

- NCDs and LCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at *http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html;*
- The ICD-10 Medicare severity-diagnosis related groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the general equivalence mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-

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10-CM) codes, located at *http://cms.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html.*

On this web page, you can also find current versions of the ICD-10-CM MS-DRG grouper, Medicare code editor (available from National Technical Information Service), and MS-DRG definitions Manual that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and

- The April 2015 version of the integrated outpatient code editor (/OCE) now includes both ICD-9-CM and ICD-10-CM. The files are available at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html*. The July 2015 I/OCE release will also include both ICD-9-CM and ICD-10-CM. The final version of the I/OCE that utilizes ICD-10-CM is scheduled for release in August 2015.

Acknowledgement testing

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

All MACs and the DME MAC common electronic data interchange (CEDI) contractor will promote this ICD-10 acknowledgement testing with trading partners. This testing allows all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A or a 999) that confirms whether the submitted test claims were accepted or rejected.

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

End-to-end testing

During 2015, CMS plans to offer three separate end-to-end testing opportunities. Each opportunity will be open to a limited number of providers that volunteer for this testing. As planned, approximately 2,550 volunteer submitters will have the opportunity to participate over the course of the three testing periods.

End-to-end testing includes the submission of test claims to Medicare with ICD-10 codes and the provider's receipt of a remittance advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

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

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. To facilitate this testing, CMS requires MACs to do the following:

- Conduct limited end-to-end testing with submitters in three testing periods; January 2015, April 2015 and July 2015. Test claims will be submitted January 26 – 30, 2015, April 27 – May 1, 2015, and July 20 – 24, 2015.
- Each MAC (and CEDI with assistance from DME MACs) will select 50 submitters for each MAC jurisdiction supported to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will also select 50 submitters. Testers will be selected randomly from a list of volunteers to represent a broad cross-section of provider types, claims types, and submitter types. At least five, but not more than fifteen, of the testers will be a clearinghouse.

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- MACs and CEDI will post a volunteer form to their website during the enrollment periods to collect volunteer information with which to select volunteers. Those interested in testing should review the minimum testing requirements on the form to ensure they qualify before volunteering.

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

Claims submission alternatives

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

This billing software only works for submitting FFS claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance.

Alternatively, all MACs offer provider internet portals, and a subset of these MAC portals offer claims submission; providers submitting to this subset of MACs may choose to use the portal for submission of ICD-10 compliant claims. Register in the portals that offer claims submission to ensure that you have the flexibility to submit professional claims this way as a contingency. More information may be found on your MAC's website.

Additional information

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

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

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FAQs – ICD-10 end-to-end testing

***Note**: This article was revised June 9, 2015, to provide updated information for physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing. This information was previously published in the December 2014 Medicare A Connection, Pages 26-29*.

Provider types affected

This *MLN Matters®* special edition article is intended for all physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing.

Provider action needed

Physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 end-to-end testing to gain an understanding of the guidelines and requirements for successful testing.

What to know prior to testing

1. How is ICD-10 end-to-end testing different from acknowledgement testing?

   The goal of acknowledgement testing is for testers to submit claims with ICD-10 codes to the Medicare fee-for-service claims systems and receive acknowledgements to confirm that their claims were accepted or rejected.

   End-to-end testing takes that a step further, processing claims through all Medicare system edits to produce and return an accurate electronic remittance advice (ERA). While acknowledgement testing is open to all electronic submitters, end-to-end testing is limited to a smaller sample of submitters who volunteer and are selected for testing.

2. What constitutes a testing slot for this testing?

   A testing slot is the ability to submit 50 claims to a particular Medicare administrative contractor (MAC) who selected you for testing.

3. What data must I provide to the MAC before testing?

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For each testing slot, you must provide the MAC the following:

- Up to two submitter identifiers (IDs);
- Up to five national provider identifiers (NPIs)/ provider transaction access numbers (PTANs), and
- Up to 10 health insurance claim numbers (HICNs).

You may use these in any combination on the 50 claims. You will need to use the same HICN on multiple claims. Therefore, you will need to consider this when designing a test plan, since claims will be subject to standard utilization edits.

If you want to change your selected submitter IDs, NPIs, PTANs, or HICNs, you must contact the MAC. If the MAC is not aware of these changes, claims submitted will not be processed.

4. What should I consider when choosing HICNs for testing?

   The MAC will copy production information into the test region for the HICNs that you provide. This includes eligibility information and other documentation such as certificates of medical necessity (CMNs). The HICNs you provide must be real beneficiaries and may not have a date of death on file. If you previously submitted HICNs for beneficiaries who are deceased, contact the MAC as soon as possible with replacement HICNs.

5. If I was selected for the January 2015 or April 2015 end-to-end testing, do I need to reapply for July 2015 testing?

   No, once you are selected for testing, you are automatically registered for the later rounds of testing.

6. Can I submit additional NPIs, PTANs, and HICNs for the later rounds of testing?

   Yes, while you do not need to re-apply for the later rounds of testing, you may choose to submit up to two additional submitter IDs, up to five additional NPIs/ PTANs, and up to 10 additional HICNs. You may also still use the information you submitted for the previous testing round. The MAC will provide the form you must use to submit this new information, and the information must be received by the due date on the form to be considered for the next round of testing.

What to know during testing

1. Is it safe to submit test claims with protected health information (PHI)?

   The test claims you submit are accepted into the system using the same secure method used for production claims on a daily basis. They will be processed by the same MACs who process production claims, and all the same security protocols will be followed. Therefore, using real data for this test does not cause any additional risk of release of PHI.

2. What dates of service can be used on test claims?

   Professional claims with an ICD-10 code must have a date of service on or after October 1, 2015.

   Inpatient claims with an ICD-10 code must have a discharge date on or after October 1, 2015.

   Supplier claims with an ICD-10 code must have a date of service between October 1, 2015, and October 15, 2015.

   For professional and institutional claims, you may use dates up to December 31, 2015. You cannot use dates in 2016 or beyond.

3. Can both ICD-9 and ICD-10 codes be submitted on the same claim?

   ICD-9 and ICD-10 codes cannot be submitted on the same claim. For additional information on how to submit claims that span the ICD-10 implementation date (when ICD-9 codes are effective for that portion of the services rendered on September 30, 2015, and earlier, and when ICD-10 codes are effective for that portion of the services rendered on October 1, 2015, and later), please refer to the following *MLN Matters*® articles:

   - SE1325, "Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims That Span the ICD-10 Implementation Date," located at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf*;

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- SE1408, "Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492," located at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf*
- SE1410, "Special Instructions for the International Classification of Diseases, Clinical Modification 10th Edition (ICD-10-CM) Coding on Home Health Episodes that Span October 1, 2015," located at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.pdf*

4. Do returned to provider (RTP) claims count toward the 50 claims submitted? Can RTP'd claims be re-submitted for testing?

   Institutional claims that fail RTP editing count toward the 50 claim submission limit. Claims that are RTP'd will not appear on the ERA, and they will not be available through direct data entry (DDE). If claims accepted by the front end edits do not appear on the ERA, please contact the MAC for further information.

   Claims that are rejected by front end editing do not count toward the 50 claim submission limit; therefore, they should be corrected and resubmitted.

5. Will a summary of test claims be provided at the conclusion of testing?

   Yes, the MAC will provide testers a summary of all accepted test claims after the April and July testing rounds. These reports will be delivered to testers approximately 4 weeks following the testing week. Reports for April 2015 testing were delivered by May 29.

6. If a CMN or DME Information Form (DIF) is required for a supplier claim, do I need to submit a CMN during testing?

   If the beneficiary has a valid CMN or DIF on file for that equipment/supply covered by the dates of service on your test claim (after October 1, 2015), you do not need to submit a new CMN/DIF.

   If the beneficiary's CMN/DIF has expired for the dates of service on your test claim (after 10/1/2015), you must submit a revised CMN/DIF to extend the end date for that CMN/DIF.

   If the beneficiary does not have a CMN or DIF for that equipment/supply, you must submit a new CMN/DIF.

7. For home health claims, how should I submit the Request for Anticipated Payment (RAP) and final claim for testing?

   Submit the RAP and final claim in the same file and the system will allow them to process. The final claim will be held and recycle (as in normal processing) until the RAP finalizes. It will then be released to the common working file (CWF). The RAP processing time will be short since the test beneficiaries are set up in advance.

   To get your results more quickly, you may also want to consider billing low utilization payment adjustment claims with four visits or less that do not require a RAP.

8. For Hospice claims, should I submit the notice of election (NOE) prior to testing?

   You will not need to provide NOEs to the MAC prior to the start of testing. MACs will set up NOEs for any hospice claims received during testing.

9. For an inpatient rehabilitation facility (IRF) or skilled nursing facility (SNF) stay, can the case-mix group (CMG) or resource utilization group (RUG) code be submitted on the claim even though the date of service is in the future?

   Yes, you can send the IRF claim with a valid CMG code on the claim and a SNF claim with a valid RUG code on the claim, even though the date is in the future. For testing purposes, only a claim with a valid health insurance prospective payment system (HIPPS) code will be required. You do not need to submit the supporting data sheets.

Additional information

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

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Information and resources for submitting correct ICD-10 codes to Medicare

Provider types affected

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

Provider action needed

This *MLN Matters*® special edition article is intended to assist physicians, providers, and suppliers by offering information and resources for submitting correct International Classification of Diseases, Tenth Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) codes to Medicare.

Background

The compliance date for implementation of ICD-10-CM/PCS is October 1, 2015, for all Health Insurance Portability and Accountability Act-covered entities. ICD-10-CM, including the "ICD-10-CM Official Guidelines for Coding and Reporting," will replace International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis codes in all health care settings for diagnosis reporting with dates of service, or dates of discharge for inpatients, that occur on or after October 1, 2015. ICD-10-PCS, including the "ICD-10-PCS Official Guidelines for Coding and Reporting," will replace ICD-9-CM procedure codes.

