Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

September 2015

In this issue

Influenza vaccine payment allowances update for 2015-2016 season

Provider types affected

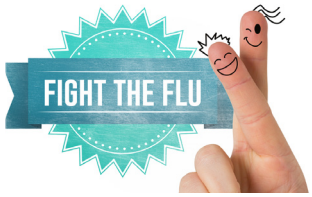
This *MLN Matters*® article is intended for physicians and other providers submitting claims to Medicare administrative contractors (MACs) for influenza vaccines provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9299 informs MACs about the payment allowances for seasonal influenza virus vaccines. These payment allowances are updated on an annual basis effective August 1st of each year. Make sure that your billing staffs are aware that the payment allowances are being updated.

The pending payment allowances will be updated in the influenza vaccine pricing Web page. Providers may visit the webpage at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html* for the updated prices.

Background



This recurring update notification provides the payment allowances for the following seasonal influenza virus vaccines, when payment is based on 95 percent of the average wholesale price (AWP). The Medicare Part B payment allowances for the following *Current Procedural Terminology* (*CPT*®) or Healthcare Common Procedure Coding System (HCPCS) codes below apply for the effective dates of August 1, 2015-July 31, 2016:

- *90655* Payment allowance is pending
- *90656* Payment allowance is pending
- *90657* Payment allowance is pending
- *90661* Payment allowance is pending
- *90685* Payment allowance is pending
- *90686* Payment allowance is pending

See **FLU**, Page 3

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Contents

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

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

FLU

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- *90687* Payment allowance is pending
- *90688* Payment allowance is pending
- Q2035 Payment allowance is pending
- Q2036 Payment allowance is pending
- Q2037 Payment allowance is pending
- Q2038 Payment allowance is pending

Payment for the following *CPT*®/HCPCS codes may be made if your MAC determines their use is reasonable and necessary for the beneficiary, for the effective dates of August 1, 2015-July 31, 2016:

- *90630* Payment allowance is pending
- *90654* Payment allowance is pending
- *90662* Payment allowance is pending
- *90672* Payment allowance is pending
- *90673* Payment allowance is pending

Payment allowances will be published in the Centers for Medicare & Medicaid Services (CMS) influenza vaccine pricing Web page at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*.

HCPCS Q2039 flu vaccine adult - not otherwise classified payment allowance is to be determined by your MAC with effective dates of August 1, 2015-July 31, 2016. Payment allowances for codes for which products have not yet been approved will be provided when the products have been approved and pricing information becomes available to the CMS. The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the quarterly average sales price (ASP) drug pricing files.

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

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

on the claim for the vaccine.

Note: MACs will not search their files either to retract payment for claims already paid or to retroactively pay claims prior to the implementation date of CR 9299. However, they will adjust claims that you bring to their attention.

Additional information

The official instruction, CR 9299 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3341CP.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: MM9299
Related Change Request (CR) #: CR 9299
Related CR Release Date: August 28, 2015
Effective Date: August 1, 2015
Related CR Transmittal #: R3341CP
Implementation Date: No later than November 24, 2015

Healthcare provider taxonomy code set update

Provider types affected

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

What you need to know

Change request (CR) 9260 instructs MACs to obtain the most recent healthcare provider taxonomy code (HPTC) set and to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims.

The standards include implementation guides, which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (x12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The National Uniform Claim Committee (NUCC) maintains the HPTC set for standardized classification of health care providers, and updates it twice a year with changes effective April 1 and October 1. These changes include the addition of a new code and addition of definitions to existing codes.

You should note that:

1. Valid HPTCs are those that the NUCC has approved for current use;
2. Terminated codes are not approved for use after a specific date;
3. Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears; and
4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

CR 9260 implements the NUCC HPTC code set that is effective on October 1, 2015, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. The HPTC

set is available from the Washington Publishing Company (WPC) at *http://www.wpc-edi.com/codes*.

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

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

Additional information

The official instruction, CR issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3336CP.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: MM9260
Related CR Release Date: August 21, 2015
Related Transmittal #: R3336CP
Change Request (CR) #: 9260
Effective Date: October 1, 2015
Implementation Date: January 4, 2016 - Contractors with the capability to do so shall implement this CR effective October 1, 2015

How to file a cost report appeal with First Coast

Once a provider receives a notice of program reimbursement (NPR) from a cost report settlement, it has a right to redress audited adjustment related issues through the cost report appeals process either as an individual or as a member of a group of providers before the provider reimbursement review board (PRRB).

Cost report appeal rights

Only a provider has appeal rights. Providers include.

- Hospitals
- Skilled nursing facilities (SNFs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- End-stage renal dialysis facilities (ESRDs)

Cost report appeal types

Providers may be a party to an individual appeal, a PRRB appeal or a group appeal.

- Intermediary appeal: Reimbursement in controversy is between $1,000 and $9,999.
- PRRB individual appeal: Reimbursement in controversy is $10,000 or more for individual providers. *Provider Reimbursement Manual, Part 1 (PRM15-1), paragraph 2920.1*.

PRRB group appeal: Reimbursement in controversy, in aggregate is at least $50,000 and providers in the group have a common question of fact or of interpretation of law, regulations or CMS rulings. *Provider Reimbursement Manual Part 1, PRM15-1, paragraph 2920.2*.

Deadline for filing request

The request for a hearing must be filed in writing with the PRRB or intermediary/Medicare administrative contractor (MAC) no later than the 180th calendar day following notice of the final determination rendered by the Centers for Medicare & Medicaid Services (CMS) or its MAC where the MAC has not issued the NPR timely, file the requests for a hearing with the Board no later than the 180th day after the expiration of the 12 month period. The audit adjustment(s) or issue(s) being appealed must be specific and directly related to the NPR.

Before filing your appeal hearing request, please obtain a copy of the *PRRB's rules* from the PRRB's website. Providers must follow the appeal process guidelines in the PRRB instructions.

Once the PRRB or the MAC has acknowledged your appeal or hearing request, you must reference the assigned appeal case number and provide information on all correspondence submitted to the PRRB or the MAC or Federal Specialized Services (FSS).

Where to send PRRB hearing request

Provider's request for a PRRB hearing should be sent to the Provider Reimbursement Review Board, First Coast Service Options, Inc. (First Coast) and Federal Specialized Services (FSS). Requests and/or correspondence sent to the PRRB and First Coast should be emailed if possible. The request should be addressed as follows:

PRRB Appeals
Federal Specialized Services
1701 S. Racine Avenue
Chicago, IL 60608-4058
Email Contact: *prrb@fssappeals.com*

Copies of the provider's request should be sent to

First Coast Service Options, Inc.
532 Riverside Avenue
Jacksonville, FL 32202
Attn: Geoff Pike
Email Contact: *geoff.pike@fcso.com*

For directions on what to include in your request, and for other information about the Board's procedures, please consult *the Board's instructions*.

You may also obtain a copy by writing to the board at the above address or by calling the Board at 410-786-2671.

Increasing tax withholding to 100 percent for the Internal Revenue Service federal payment levy program

Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers who submit claims to Medicare administrative contractors (MACs) and who may owe back taxes to the Internal Revenue Service (IRS).

What you need to know

Change request (CR) 9154 instructs the healthcare integrated general ledger accounting system (HIGLAS) system maintainer to make necessary programming changes to increase the tax withhold percentage from 30 percent to 100 percent.

If you owe back taxes to the IRS and those taxes are eligible to be withheld from payments due you from Medicare, the withhold rate will increase from the current 30 percent to 100 percent on October 16, 2015.

Background

In July 2000, the IRS, in conjunction with the Department of the Treasury, started the federal payment levy program (FPLP) which is authorized by Internal Revenue Code Section 6331 (h) (see *http://www.gpo.gov/fdsys/pkg/USCODE-2011-title26/pdf/USCODE-2011-title26-subtitleF-chap64-subchapD-partIIsec6331.pdf*), as prescribed by the Taxpayer Relief Act of 1997 Section 1024 (see *http://www.gpo.gov/fdsys/pkg/PLAW-105publ34/html/PLAW-105publ34.htm*).

Through the FPLP, authority is provided to the Centers for Medicare & Medicaid Services (CMS) to collect overdue taxes through a levy on certain federal payments. This includes federal payments made to providers, contractors and vendors doing business with the government.

Consistent with this authority, CMS introduced CR 6125 in October of 2008, which reduced federal payments subjected to the levy by the required 15 percent, or the exact amount of the tax owed if it is less than 15 percent of the payment.

You can review the *MLN Matters*® article MM6125, corresponding to CR 6125, at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm6125.pdf*.

In December 2014, the Internal Revenue Code Section 6331(h) was amended by the Tax Increase Prevention Act of 2014 Section 209(a) (see *http://www.gpo.gov/fdsys/pkg/BILLS- 113hr5771enr/html/BILLS-113hr5771enr.htm*), which mandated an increase to the tax levy to 30 percent. In order to do this, CMS introduced CR 9154.