Use of external cause and unspecified codes in ICD-10-CM

Similar to ICD-9-CM, there is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless you are subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, you are not required to report ICD-10-CM codes found in Chapter 20 of the ICD-10-CM, External Causes of Morbidity.

If you have not been reporting ICD-9-CM external cause codes, you will not be required to report ICD-10-CM codes found in Chapter 20 unless a new state or payer-based requirement about the reporting of these codes is instituted.

If such a requirement is instituted, it would be independent of ICD-10-CM implementation. In the absence of a mandatory reporting requirement, you are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

In both ICD-9-CM and ICD-10-CM, sign/symptom and unspecified codes have acceptable, even necessary, uses. While you should report specific diagnosis codes when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter. You should code each health care encounter to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined).

In fact, you should report unspecified codes when such codes most accurately reflect what is known about the patient's condition at the time of that particular encounter. It is inappropriate to select a specific code that is not supported by the medical record documentation or to conduct medically unnecessary diagnostic testing to determine a more specific code.

All the Medicare claims audit programs will use the same approach under ICD-10 as is used under ICD-9. Physicians, like all providers, are expected to code correctly and have sufficient documentation to support the codes selected.

For example, if a physician is treating a patient for diabetes, there should be an ICD-10 code on the claim for diabetes. The level of specificity of the diabetes code selected will not change the coverage and payment of services in most cases.

Information and resources

Visit the following web pages to find information and resources that will assist you in submitting correct ICD-10 codes to Medicare:

- General ICD-10-CM/PCS information: *http://www.cms.gov/Medicare/Coding/ICD10/index.html* on the Centers for Medicare & Medicaid Services (CMS) website;
- ICD-10 fee-for-service educational resources, including *MLN Matters*® articles, MLN products, *MLN Connects*® videos, and CMS resources: *http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-for-Service-Provider-Resources.html*;

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CMS conducts second successful Medicare ICD-10 test

From April 27 through May 1, 2015, Medicare fee-for-service (FFS) health care providers, clearinghouses, and billing agencies participated in a second successful ICD-10 end-to-end testing week with all Medicare administrative contractors (MACs) and the durable medical equipment (DME) MAC common electronic data interchange (CEDI) contractor. CMS was able to accommodate most volunteers, representing a broad cross-section of provider, claim, and submitter types.

This second end-to-end testing week demonstrated that CMS systems are ready to accept ICD-10 claims. Approximately 875 providers and billing companies participated, and testers submitted over 23,000 test claims. View the *results file.*

Overall, participants in the April end-to-end testing week were able to successfully submit ICD-10 test claims and have them processed through Medicare billing systems. The acceptance rate for April was higher *than January*, with an increase in test claims submitted and a decrease in the percentage of errors related to diagnosis codes. Most of the claim rejections that occurred were due to errors unrelated to ICD-9 or ICD-10.

In addition to acknowledgement testing, which may be completed at any time, a final end-to-end testing week will be held on July 20 through 24, 2015. The opportunity to volunteer for this testing week has closed. Testers who participated in the January and April end-to-end testing weeks are automatically eligible to test again in July.

Prepare now for ICD-10 implementation

Medicare claims with a date of service on or after October 1, 2015, will be rejected if they do not contain a valid ICD-10 code.

The Medicare claims processing systems do not have the capability to accept ICD-9 codes for dates of service after September 30, 2015; or accept claims that contain both ICD-9 and ICD-10 codes.

There is still time to get ready

Even though the October 1, 2015, mandatory implementation date is quickly approaching, providers still have time to prepare for ICD-10, and CMS has created a number of tools and resources to help you succeed.

One tool is the *Road to 10*, aimed specifically at smaller physician practices with primers for clinical documentation, clinical scenarios, and other specialty-specific resources to help you with implementation.

For more information

- *MLN Matters® article MM8867*, “ICD-10 Limited End-to-End Testing with Submitters for 2015
- *MLN Matters® special edition article SE1435*, “FAQs – ICD-10 End-to-End Testing”
- *MLN Matters® special edition article #SE1409*, “Medicare FFS ICD-10 Testing Approach”

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- ICD-10 fee-for-service educational resources, including *MLN Matters®* articles, MLN products, *MLN Connects®* videos, and CMS resources: *http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-for-Service-Provider-Resources.html*;
- “Coding for ICD-10-CM: More of the Basics” *MLN Connects®* video: *http://www.cms.gov/Medicare/Coding/ICD10/CMS-Sponsored-ICD-10-Teleconferences-Items/2014-12-02-ICD-10-Basics.html*;
- **General equivalence mappings:**
- *http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html*; and
- **ICD-10 National coverage determinations:**
- *http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html.*

Additional information

If you have any questions, please contact your MAC at their toll-free number. To find MAC toll-free numbers, please refer to the review contractor interactive map located at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index.html*.

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Using the ICD-10-PCS new technology 'Section X' codes

Provider types affected

This article is intended for all hospitals who submit inpatient claims to Medicare administrative contractors (MACs), for services provided to Medicare beneficiaries.

Provider action needed

This *MLN Matters*® special edition article is intended to assist hospital providers by offering details about the new International Classification of Diseases, Tenth Edition, Procedure Coding System (ICD-10-PCS) *Section X New Technology (Section X)*, as well as specific coding instruction for the new section.

Background

The compliance date for implementation of ICD-10-CM/PCS is October 1, 2015, for all Health Insurance Portability and Accountability Act-covered entities. ICD-10-CM, including the "ICD-10-CM Official Guidelines for Coding and Reporting," will replace International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis codes in all health care settings for diagnosis reporting with dates of service, or dates of discharge for inpatients, that occur on or after October 1, 2015. ICD-10-PCS, including the "ICD-10-PCS Official Guidelines for Coding and Reporting," will replace ICD-9-CM procedure codes. ICD-10-PCS will be used for reporting inpatient hospital procedures.

Section X new technology – general information

Section X is a section added to ICD-10-PCS beginning October 1, 2015. The new section provides a place for codes that uniquely identify procedures requested via the New Technology Application Process or that capture other new technologies not currently classified in ICD-10-PCS.

Section X was created in response to public comments received regarding new technology proposals presented at ICD-10 coordination and maintenance committee meetings, and general issues facing classification of new technology procedures. The public had opposed many requests to add new codes to the existing ICD-10-PCS sections for the use of specific drugs, devices, or supplies in an inpatient setting, even when the code related to an application for New Technology add-on payments.

The new section is simply a separate place for certain new technology procedures, such as infusion of new technology drugs, and was created because the public did not support adding any more of these types of codes to the other sections of ICD-10-PCS. *Section X* does not introduce any new coding concepts or unusual guidelines for correct coding.

In fact, *Section X* codes maintain continuity with the other sections in ICD-10-PCS by using the same root operation and body part values as their closest counterparts in other sections of ICD-10-PCS. For example, the two new codes for the infusion of ceftazidime-avibactam, a new technology antibiotic that requires unique procedure codes for October 1, 2015, use the same root operation (Introduction) and body part values (Central Vein and Peripheral Vein) in *Section X* as the infusion codes in section 3 *Administration*, which are their closest counterparts in the other sections of ICD-10- PCS.

In ICD-10-PCS, the information specified in the seventh character is called the qualifier, and the type of information specified depends on the section. In *Section X*, the seventh character is used exclusively to indicate the new technology group.

The new technology group is a number or letter that changes each year that new technology codes are added to the system. For example, *Section X* codes added for the first year have the seventh character value 1, new technology group 1, and the next year that *Section X* codes are added have the seventh character value 2, new technology group 2, and so on. This is a much simpler use of the qualifier than in many other sections of ICD-10-PCS, such as the *Medical and Surgical* section.

Because it is only used to indicate the update year the code was created, there are no special coding instructions or requirements for the use of the qualifier, because all codes for a particular new technology procedure will all have the same qualifier. Therefore, the new technology group has no impact for correct coding. Its function is to allow the section to maintain consistency between the root operation and body part values of the other sections, as described above, and to allow the section to evolve over time, as medical technology evolves.

Section X coding instruction

Section X codes are stand-alone codes. They are not supplemental codes. *Section X* codes fully represent the specific procedure described in the code title, and do not require any additional codes from other sections of ICD-10-PCS. When *Section X* contains a code title which describes a specific new technology procedure, only that X code is reported for the procedure. There is no need to report a broader, non-specific code in another section of ICD-10-PCS.

For example, code XW04321 Introduction of Ceftazidime-Avibactam Anti-infective into Central Vein, Percutaneous Approach, New Technology Group 1, would be reported to indicate that Ceftazidime-Avibactam Anti-infective was administered via central vein. A separate code from table 3E0 in the *Administration* section of ICD-10-PCS would not be reported in addition to this code. The *Section X* code fully identifies the administration of the ceftazidime-avibactam antibiotic, and no additional code is needed.

The new technology section codes are easily found by

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Section	X	New technology	
Body System	W	Anatomical regions	
Operation	0	Introduction: Putting in or on a therapeutic, diagnostic, nutritional, physiological, or prophylactic substance except blood or blood products	
Body Part	*Approach*	*Device / Substance / Technology*	*Qualifier*
3 Peripheral Vein 4 Central Vein	3 Percutaneous	2 Ceftazidime-Avibactam Anti-infective 3 Idarucizumab, Dabigatran Reversal Agent 4 Isavuconazole Anti-infective 5 Blinatumomab Antineoplastic Immunotherapy	1 New Technology Group 1

looking in the ICD-10-PCS index or the tables. In the index, the name of the new technology device, substance or technology for a *Section X* code is included as a main term. In addition, all codes in *Section X* are listed under the main term *New Technology*. The new technology code index entry for ceftazidime-avibactam is shown below.