You can review the *MLN Matters*® article MM9154 corresponding to CR 9154, at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9154.pdf*.

In April 2015, the Internal Revenue Code Section 6331(h) was amended by the Medicare Access and CHIP Reauthorization Act of 2015, Section 413(a), which increases the tax levy withholding to 100 percent.

Additional information

The official instruction, CR 9285, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1536OTN.pdf*.

> ***"If you owe back taxes to the IRS and those taxes are eligible to be withheld from payments due you from Medicare, the withhold rate will increase from the current 30 percent to 100 percent on October 16, 2015."***
>
> *– Change request 9154*

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-LearningNetworkMLN/MLNMattersArticles/index.html* under - *How Does It Work*.

MLN Matters® Number: MM9285
Related CR Release Date: August 21, 2015
Related Transmittal #: R1536OTN
Change Request (CR) #: CR 9285
Implementation Date: October 16, 2015
Effective Date: October 16, 2015

CMS updates 'NCD Manual' for speech generating device

Provider types affected

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

Provider action needed

Change request (CR) 9281 updates the *Medicare National Coverage Determinations Manual* to add a revised scope of benefit national coverage determination (NCD) for speech generating devices (SGDs) covered under the Medicare benefit category for durable medical equipment (DME). Please make sure that your billing staff are aware of these changes.

Background

Key information in the revised NCD in Chapter 1 of the *NCD Manual* is as follows:

SGDs are considered to fall within the DME benefit category established by Section 1861(n) of the Social Security Act. They are covered for patients who suffer from severe speech impairment and have a medical condition that warrants the use of a device based on the following definitions.

SGDs are defined as DME that provide an individual who has severe speech impairment with the ability to meet his or her functional, speaking needs. SGDs are devices or software that generate speech and are used solely by the individual who has severe speech impairment. The speech is generated using one of the following methods:

- Digitized audible/verbal speech output, using prerecorded messages;
- Synthesized audible/verbal speech output which requires message formulation by spelling and device access by physical contact with the device-direct selection techniques;
- Synthesized audible/verbal speech output which permits multiple methods of message formulation and multiple methods of device access; or
- Software that allows a computer or other electronic device to generate audible/verbal speech.

Other covered features of the device include the capability to generate email, text, or phone messages to allow the patient to "speak" or communicate remotely, as well as the capability to download updates to the covered features of the device from the manufacturer or supplier of the device.

If an SGD is limited to use by a patient with a severe

speech impairment and is primarily used for the purpose of generating speech, it is not necessary for the device to be dedicated only to audible/verbal speech output to be considered DME. Computers and tablets are generally not considered DME because they are useful in the absence of an illness or injury.

Nationally non-covered indications

Internet or phone services or any modification to a patient's home to allow use of the SGD are not covered by Medicare because such services or modifications could be used for non-medical equipment such as standard phones or personal computers. In addition, specific features of an SGD that are not used by the individual who has a severe speech impairment to meet his or her functional speaking needs are not covered.

This would include any computing hardware or software not necessary to allow for generation of speech, email, text or phone messages, such as hardware or software used to create documents and spreadsheets or play games or music, and any other function a computer can perform that is not directly related to meeting the functional speaking communication needs of the patient, including video communications or conferencing.

These features of a speech generating device do not fall within the scope of Section 1861(n) of the Social Security Act and the cost of these features are the responsibility of the beneficiary. Suppliers of SGDs are encouraged to furnish the beneficiary with a voluntary advance beneficiary notice (ABN) which informs that these features are not covered by Medicare and the beneficiary is liable for the expense of these features.

Other

MACs acting within their respective jurisdictions have discretion to cover or not cover speech generating devices based on their individual reasonable and necessary determinations.

See **SPEECH**, next page

Processing Issues

Delay in implementing single-chamber and dual-chamber cardiac pacemakers

Issue

On August 13, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a final decision memorandum regarding coverage of implanted permanent cardiac pacemakers, single chamber or dual chamber, and determined they are reasonable and necessary for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block.

Resolution

On February 20, 2015, CMS released change request (CR) 9078, transmittals *179* and *3204*, implementing national coverage determination (NCD) 20.8.3 July 6, 2015, for claims with dates of service on and after August 13, 2013, for those beneficiaries who meet specific coverage criteria.