Ceftazidime-Avibactam Anti-infective XW0
New Technology
Ceftazidime-Avibactam Anti-infective XW0

In the table below, new technology codes are displayed like all other ICD-10-PCS tables, with a separate table for each root operation and body system. All *Section X* codes for the root operation Introduction valid for October 1, 2015, are shown in the table below.

Information and resources

Visit the following Web pages to find information and resources that will assist you in submitting correct ICD-10 codes to Medicare:

- General ICD-10-CM/PCS information: *http://www.cms.gov/Medicare/Coding/ICD10/index.html*
- ICD-10 Fee-For-Service educational resources, including *MLN Matters*® articles, MLN products, *MLN Connects*® videos, and CMS resources: *http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-for-Service-Provider-Resources.html*;
- General equivalence mappings: *http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html;* and
- ICD-10 National coverage determinations: *http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html*.

Additional information

If you have any questions, please contact your MAC at their toll-free number. To find MAC toll-free numbers, please refer to the review contractor interactive map located at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index.html*.

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Related CR Transmittal #: N/A
Implementation Date: N/A

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Beneficiary data for hospitals, rehabilitation facilities and long term care hospitals

Provider types affected

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

What you need to know

Change request (CR) 9195 informs MACs about updated data for determining the disproportionate share adjustment for IPPS hospitals and the low income patient (LIP) adjustment for IRFs as well as payments applicable to certain LTCH discharges (for example, discharges paid the IPPS comparable amount under the short-stay outlier payment adjustment).

The SSI/Medicare beneficiary data for hospitals are available electronically and contains the name of the hospital, the Centers for Medicare & Medicaid Services (CMS) certification number, SSI days, total Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients.

Background

CR 9195 provides updated data for determining the disproportionate share hospital (DSH) adjustment for IPPS hospitals and the LIP adjustment for IRFs as well as payments as applicable for certain LTCH discharges. The data are in files located at:

- IPPS: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html*
- IRF: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/SSIData.html*
- LTCH: *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 2013 (cost reporting periods beginning on or after October 1,2012, and before October 1, 2013), except when explicitly directed otherwise by CMS. Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 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 DSH adjustment factor, and beginning for discharges occurring on or after October 1, 2013, the additional payment is determined by multiplying the DRG payment by the DSH adjustment factor reduced by 75 percent. (See 42 CFR 412.106.)

Under IRF 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 LIP adjustment formula. The LIP adjustment formula is: (1+DSH) ^ 0.3177.

Under the LTCH PPS, certain payment adjustments, such as for short-stay outlier (SSO) cases at 42 CFR 412.529, require the calculation of an amount comparable to the amount that would otherwise be paid under the IPPS (i.e., 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)).

Additional information

The official instruction, CR 9195 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1508OTN.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 9195
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Effective Date: July 6, 2015
Related CR Transmittal #: R1508OTN
Implementation Date: July 6, 2015

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Inpatient prospective payment system hospital extensions

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 9197 which provides information and implementation instructions for Sections 204 and 205 of the Medicare Access and CHIP Reauthorization Act of 2015.

Caution – what you need to know

On April 16, 2015, the president signed into law the Medicare Access and CHIP Reauthorization Act of 2015. The new law includes the extension of certain provisions of the Affordable Care Act. Specifically, Section 204 and Section 205 (see below) of the Medicare Inpatient Prospective Payment System (IPPS) fee-for-service policies have been extended through September 30, 2017.

Go – What you need to do

Make sure that your billing staffs are aware of these changes.

Background

On April 16, 2015, President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (see *https://www.congress.gov/114/bills/hr2/BILLS-114hr2ih.pdf*). The following Medicare inpatient prospective payment system (IPPS) fee-for-service policies have been extended through September 30, 2017.

Section 204 – Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals

The Affordable Care Act (see *http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf*) provided for temporary changes to the low-volume hospital adjustment for Fiscal Years (FYs) 2011 and 2012. To qualify, the hospital must have less than 1,600 Medicare discharges and be located more than 15 miles from the nearest IPPS hospital.

Section 205 - Extension of the Medicare-dependent hospital (MDH) program

The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges.

The Medicare Access and CHIP Reauthorization Act of 2015 provides for an extension of the temporary changes to the low-volume hospital adjustment and of the MDH program for discharges occurring on or after April 1, 2015, through FY 2017 (that is, for discharges occurring on or before September 30, 2017). Prior legislation extended these adjustments through March 31, 2015.

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

The Centers for Medicare & Medicaid Services (CMS) implemented the changes to the low-volume hospital adjustment provided by the Affordable Care Act as extended by subsequent legislation in the regulations at 42 CFR §412.101. For additional information, refer to the FY 2011 IPPS/LTCH PPS final rule, 75 FR 50238 through 50275, the FY 2014 IPPS/LTCH PPS final rule, 78 FR 50611 through 50613,) and the FY 2015 IPPS/LTCH PPS final rule, 79 FR 50428.

To implement the extension of the temporary change in the low-volume hospital payment policy [as provided for by Section 204 of the Medicare Access and CHIP Reauthorization Act of 2015, consistent with the existing regulations at 42 CFR §412.101(b)(2)(ii)], the same discharge data used for the low-volume adjustment for discharges occurring during the first half of FY 2015 will continue to be used for discharges occurring during the last half of FY 2015, as these data were the most recent available data at the time of the development of the FY 2015 payment rates.

Specifically, for FY 2015 discharges occurring on or after April 1, 2015, through September 30, 2015, the low-volume hospital qualifying criteria and payment adjustment (percentage increase) is determined using FY 2013 Medicare discharge data from the March 2014 update of the MedPAR files. This discharge data can be found in Table 14 of the Addendum of the FY 2015 IPPS final rule (CMS-1607-F).

In order to facilitate administrative implementation, the only source that CMS and the MACs will use to determine the number of Medicare discharges for purposes of the low-volume adjustment for FY 2015 is the data from the March 2014 update of the FY 2013 MedPAR file. CMS notes, Table 14 provides a list of IPPS hospitals with

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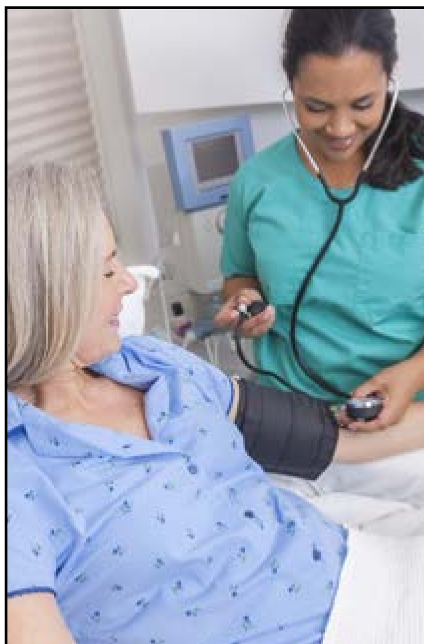
fewer than 1,600 Medicare discharges, and is not a listing of the hospitals that qualify for the low-volume hospital adjustment for FY 2015 since it does not reflect whether or not the hospital meets the mileage criterion (that is, the hospital must also be located more than 15 road miles from any other IPPS hospital). In order to receive the applicable low-volume hospital payment adjustment (percentage increase) for FY 2015 discharges, a hospital must meet both the discharge and mileage criteria.

MACs will notify hospitals that had a FY 2015 low-volume hospital status determination on March 31, 2015, that their status has been reinstated for the remainder of FY 2015 provided that the hospital continues to meet the mileage criterion (that is, it continues to be located more than 15 road miles from any other IPPS hospital). In other words, the hospital will continue to have low-volume hospital status for the last half of FY 2015 provided there have not been any changes in the hospital's proximity to another IPPS hospital subsequent to the hospital's notification to its MAC that it met the low-volume hospital criteria for the first half of FY 2015.

For requests for low-volume hospital status for FY 2015 received after April 1, 2015, if the hospital meets the criteria to qualify as a low-volume hospital, the MAC will establish a low-volume hospital status effective date that will be applicable prospectively within 30 days of the date of the MAC's low-volume hospital status determination, consistent with the historical policy of CMS.



In order to implement this policy for FY 2015 discharges occurring on or after April 1, 2015, the Pricer will continue to include a table containing the provider number and discharge count determined from the March 2014 update of the FY 2013 MedPAR file.

The discharge count includes any billed Medicare advantage claims in the MedPAR file but excludes any claims serviced in non-IPPS units. Consistent with prior practice, the table in pricer includes IPPS providers with fewer than 1,600 Medicare discharges but does not consider whether the IPPS hospital meets the mileage criterion (that is, it is located more than 15 road miles from the nearest IPPS hospital).

The applicable low-volume hospital adjustment (percentage increase) is based on and in addition to all other IPPS per discharge payments, including capital, Disproportionate Share Hospital (DSH), uncompensated care, indirect medical education (IME) and outliers. For sole-community hospitals (SCHs) and Medicare dependent hospitals (MDHs), the applicable low-volume percentage increase is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Reinstatement of Medicare dependent hospital status

Under Section 3124 of the Affordable Care Act, the MDH program authorized by the Social Security Act (section 1886(d)(5)(G) was set to expire at the end of FY 2012. These amendments were extended through March 31, 2015 by subsequent legislation. Section 205 of the Medicare Access and CHIP Reauthorization Act of 2015 extends the MDH program through September 30, 2017. CMS implemented the extension of the MDH program provided by the Affordable Care Act and subsequent legislation in the regulations at 42 CFR §412.108.

For additional information, refer to the FY 2011 IPPS/LTCH PPS final rule 75 FR 50287, the FY 2013 IPPS/LTCH PPS notice (78 FR 14691 through 14692), the FY 2014 IPPS/LTCH PPS final rule 78 FR 50647 through 50649 , the FY 2014 Extension of the Low-Volume Hospital Payment Adjustment and MDH program interim final rule with Comment (IFC) (March 18, 2014; 79 FR 15025 through 15028) and the FY 2015 IPPS/LTCH PPS final rule, 79 FR 50429.

Consistent with the implementation of previous CMS extensions of the MDH program, generally, providers that were classified as MDHs as of the date of expiration of the MDH provision will be reinstated as MDHs effective April 1, 2015, with no need to reapply for MDH classification. However, there are the following two exceptions:

a. MDHs that were classified as sole-community hospitals (SCHs) on or after April 1, 2015

In anticipation of the expiration of the MDH provision, CMS allowed MDHs that applied for classification as an SCH by March 1, 2015 (that is, 30 days prior to the expiration of the MDH program), to be granted such status effective with the expiration of the MDH program.

Hospitals that applied in this manner and were approved for SCH classification received SCH status as of April 1, 2015. Additionally, some hospitals that had MDH status as of the April 1, 2015, expiration of the MDH program may have missed the March 1, 2015, application deadline.

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These hospitals applied for SCH status in the usual manner instead and may have been approved for SCH status effective 30 days from the date of approval resulting in an effective date later than April 1, 2015.

b. MDHs that requested a cancellation of their rural classification under 42 CFR §412.103(b)

In order to meet the criteria to become an MDH, a hospital must be located in a rural area. To qualify for MDH status, some MDHs may have reclassified as rural under the regulations at 42 CFR §412.103. With the expiration of the MDH provision, some of these providers may have requested a cancellation of their rural classification.

Any provider that falls within either of the two exceptions listed above will not have its MDH status automatically reinstated retroactively to April 1, 2015. All other former MDHs will be automatically reinstated as MDHs effective April 1, 2015.

Providers that fall within either of the two exceptions will have to reapply for MDH classification in accordance with the regulations at 42 CFR 412.108(b) and meet the classification criteria at 42 CFR §412.108(a). You can review 42 CFR §412.108. Specifically, the regulations at 42 CFR §412.108(b) require that:

1. The hospital submit a written request along with qualifying documentation to its MAC to be considered for MDH status (42 CFR §412.108(b)(2)).
2. The MAC make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification (42 CFR §412.108(b)(3)).
3. The determination of MDH status be effective 30 days after the date of the MAC's written notification to the hospital (42 CFR§412.108(b)(4)).

Cancellation of MDH status

As required by the regulations at 42 CFR §412.108(b)(5), MACs must "evaluate on an ongoing basis" whether or not a hospital continues to qualify for MDH status.

Therefore, as required by the regulations at 42 CFR §412.108(b)(5) and (6), the MACs will ensure that the hospital continues to meet the MDH criteria at 42 CFR §412.108(a), and will notify any MDH that no longer qualifies for MDH status. The cancellation of MDH status will become effective 30 days after the date the contractor provides written notification to the hospital.

It is important to note that despite the fact some providers might no longer meet the criteria necessary to be classified as MDHs, these providers could qualify for automatic reinstatement of MDH status retroactive to April 1, 2015 (unless they meet either of the two exceptions for automatic reinstatement as explained above) and would subsequently lose their MDH status prospectively.

The following table outlines the various possible actions to be followed for each former MDH and the corresponding examples for each scenario. The examples immediately follow the table.

If the provider was classified as an MDH as of the March 31, 2015 expiration of the MDH provision and the provider:	Then	Corres. example #
Did not reclassify as an SCH since April 1, 2015 and continues to be classified as a rural provider	MDH status will be automatically reinstated to April 1, 2015.	1
Reclassified as an SCH immediately following the expiration of the MDH provision with SCH status effective April 1, 2015.	The provider's MDH status will not be automatically reinstated and the provider will have to reapply for MDH classification (§412.108(b)).	2
Reclassified as an SCH, but the effective date of SCH status was a date after April 1, 2015.	The provider's MDH status will be reinstated, effective April 1, 2015 for the portion of time during which it was not classified as an SCH. The provider's MDH status will be cancelled effective with the effective date of its SCH status. The provider will have to reapply for MDH classification (§412.108(b)).	3

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If the provider was classified as an MDH as of the March 31, 2015 expiration of the MDH provision and the provider:	Then	Corres. example #
Cancelled its rural classification under §412.103 effective April 1, 2015	The provider's MDH status will not be automatically reinstated and the provider will have to reapply for rural classification (§412.103(b)) and then reapply for MDH classification (§412.108(b)).	4
Cancelled its rural classification under §412.103, but the effective date of the rural status cancellation was a date after April 1, 2015	The provider's MDH status will be reinstated for the portion of time during which it was classified as rural. The provider's MDH status will then be cancelled effective with the date that its rural classification cancellation became effective. The provider will have to reapply for rural classification (§412.103(b)) and then reapply for MDH classification (§412.108(b)).	5
Did not reclassify as an SCH and continues to be classified as a rural provider but has a Medicare utilization rate < 60 percent in the three most recently settled cost reports	MDH status will be automatically reinstated to April 1, 2015. The MAC will then notify the provider that it no longer meets MDH criteria and will cancel MDH status in accordance with the regulations at §412.108(b)(6).	6

Examples

Example 1: Hospital A was classified as an MDH prior to the March 31, 2015, expiration of the MDH program. Hospital A retained its rural classification and did not reclassify as an SCH. Hospital A's MDH status will be automatically reinstated to April 1, 2015.

Example 2: Hospital B was classified as an MDH prior to the March 31, 2015, expiration of the MDH program. In accordance with the regulations at §412.92(b)(2)(v) and in anticipation of the expiration of the MDH program, Hospital B applied for classification as an SCH by March 1, 2015, and was approved for SCH status effective on April 1, 2015. Hospital B's MDH status will not be automatically reinstated. In order to reclassify as an MDH, hospital B must cancel its SCH status, in accordance with §412.92(b)(4), and reapply for MDH status in accordance with the regulations at §412.108(b).

Example 3: Hospital C was classified as an MDH, prior to the March 31, 2015, expiration of the MDH program. Hospital C missed the application deadline of March 1, 2015, for reclassification as an SCH under the regulations at §412.92(b)(2)(v) and was not eligible for its SCH status to be effective as of April 1, 2015. Hospitals C's MAC approved its classification request for SCH status effective May 16, 2015. Hospital C's MDH status will be reinstated but only for the portion of time in which they met the criteria for MDH status. Hospital C's MDH status will be reinstated effective April 1, 2014, through May 15, 2015, and will be cancelled effective May 16, 2015. In order to reclassify as an MDH, hospital C must cancel its SCH status, in accordance with §412.92(b)(4), and then reapply for MDH status in accordance with the regulations at §412.108(b).

Example 4: Hospital D was classified as an MDH prior to the March 31, 2015 expiration of the MDH program. In anticipation of the expiration of the MDH program, hospital D requested that its rural classification be cancelled in accordance with the regulations at §412.103(g). Hospital D's rural classification was cancelled effective April 1, 2015. Hospital D's MDH status will not be automatically reinstated. In order to reclassify as an MDH, hospital D must request to be reclassified as rural under §412.103(b) and must reapply for MDH status under §412.108(b).

Example 5: Hospital E was classified as an MDH prior to the March 31, 2015, expiration of the MDH program. In anticipation of the expiration of the MDH program, hospital E requested that its rural classification be cancelled in accordance with the regulations at §412.103(g). Hospital E's rural classification was cancelled effective July 1, 2015. Hospital E's MDH status will be reinstated but only for the portion of time in which they met the criteria for MDH status. Since hospital E cancelled its rural status

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MDH status. Since hospital E cancelled its rural status and became urban effective July 1, 2015, MDH status will only be reinstated effective April 1, 2015, through June 30, 2015, and will be cancelled effective July 1, 2015. In order to reclassify as an MDH, hospital E must request to be reclassified as rural under §412.103(b) and must reapply for MDH status under §412.108(b).

Example 6: Hospital F was classified as an MDH prior to the March 31, 2015, expiration of the MDH provision. The hospital's MAC found that hospital F had a Medicare utilization rate of less than 60 percent in all three of the most recently settled cost reports.

Hospital F did not reclassify as an SCH nor did it drop its rural status with the expiration of the MDH provision. In this case, Hospital F's MAC will automatically reinstate its MDH status retroactive to April 1, 2015. The MAC will then notify hospital F that it no longer qualifies for MDH status. The change in hospital F's status (that is, disqualification from MDH status) will become effective 30 days after the date the MAC's written notification to hospital F.

Notification to provider

MACs will notify providers by a letter if the provider's MDH status is not reinstated seamlessly from April 1, 2015, because it falls within one of the two exceptions listed above or if the provider will lose its MDH status due to no longer meeting the criteria for MDH status, per the regulations at 42 CFR §412.108(b)(6).

Each MAC will add to each letter, information specific to that provider regarding how it is affected by the MDH program extension, that is, notifying the provider of its status under the extension of the MDH program. The status of each former MDH will either be:

1. MDH status not reinstated; additional action required by the provider in order to be classified as an MDH. Provider must request a cancellation of SCH status or submit a request for rural classification under 42 CFR §412.103. Provider will then have to reapply for MDH status in accordance with the regulations under 42 CFR §412.108(b).

2. MDH status reinstated and then subsequently cancelled due to the provider not continuing to meet the criteria for MDH classification under the requirements at 42 CFR §412.108(b)(5).

Hospital specific (HSP) rate update for MDHs

For the payment of FY 2015 discharges occurring on or after April 1, 2015, the hospital specific (HSP) amount for MDHs in the PSF will continue to be entered in FY 2012 dollars. The pricer will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2013 of 0.9480 and apply all update and other adjustment factors to the HSP amount for FY 2013 and beyond.

Additional information

The official instruction, CR 9197, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3281CP.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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Mass adjustment of FQHC PPS claims

As a result of the recent passing of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, Medicare administrative contractors (MACs) will be mass adjusting all federally qualified health center (FQHC) claims billed under the prospective payment system (PPS) with dates of service on or after April 1, 2015, through May 3, 2015.

April Medicare physician fee schedule database update

***Note**: This article was revised June 15, 2015, to reflect changes required by the Medicare Access and CHIP Reauthorization Act of 2015. The change request (CR) release date, transmittal number, and Web address for accessing it are revised. This information was previously published March 2015 Medicare A Connection, Page 46.*

Provider types affected

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

Provider action needed

CR 9104 informs MACs about the release of payment files based upon the 2015 Medicare physician fee schedule (MPFS) final rule. Make sure that your billing staffs are aware of these changes.

Background

Payment files were issued to MACs based upon the 2015 MPFS final rule, published in the *Federal Register* December 19, 2014, to be effective for services furnished between January 1, 2015, and December 31, 2015. Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services. The Medicare Access and CHIP Reauthorization Act of 2015 allowed the zero percent update that would have ended March 31, 2015, to continue through to June 30, 2015, and allows for a 0.5 percent update from July 1, 2015, to December 31, 2015. It also extends the physician work geographic practice cost index (GPCI) floor of 1.0, and the therapy cap exceptions process, through December 2017.

In the 2015 Medicare physician fee schedule final rule, the Centers for Medicare & Medicaid Services (CMS) announced a conversion factor (CF) of $28.2239 for services furnished on or after April 1, 2015, resulting in an average reduction of 21.2 percent from the 2014 rates (this CF was later corrected to $28.1872 in a correction notice). However, the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 allowed the zero percent update that would have ended March 31, 2015, to continue through to June 30, 2015. Therefore, the CF of 35.7547 in effect from January 1, 2015, through March 31, 2015, was extended to June 30, 2015. Changes for certain *CPT®*/ HCPCS codes included in the April update to the 2015 MPFSDB are as follows:

- J1826 - Procedure status = E
- J9010 - Procedure status = N
- *77063* - Type of service = 1
- *93355* - Multiple surgery indicator = 2 and type of service = 4
- *93644* -Type of service = 2

Code G0279 has a new short descriptor of "Tomosynthesis, mammo." In addition, the following codes have a procedure status of "I": *80300, 80301, 80302, 80303, 80304, 80320, 80321, 80322, 80323, 80324, 80325, 80326, 80327, 80328, 80329, 80330, 80331, 80332, 80333, 80334, 80335, 80336, 80337, 80338, 80339, 80340, 80341, 80342, 80343, 80344, 80345, 80346, 80347, 80348, 80349, 80350, 80351, 80352, 80353, 80354, 80355, 80356, 80357, 80358, 80359, 80360, 80361, 80362, 80363, 80364, 80365, 80366, 80367, 80368, 80369, 80370, 80371, 80372, 80373, 80374, 80375, 80376*, and *80377*.

Effective for services on or after April 1, 2015, the following codes will have a procedure status of "X": *81500, 81503, 81506, 81508, 81509, 81510, 81511, 81512,* and *81599*. Also, effective for services on or after April 1, 2015, new code Q9975 is added with a short descriptor of "Factor VIII FC Fusion Recomb" and a long descriptor of "Injection, Factor VIII, FC Fusion Protein (Recombinant), per iu". The procedure status code for Q9975 is "E" and it has a global surgery modifier of "XXX". Finally, S8032 was transposed as S0832 in the January 2015 MPFS; S0832 has been replaced with S8032 in the April 2015 MPFS.

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

Additional information

The official instruction, CR 9104, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3283CP.pdf*.

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

MLN Matters® Number: MM9104 *Revised*
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Implementation Date: April 6, 2015

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July update to the Medicare physician fee schedule database

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9152 which amends payment files that were previously issued to your MAC based upon the 2015 Medicare physician fee schedule database (MPFSDB) final rule.

Affected providers should be aware that MACs will only adjust claims brought to their attention. Please make sure your billing staff is aware of these changes.

Background

The Social Security Act (Section 1848(c)(4); see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services.

Payment files were previously issued to your MAC based on the 2015 MPFS final rule, which was published in the *Federal Register* and effective for services furnished between January 1 and December 31, 2015 (See *http://www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.pdf*).

Quarterly update to the MPFSDB July 2015 update

The Medicare Access and CHIP Reauthorization Act of 2015 allowed the zero percent update that would have ended on March 31, 2015, to continue through to June 30, 2015, and allows for a 0.5 percent from July 1 to December 31, 2015. It also extends the physician work geographic practice cost index (GPCI) floor of 1.0, and the therapy cap exceptions process, through December 2017.

CR 9152 provides files for MPFS changes that are effective for dates of service

January 1 through June 30, 2015, at the zero percent update, and files for changes effective for dates of service on or after July 1, 2015, at the 0.5 percent rate.

The attachment in CR 9152 lists new codes Q5101, Q9976, Q9977, Q9978, *0392T, 0393T, 90620, 90621*, and *90697* with the applicable "HCPCS effective date" for each code.

Tables 1-3 also list those codes.

In accordance with Chapter 23, Section 30.1 of the *Medicare Claims Processing Manual*, MACs will give providers 30-day notices before implementing the changes identified in CR 9152.

Your MAC will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, they will adjust claims brought to their attention.

New codes: Table 1

HCPCS code	Q5101	Q9976	Q9977
HCPCS eff. date	3-6-2015	7-1-2015	7-1-2015
Type(s) of serv.	1, P	1, L	1, P
HCPCS cov. code	D	C	D
Long desc.	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	Injection, Ferric Pyro-phosphate Citrate Sol., 0.1 mg of iron	Compounded Drug, Not Otherwise Classified
Short desc.	Inj filgrastim g-csf biosim	Inj Ferric Pyro-phosphate Cit	Compounded Drug NOC
MPFSDB record date	20150306	20150701	20150701
MPFS proc. status	E	E	E
Work RVU	0.00	0.00	0.00
Full non-facility PE RVU	0.00	0.00	0.00
Full facility PE RVU	0.00	0.00	0.00

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HCPCS code	Q5101	Q9976	Q9977
Mal-practice RVU	0.00	0.00	0.00
Site of service	0	0	0
PC/TC	9	9	9
Global surgery	XXX	XXX	XXX
Pre	0.00	0.00	0.00
Intra	0.00	0.00	0.00
Post	0.00	0.00	0.00
Multiple proc. ind.	9	9	9
Bilateral surgery ind.	9	9	9
Asst. surg. ind.	9	9	9
Co-surgery indicator	9	9	9
Team surgery indicator	9	9	9
Physician super. diag. ind.	09	09	09
Diag. family imaging indicator	99	99	99
Non-facility PE used for OPPS payment amount	0.00	0.00	0.00
Facility PE used for OPPS payment amount	0.00	0.00	0.00
MP used for OPPS payment amount	0.00	0.00	0.00

New codes: Table 2

HCPCS code	Q9978	*0392T*	*0393T*
HCPCS effective date	7-1-2015	7-1-2015	7-1-2015
Type(s) of service	1	2, 8	2, 8
HCPCS cov. code	D	C	C
Long desc	Netupitant 300 mg and Palonosetron 0.5 mg, oral	*Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band)*	*Removal of esophageal sphincter augmentation device*
Short desc.	Netupitant Palonosetron oral	Lap es sph augment dev place	Es sph augmnt device removal
MPFSDB record date	20150701	20150701	20150701
MPFS proc. status	E	C	C
Work RVU	0.00	0.00	0.00
Full non-facility PE RVU	0.00	0.00	0.00

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HCPCS code	Q9978	*0392T*	*0393T*
Full facility PE RVU	0.00	0.00	0.00
Mal-practice RVU	0.00	0.00	0.00
Site of serv.	0	0	0
PC/TC	9	0	0
Global surgery	XXX	YYY	YYY
Pre	0.00	0.00	0.00
Intra	0.00	0.00	0.00
Post	0.00	0.00	0.00
Multiple proc. ind.	9	0	0
Bilateral surgery ind.	9	0	0
Asst. surgery ind.	9	0	0
Co-surg. ind.	9	0	0
Team surgery ind.	9	0	0
Phys. super. diag. ind.	09	09	09
Diag. family imaging ind.	99	99	99
Non-facility PE used for OPPS pmt. amt	0.00	0.00	0.00
Facility PE used for OPPS pmt. amt	0.00	0.00	0.00
MP used for OPPS pmt amt	0.00	0.00	0.00

New codes: Table 3

HCPCS code	*90620*	*90621*	*90697*
HCPCS effective date	2-1-2015	2-1-2015	1-1-2015
Type(s) of service	1	1	1
HCPCS cov. code	C	C	C
Long desc.	*Meningo-coccal recombinant protein and outer membrane vesicle vaccine, Serogroup B, 2 dose schedule, for intra-muscular use*	*Meningo-coccal recombinant lipoprotein vaccine, Serogroup B, 3 dose schedule, for intra-muscular use*	*Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemo-philus influenza type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intra-muscular use*
Short desc.	Menb rp w/ omv vaccine im	Menb rlp vaccine im	Dtap-ipv-hib-hepb vaccine im
MPFSDB record date	20150201	20150201	20150101
MPFS proc. status	E	E	E
Work RVU	0.00	0.00	0.00

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HCPCS code	*90620*	*90621*	*90697*
Full non-facility PE RVU	0.00	0.00	0.00
Full facility PE RVU	0.00	0.00	0.00
Mal-pract RVU	0.00	0.00	0.00
Site of service	0	0	0
PC/TC	9	9	9
Global surgery	XXX	XXX	XXX
Pre	0.00	0.00	0.00
Intra	0.00	0.00	0.00
Post	0.00	0.00	0.00
Multiple proc. ind.	9	9	9
Bilateral surgery ind.	9	9	9
Asst. surg. ind.	9	9	9
Co-surgery indicator	9	9	9
Team surgery indicator	9	9	9
Physician sup. diag. ind.	09	09	09

The following changes are effective for dates of service on and after January 1, 2015.

CPT®/ HCPCS	Modifier	Action
34839		PC/TC indicator = 0
88366		Non-facility PE RVU = 5.27; facility PE RVU = 5.27
88366	TC	Non-facility PE RVU = 4.76; facility PE RVU = 4.76
93355		Multiple surgery indicator = 6

Additional information

You may want to review the following articles:

- MM9081 titled "Emergency Update to the Calendar Year (CY) 2015 Medicare Physician Fee Schedule Database (MPFSDB) at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9081.pdf*; and
- MM9104 titled "Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) April Calendar Year (CY) 2015 Update" at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9104.pdf*.

The official instruction, CR 9152, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3259CP.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-Net work-MLN/MLNMattersArticles/index.html* under - *How Does It Work*.

MLN Matters® Number: MM9152
Related Change Request (CR) #: CR 9152
Effective Date: January 1, 2015 - Effective for dates of service on or after January 1, 2015, unless otherwise stated
Related CR Release Date: May 15, 2015
Related CR Transmittal #: R3259CP
Implementation Date: July 6, 2015

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July 2015 quarterly ASP drug pricing files and revisions to prior pricing files

Provider types affected

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

Provider action needed

Change request (CR) 9159 which instructs MACs to download and implement the July 2015 average sales price (ASP) drug pricing files and, if released by CMS, the April 2015, January 2015, October 2014, and July 2014 ASP drug pricing files for Medicare Part B drugs.

Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 6, 2015, with dates of service July 1, 2015, through September 30, 2015. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis. The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis.

Payment allowance limits under the OPPS are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER).

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

Files	Effective dates of service
July 2015 ASP and ASP NOC	July 1, 2015, through September 30, 2015
April 2015 ASP and ASP NOC	April 1, 2015, through June 30, 2015
January 2015 ASP and ASP NOC	January 1, 2015, through March 31, 2015
October 2014 ASP and ASP NOC	October 1, 2014, through December 31, 2014

Files	Effective dates of service
July 2014 ASP and ASP NOC	July 1, 2014, through September 30, 2014

Note: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local MAC processing the claim shall make these determinations.

Additional information

The official instruction, CR 9159, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3258CP.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: MM9159
Related Change Request (CR) #: CR 9159
Related CR Release Date: May 15, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3258CP
Implementation Date: July 6, 2015

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July quarterly update for 2015 durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) fee schedule

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9177 which advises providers of the July 2015 update for the Medicare DMEPOS fee schedule.

The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your staff is aware of these updates.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies.

The quarterly update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf*.

Section 1834 (a), (h), and (i) of the Social Security Act requires payment on a fee schedule basis for DME, prosthetic devices, orthotics, prosthetics, and surgical dressings. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for parenteral and enteral nutrition (PEN), splints and casts, and intraocular lenses (IOLs) inserted in a physician's office.

Key points

Specific coding and pricing issues

1. As part of this update, fees are established for Healthcare Common Procedure Coding System (HCPCS) code A4602, which was added to the HCPCS file effective January 1, 2015. This item has been paid on a local fee schedule basis prior to this update. **Claims for code A4602 that have already been processed and have dates of service on or after January 1, 2015, may not be adjusted to reflect newly established fees.**
2. Section 203 of the Achieving a Better Life Experience (ABLE) Act of 2014 amended Section 1834(a)(1) of the Social Security Act to exclude Medicare coverage for vacuum erection systems.
3. As of July 1, 2015, HCPCS codes describing vacuum erection systems are statutorily excluded from Medicare coverage and are not payable when billed to Medicare. The fee schedules for the following vacuum erection system HCPCS codes will be removed from the DMEPOS fee schedule file effective July 1, 2015:

a. L7900 Male vacuum erection system; and

b. L7902 Tension ring, for vacuum erection device, any type, replacement only, each

Effective for claims with dates of service on or after July 1, 2015, claims submitted with HCPCS codes L7900 and L7902 will be denied using the following codes:

- Group code -PR – "patient responsibility."
- Claim adjustment reason codes (CARC) 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT.)

Note: Refer to the 835 healthcare policy identification segment (loop 2110 Service Payment Information REF), if present.

- Remittance advice remark code (RARC) N425 – "Statutorily excluded service(s)". Also, note that MACs will follow existing procedures for denying statutorily non-covered items, when these codes are billed with the "GY" modifier.

4. As part of the January 2015 update, fee schedules for HCPCS code A7048 (Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each) were added to the DMEPOS fee schedule file. In response to questions received on these fee schedule amounts, CMS is providing the following clarification:
   a. HCPCS code A7048 describes all supplies, including the appropriately sized collection container, that are needed for a collection unit change when draining an implanted catheter.
   b. A7048 is used for each single, complete

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collection and represents a supply allowance rather than a specifically defined kit.

c. Items included in this code are not limited to pre-packaged kits that are bundled by manufacturers or distributors.

d. The A7048 supplies include, but are not limited to, drainage tubing, gauze, dressings and any number of collection units of various sizes needed to capture the drainage for each complete drainage collection.

e. Since included in A7048, supplies that are used in a collection change should not be separately billed using miscellaneous codes.

Additional information

The official instruction, CR 9177, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3277CP.pdf.

You may want to review the related *MLN Matters*® article, SE1511 (Discontinued Coverage of Vacuum Erection Systems (VES) Prosthetic Devices in Accordance with the Achieving a Better Life Experience Act of 2014).

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: MM9177
Related Change Request (CR) #: CR 9177
Related CR Release Date: May 29, 2015
Effective Date: January 1, 2015 - for implementation of fee schedule amounts for codes in effect on January 1, 2015; July 1, 2015 for all other changes
Related CR Transmittal #: R3277CP
Implementation Date: July 6, 2015

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Corrections to the 2015 home health pricer program

Provider types affected

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

Provider action needed

Change request (CR) 9198 instructs MACs to install a new home health (HH) pricer program which contains updates to allow processing of type of bill 032Q or 033Q, as required by CR 8581. CR 9198 also corrects errors affecting the payments on 2015 claims and instructs the MACs to adjust claims in order to correct payment amounts. Make sure that your billing staffs are aware of these changes.

Background

Change request (CR) 9198 provides the following three updates to the home health (HH) pricer program:

1. The National Uniform Billing Committee (NUBC) recently created a new type of bill (TOB) frequency code to facilitate the automation of certain requests for re-openings.

The Centers for Medicare & Medicaid Services (CMS) implemented the new TOB frequency code Q in CR 8581. However, this frequency code is not currently recognized in the HH pricer program. CR 9198 makes the necessary changes to process TOB frequency code 'Q'. While all HH claims are currently submitted using TOB 032x, the HH Pricer must accommodate TOBs 032Q and 033Q since reopening requests may affect claims which were submitted when TOB 033x was still valid.

The *MLN Matters*® article, MM8581, corresponding to CR 8581 is available at *http://www.cms.gov/outreach-and-education/medicare-learning-networkmln/mlnmattersarticles/downloads/mm8581.pdf*.

2. The 2015 HH Pricer currently uses a table that contains incorrect case-mix weights for all health insurance prospective payment system (HIPPS) codes beginning with '4.' The weights for all codes beginning with '4' are using the weight for the corresponding code that begins with '2' (for example, a claim submitted with HIPPS code 4AFKS is being paid using the weight for 2AFKS). CR 9198 corrects the weight table and instructs MACs to adjust claims to correct payments within 60 calendar days of the implementation of CR 9198.

3. CR 8950 contained re-coding instructions for the HH pricer, to reflect the updated case-mix scoring tables for 2015. These instructions contained an error in a table used when HIPPS codes beginning with '1' or '2' are submitted with 20 or more therapy visits and must be re-coded to a HIPPS code beginning with '5.'

If the clinical severity value encoded in the treatment authorization code was a 'D', the claim was re-coded into a higher case-mix group in error. CR 9198 corrects the instructions and the re-coding logic in the Pricer. It also instructs MACs to adjust claims to correct payments.

The *MLN Matters*® article, MM8950, corresponding to CR 8950 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8950.pdf.*

Note: CR 9198 contains no new policy, but it corrects the implementation of existing policies.

Additional information

The official instruction, CR 9198, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3268CP.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: MM9198
Related Change Request (CR) #: CR 9198
Related CR Release Date: May 29, 2015
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Related CR Transmittal #: R3268CP
Implementation Date: October 5, 2015

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Outpatient prospective payment system July 2015 update

Provider types affected

This *MLN Matters*® article is intended for providers and suppliers who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS).

Provider action needed

Change request (CR) 9205 describes changes to and billing instructions for various payment policies implemented in the July 2015 OPPS update. Make sure your billing staff is aware of these changes.

Background

Change request (CR) 9205 describes changes to and billing instructions for various payment policies implemented in the July 2015 OPPS update. The July 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 9205. CR 9205 also revises the *Medicare Claims Processing Manual* (Chapter 4, Section 20.6.11 (Use of HCPCS Modifier – PO)) which is included as an attachment to CR 9205.The July 2015 revisions to I/OCE data files, instructions, and specifications are provided in CR 9190.

The *MLN Matters*® article related to CR 9190 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9190.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

Key changes to and billing instructions for various payment policies implemented in the July 2015, OPPS update is as follows:

New device pass-through categories

The Social Security Act (Section 1833(t)(6)(B); see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. 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 July 1, 2015. Table 1 below provides a listing of new coding and payment information, including ambulatory payment classification (APC) and status indicator (SI), concerning the new device category for transitional pass-through payment.

Table 1 - New device pass-through code

HCPCS	Eff. date	SI	APC	Short desc	Long desc.	Device offset from pmt
C2613	07-01-15	H	2613	Lung bx plug w/del sys	Lung biopsy plug with delivery system	$24.83

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. CMS has determined that a portion of the APC payment amount associated with the cost of C2613 is reflected in APC 0005.

The C2613 device should always be billed with *CPT*® code *32405* (Biopsy, lung or mediastinum, percutaneous needle) which is assigned to APC 0005 for 2015. The device offset from payment represents a deduction from pass-through payments for the device in category C2613.

b. Application of offset to C2623: On April 1, 2015, CMS determined that an offset would apply to C2623 because APCs 0083, APC 0229, and APC 0319 already contain costs associated with the device described by C2623. The device offset is a deduction from pass-through payments for C2623. After further review, CMS has determined that the costs associated with C2623 are already reflected in APCs 0083, APC 0229, or APC 0319.

Therefore, CMS is not applying an offset to C2623. This determination to not apply the device offset from payment will be retroactive to April 1, 2015. For further discussion about the device offset policy, see 68 FR 63438-9 at *http://www.gpo.gov/fdsys/pkg/FR-2003-11-07/pdf/03-27791.pdf*. Providers with previously-processed claims with C2623 and with dates of service on or after April 1, 2015, through July 1, 2015, may bring those claims to the attention of their MAC for adjustment.

Category III *CPT*® codes

The American Medical Association (AMA) releases Category III *Current Procedural Terminology* (*CPT*®) codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January. For the July 2015 update, CMS is implementing in the OPPS two Category III

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CPT® codes that the AMA released in January 2015 for implementation on July 1, 2015.

Both Category III *CPT*® codes are separately payable under the hospital OPPS. The status indicators (SIs) and APCs for these codes are shown in Table 2, below. Payment rates for these services are in Addendum B of the July 2015 OPPS update that is posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

Table 2 -- Category III *CPT*® codes implemented as of July 1, 2015

2015 *CPT*® code	2015 Long descriptor	July 2015 OPPS status indicator	July 2015 OPPS APC
0392T	Laparo-scopy, surgical, esophageal sphincter aug-mentation procedure, placement of sphincter aug-mentation device (ie, magnetic band)	T	0174
0393T	Removal of esophageal sphincter augmentation device	Q2	0130

LINX reflux management system

In January 2014, CMS established HCPCS code C9737 to describe the laparoscopic implantation of a magnetic esophageal ring for the treatment of gastroesophageal reflux disease (GERD), which is the procedure associated with the LINX Reflux Management System.

For the July 2015 update, the *CPT*® editorial panel established *CPT*® code *0392T* to describe the LINX reflux management system. With the establishment of the *CPT*® code, CMS is deleting HCPCS code C9737 effective June 30, 2015. Therefore, effective July 1, 2015, hospital outpatient departments (HOPDs) must report *CPT*® code *0392T* to report the implantation of a magnetic esophageal ring associated with the LINX reflux management system procedure.

Table 3, below, lists the long descriptors for HCPCS C9737 and *CPT*® code *0392T*. To view the July 2015 OPPS payment rate for *CPT*® code *0392T*, refer to the July 2015 OPPS Addendum B (which is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

Table 3 – Long descriptors for HCPCS C9737 and *CPT*® Code *0392T*

CPT® / HCPCS code	Long descriptor	Add date	Term. date	July 2015 OPPS SI	July 2015 OPPS APC
C9737	*Laparo-scopy, surgical, esophageal sphincter aug-mentation with device (eg, magnetic band)*	1-1-2014	6-30-2015	T	0174
0392T	*Laparo-scopy, surgical, esophageal sphincter aug-mentation procedure, placement of sphincter aug-mentation device (ie, magnetic band)*	7-1-2015	T	0174	

Use of HCPCS modifier - PO

Effective January 1, 2015, the definition of modifier 'PO' is "Services, procedures, and/or surgeries furnished at off-campus provider-based outpatient departments."

This modifier is to be reported with every HCPCS code for all outpatient hospital items and services furnished in an off-campus provider-based department of a hospital. See 42 CFR 413.65(a)(2) at *http://www.ecfr.gov/cgi-bin/text-idx?SID=867b6f12ebf5c84c0469ca86a7bbe88a&mc=true&node=pt42.2.413&rgn=div5#se42.2.413_165* for a definition of "campus."

This modifier should not be reported for remote locations

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of a hospital (defined at 42 CFR 413.65(a)(2)), satellite facilities of a hospital (defined at 42 CFR 412.22(h); see *http://www.ecfr.gov/cgi-bin/text-idx?SID=867b6f12ebf5c84c0469ca86a7bbe88a&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_122*), or for services furnished in an emergency department.

Reporting of this modifier is voluntary for 2015; reporting of this modifier is required beginning January 1, 2016.

Drugs, biologicals, and radiopharmaceuticals

a. Drugs and biologicals with payments based on average sales price (ASP) Effective July 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 July 1, 2015 and drug price restatements can be found in the July 2015 update of the OPPS Addendum A and Addendum B at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

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

Some drugs and biologicals paid based on the 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.

c. Drugs and biologicals with OPPS pass-through status effective July 1, 2015

Three drugs and biologicals have been granted OPPS pass-through status effective July 1, 2015. These items, along with their descriptors and APC assignments, are identified in Table 4 as follows.

Table 4 – Drugs and biologicals with OPPS pass-through status Effective July 1, 2015

HCPCS code	Long descriptor	Status indicator	APC
C9453	Injection, nivolumab, 1 mg	G	9453
C9454	Injection, pasireotide long acting, 1 mg	G	9454
C9455	Injection, siltuximab, 10 mg	G	9455

d. New HCPCS codes and dosage descriptors for certain drugs, biologicals, and biosimilar biological products

Effective July 1, 2015 two new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 5, below.

Table 5 – New HCPCS codes effective July 1, 2015, for Certain Drugs, Biologicals, and Radiopharmaceuticals

2015 HCPCS code	2015 Long desc.	2015 SI
Q9976	Injection, Ferric Pyrophosphate Citrate Solution, 0.01 mg of iron	E
Q9977	Compounded Drug, Not Otherwise Classified	N

The first biosimilar, Zarxio®, listed in Table 6 on the next page, was approved by the FDA on March 6, 2015.

As the biosimilar is currently not being marketed, pricing information is not available for Zarxio® for the July OPPS quarterly release. Once Zarxio® is marketed, CMS will make pricing information available at the soonest possible date on the OPPS payment files and payment for Zarxio® will be retroactive to the date the product is first marketed.

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Table 6 – New HCPCS code effective March 6, 2015, for certain drugs, biologicals, and radiopharmaceuticals

2015 HCPCS code	2015 Long descriptor	2015 SI
Q5101	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	E

e. Revised descriptor for HCPCS code C9349

Effective July 1, 2015, the descriptor for HCPCS code C9349 will change from FortaDerm, and FortaDerm Antimicrobial, any type, per square centimeter to PuraPly, and PuraPly Antimicrobial, any type, per square centimeter. See Table 7 below.

Table 7 – Revised descriptor for HCPCS code C9349

HCPCS code	Previous 2015 short desc.	Previous 2015 long descriptor	Revised July 2015 short desc.	Revised July 2015 long desc.
C9349	FortaDerm, FortaDerm Antimic	FortaDerm, and FortaDerm Anti-microbial, any type, per square centimeter	PuraPly, PuraPly Antimic	PuraPly, and PuraPly Anti-microbial, any type, per square centimeter

f. Revised status indicators for HCPCS codes J0365, *90620*, and *90621*

Effective April 1, 2015, the status indicator for HCPCS code J0365 (Injection, aprotonin, 10,000 kiu) will change from SI=K (Paid under OPPS; separate APC payment) to SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

Effective February 1, 2015, the status indicators for HCPCS codes *90620* (Menb pr w/omv vaccine im) and *90621* (Menb rlp vaccine im) will change from SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (Paid under OPPS; separate APC payment). These codes are listed in Table 8, below, along with the effective date for the revised status indicator.

Table 8 – Drug and biological with revised status indicator

HCPCS code	Long desc.	APC	Status ind.	Eff. date
J0365	Injection, aprotonin, 10,000 kiu		E	4-1-2015
90620	*Meningo-coccal recombinant protein and outer mem-brane vesicle vaccine, serogroup B, 2 dose schedule, for intra-muscular use*	1807	K	2-1-2015
90621	*Meningo-coccal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intra-muscular use*	1808	K	2-1-2015

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

Effective July 1, 2015, HCPCS code Q9978 Netupitant Palonosetron oral will replace HCPCS code C9448 Netupitant Palonosetron oral. The status indicator will remain G, “Pass-Through Drugs and Biologicals”. Table 9, below, describes this HCPCS code change and effective date.

Table 9 – Other changes to 2015 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals

HCPCS code	Short desc.	Long desc.	Stat. ind.	APC	Added date	Term. date
C9448	Netupi-tant Palono-setron oral	Netupi-tant 300 mg and Palono-setron 0.5 mg, oral	G	9448	04-01-2015	06-30-2015
Q9978	Netupi-tant Palono-setron oral	Netupi-tant 300 mg and Palono-setron 0.5 mg, oral	G	9448	07-01-2015	

Hyperbaric oxygen therapy

Effective January 1, 2015, HCPCS code C1300, Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval has been discontinued. Hospitals providing hyperbaric oxygen (HBO) therapy should report this service using HCPCS code G0277, Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval that is effective January 1, 2015. The following may be

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included in calculating the total number of 30-minute intervals billable under G0277:

1) Time spent by the patient under 100 percent oxygen;

2) Time for descent;

3) Time for air breaks; and

4) Time for ascent.

Note: A physician order for a 90-minute HBO treatment typically means that the physician desires that the patient be placed under 100 percent oxygen for 90 minutes. In order to safely achieve 100 percent oxygen for 90 minutes, additional time may be needed to provide for the descent, air breaks, and ascent. Therefore, the total number of billable 30-minute intervals would not be based solely on the amount of time noted on the physician order.

In calculating how many 30-minute intervals to report, hospitals should take into consideration the time spent under pressure during descent, air breaks, and ascent. Additional units may be billed for sessions requiring at least 16 minutes of the next 30-minute interval.

For example, two units of HCPCS code G0277 should be billed for a session in duration of between 46 and 75 minutes, while three units should be billed for a session in duration of between 76 and 105 minutes.

Furthermore, four units of HCPCS code G0277 should be billed for a session in duration of between 106 and 135 minutes. HBO is typically prescribed for an average of 90 minutes, which hospitals should report using appropriate units of HCPCS code G0277 in order to properly bill for full body HBO therapy. In general, CMS does not expect that a physician order for 90 minutes of HBO therapy would exceed four billed units of HCPCS code G0277.

Example:

Physician orders and patient receives 90 minutes of therapeutic HBO;

- Patient requires and receives 10 minutes of descent time;
- Patient requires and receives 10 minutes of air breaks; and
- Patient requires and receives 10 minutes of ascent time.

The above example would be billed correctly by

- Reporting four units of HCPCS code G0277,
- Reflecting the sum of:
  - 90 minutes of therapeutic HBO,
  - 10 minutes for descent,
  - 10 minutes for air breaks, and
  - 10 minutes for ascent.

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 9205, issued to your MAC regarding these changes is available at *http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3280CP.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: MM9205
Related Change Request (CR) #: CR 9205
Related CR Release Date: June 5, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3280CP
Implementation Date: July 6, 2015

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HCPCS codes update for home health consolidated billing

Provider types affected

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

Provider action needed

This article, based on change request (CR) 9192, provides the quarterly update to the list of Healthcare Common Procedure Coding System (HCPCS) codes used by Medicare systems to enforce consolidated billing of HH services.

CR 9192 announces the addition of HCPCS codes *97607* and *97608*, negative pressure wound therapies, to the HH consolidated billing therapy code list, effective for services on or after October 1, 2015. These codes replace codes G0456 and G0457, negative pressure wound therapies, which are deleted from the HH consolidated billing therapy code list. In addition, code A7048 replaces code A7043 on the HH consolidated billing non-routine supply code list, effective for services on or after October 1, 2015.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the HH prospective payment system (HH PPS).

With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to MACs will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a HH plan of care administered by an HHA).

Medicare will only directly reimburse the primary HHAs that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing. The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, ‘K’ codes) throughout the calendar year.

The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates.

No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Key points

Effective for claims with dates of service on or after October 1, 2015, the following HCPCS code is added to the HH consolidated billing non-routine supply code list and will replace code A7043, which is deleted from the same list effective October 1, 2015:

- A7048 - Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each.

Effective for claims with dates of service on or after October 1, 2015, the following HCPCS codes are added to the HH consolidated billing therapy code list and will replace HCPCS codes G0456 and G0457, which are deleted from this list, effective on October 1, 2015:

- HCPCS *97607* - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters; and
- HCPCS *97608* - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.

Additional information

The official instruction, CR 9192, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3269CP.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: MM9192
Related Change Request (CR) #: CR 9192
Related CR Release Date: May 29, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3269CP
Implementation Date: October 5, 2015

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Educational Events

Provider outreach and educational events – July/ August 2015

Medicare Speaks - Jacksonville

When: Tuesday, July 16-17
Time: 7:30 a.m. - 4:00 p.m. ET – Delivery language: English
Type of Event: Seminar
Location: Jacksonville, Fl
http://medicare.fcso.com/Medicare_Speaks/278355.pdf

Internet-based PECOS class

When: Thursday, August 13
Time: 1:00 p.m. -5:00 p.m. ET – Delivery language: English
Type of Event: Conference/Seminar
http://medicare.fcso.com/Events/0293487.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.

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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 May 21, 2015

MLN Connects® Provider eNews for May 21, 2015
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MLN Connects® National Provider Calls

- 2014 Mid-Year QRURs — Register Now
- Medicare Shared Savings Program ACO: Application Review — Register Now
- National Partnership to Improve Dementia Care and QAPI — Register Now
- Hospice Quality and Hospice Item Set Manual V1.02 — Registration Now Open
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X — Register Now

MLN Connects® Videos

- New Video on PQRS and the Value-Based Payment Modifier

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

Announcements

- 2014 Mid-Year QRURs Available
- EHR Proposed Rules Available for Comment: Stage 3 Comments Due by May 29
- Call for TEP Nominations: Closing Date June 1
- CMS to Release Comparative Billing Report on CT Scans of the Abdomen and Pelvis in June
- EHR Incentive Program: Deadline for Eligible Professional Hardship Exception is July 1
- PQRS: IACS Transitioning to EIDM on July 13
- CMS is Accepting Suggestions for Potential PQRS Measures

Medicare Learning Network® Educational Products

- "Chronic Care Management (CCM) Services Frequently Asked Questions (FAQs)" *MLN Matters®* Article — Released
- "Power Mobility Pearls for the Practicing Physician" Web-Based Training Course — Released
- "Clarification of the Use of Modifiers When Billing Wrong Surgery on a Patient" Podcast — Released
- "Co-Surgery Not Billed with Modifier 62" Podcast — Released
- "Chronic Care Management Services" Fact Sheet — Reminder
- New Medicare Learning Network® Educational Web Guides Fast Fact
- Medicare Learning Network Product® Available In Electronic Publication Format

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 May 28, 2015

MLN Connects® Provider eNews for May 28, 2015
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- 2014 Mid-Year QRURs — Last Chance to Register
- Medicare Shared Savings Program ACO: Application Review — Register Now
- National Partnership to Improve Dementia Care and QAPI — Register Now
- Hospice Quality and Hospice Item Set Manual V1.02 — Register Now
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X — Register Now
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data — Registration Now Open
- ESRD QIP: Proposed Rule for Payment Year 2019 — Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Special Open Door Forum: Home Health Quality Reporting Requirements
- Physician Compare Virtual Office Hour Session
- EHR Proposed Rules: Recordings and Presentations from Webinars

Announcements

- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- 2015 PQRS GPRO: 4 Weeks Left to Register by June 30 Deadline
- HHS Awards $112 Million to Help 5,000 Primary Care Professionals Advance Heart Health
- Guidance on Beneficiary Disenrollments by Long Term Care Facilities

Claims, Pricers, and Codes

- ICD-10 FAQs: CMNs and Prescriptions
- Transition to ICD-10 for Home Health
- April 2015 IOCE Updated with ICD-10-CM Codes
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
- Mass Adjustment of FQHC PPS Claims

Medicare Learning Network® Educational Products

- "Medically Unlikely Edits Compliant" Podcast — Released
- "Electronic Prescribing (eRx) Incentive Program - A Compilation of 2013 Educational Resources" Booklet — Released
- "Medicare Appeals Process" Fact Sheet — Revised

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 June 4, 2015

MLN Connects® Provider eNews for June 4, 2015

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In this edition:

MLN Connects® National Provider Calls

- Medicare Shared Savings Program ACO: Application Review — Last Chance to Register
- National Partnership to Improve Dementia Care and QAPI — Register Now
- Hospice Quality and Hospice Item Set Manual V1.02 — Register Now
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X — Register Now
- Hospital Compare Overall Star Ratings Methodology — Save the Date
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data — Register Now
- ESRD QIP: Proposed Rule for Payment Year 2019 — Register Now

MLN Connects® Videos

- Prepare for ICD-10 with MLN Connects® Videos

CMS Events

- Participate in Final ICD-10 Acknowledgement Testing Week through June 5
- Webinar for Comparative Billing Report on CT of the Abdomen and Pelvis

Announcements

- New Affordable Care Act Payment Model Seeks to Reduce Cardiovascular Disease
- New Medicare Data Available to Increase Transparency on Hospital and Physician Utilization
- Entrepreneurs and Innovators to Access Medicare Data
- DMEPOS Competitive Bidding Round 1 2017 — Get Licensed
- Quality Reporting Programs: 2014 eCQM Updates for 2016 Reporting

Claims, pricers, and codes

- July 2015 Average Sales Price Files Now Available

Medicare Learning Network® Educational Products

- "Home Health Change of Care Notice (HHCCN) and Advance Beneficiary Notice of Noncoverage (ABN)" Web-Based Training Course — Released
- "Anesthesiologist Services with a Modifier GC in a Method II Critical Access Hospital (CAH)" Podcast — Released
- "ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets" Educational Tool — Revised
- "Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff" Fact Sheet — Revised

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- National Partnership to Improve Dementia Care and QAPI — Last Chance to Register
- Hospice Quality and Hospice Item Set Manual V1.02 — Last Chance to Register
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- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data — Register Now
- ESRD QIP: Proposed Rule for Payment Year 2019 — Register Now

CMS Events

- Medicare Learning Network® Webinar: Medicare Basics for New Providers Part Two: Billing, Reimbursement, and Appeals
- PERM Cycle 1 Provider Education Sessions

Announcements

- Updated Results for ICD-10 End-to-End Testing Week in April
- Recognizing Men's Health Month and Men's Health Week
- CMS Finalizes Rules for Medicare Shared Savings Program
- Comprehensive Prevention Program Effectively Reduces Falls among Older People
- EHR Incentive Programs: Comments on Meaningful Use Proposed Rule Due June 15
- 2015 PQRS GPRO: 2 Weeks Left to Register by June 30 Deadline
- EHR Incentive Program: Deadline for Eligible Professionals Hardship Exception is July 1
- ICD-10 Resources for Medicare Providers

Medicare Learning Network® Educational Products

- "Information and Resources for Submitting Correct ICD-10 Codes to Medicare" MLN Matters® Article — Released
- "Transcatheter Aortic Valve Replacement (TAVR) Hospital Program Volume Requirements" MLN Matters® Special Edition Article — Released
- "Revised and Clarified Place of Service (POS) Coding Instructions" Podcast — Released
- "Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach" *MLN Matters®* Article — Revised
- "Skilled Nursing Facility (SNF) Billing Reference" Fact Sheet — Reminder
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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