Status/date resolved

Open. There is a temporary delay in implementing NCD 20.8.3 meaning that all editing and decisions on coverage relative to CR 9078 will be made at the local Medicare administrative contractor (MAC) level until further CMS

notice. CMS will advise of the new implementation date in the near future.

Provider action

None. CMS will advise of the new implementation date in the near future.

Current processing issues

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

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Additional information

The official instruction, CR 9281, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R184NCD.pdf*. The revised portion of the NCD Manual is part of CR 9281.

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: MM9281

Related Change Request (CR) #: CR 9281
Related CR Release Date: August 21, 2015
Effective Date: July 29, 2015
Related CR Transmittal #: R184NCD
Implementation Date: September 21, 2015

Flu season resources for health care professionals

Provider types affected

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

What you need to know

- Keep this special edition *MLN Matters*® article and refer to it throughout the 2015 - 2016 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the new year.
- Remember to immunize yourself and your staff.

Introduction

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)

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

Know what to do about the flu!

Payment rates for 2015-2016

Each year, CMS updates the Medicare Healthcare Common Procedure Coding System (HCPCS) and *Current Procedure Terminology* (*CPT*®) codes and payment rates for personal influenza (flu) and pneumococcal vaccines. Payment allowance limits for such vaccines are 95 percent of the average wholesale price (AWP), except where the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC). In these cases, the payment for the vaccine is based on reasonable cost.

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

Effective for services provided on August 1, 2015, through those provided on July 31, 2016, the following Medicare Part B payment allowances for HCPCS and *CPT*® codes apply.

***CPT*® codes**

CPT® code	Effective dates	Payment allowance
90630	8/1/2015-7/31/2016	$23.467
90654	8/1/2015-7/31/2016	Pending
90655	8/1/2015-7/31/2016	Pending
90656	8/1/2015-7/31/2016	$13.880
90657	8/1/2015-7/31/2016	$6.022
90661	8/1/2015-7/31/2016	$22.288
90662	8/1/2015-7/31/2016	$36.315
90672	8/1/2015-7/31/2016	Pending
90673	9/26/2015-7/31/2016	$37.193
90685	8/1/2015-7/31/2016	$24.596
90686	8/1/2015-7/31/2016	$18.155
90687	8/1/2015-7/31/2016	$9.134
90688	8/1/2015-7/31/2016	$18.269

HCPCS codes

HCPCS code	Effective dates	Payment allowance
Q2035	8/1/2015-7/31/2016	$13.025
Q2036	8/1/2015-7/31/2016	Pending
Q2037	8/1/2015-7/31/2016	$15.830
Q2038	8/1/2015-7/31/2016	$12.044
Q2039	8/1/2015-7/31/2016	**Flu vaccine adult** – Not otherwise classified: Payment allowance is to be determined by the local claims processing contractor.

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The above pricing, and any required updates, will be available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*.

Educational products for health care professionals

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

1. MLN Influenza Related Products for Health Care Professionals

- **Medicare Part B Immunization Billing chart** – *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf*
- **Preventive Services chart** – *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf*
- **MLN Preventive Services Educational Products Web page** – *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html*
- **Preventive Services Educational Products PDF**– *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/education_products_prevserv.pdf*

2. Other CMS resources

- **Immunizations Web page** – *http://www.cms.gov/Medicare/Prevention/Immunizations/index.html*
- **Prevention General Information** – *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html*
- **CMS Frequently Asked Questions** – *http://questions.cms.gov/faq.php*
- ***Medicare Benefit Policy Manual* - Chapter 15, Section 50.4.4.2 – Immunizations** *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf*
- ***Medicare Claims Processing Manual*** – Chapter 18, Preventive and Screening Services *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf*

3. Other resources

The following non-CMS resources are just a few of the many available in you may find useful information and tools for the 2015–2016 flu season:

- **Advisory Committee on Immunization Practices** – *http://www.cdc.gov/vaccines/acip/index.html*
- Other sites with helpful information include:
  - **Centers for Disease Control and Prevention** – *http://www.cdc.gov/flu*;
  - **Flu.gov** - *http://www.flu.gov*;
  - **Food and Drug Administration** – *http://www.fda.gov*;
  - **Immunization Action Coalition** – *http://www.immunize.org*;
  - **Indian Health Services** – *http://www.ihs.gov*;
  - **National Alliance for Hispanic Health** – *http://www.hispanichealth.org*;
  - **National Foundation For Infectious Diseases** – *http://www.nfid.org/influenza*;
  - **National Library of Medicine and NIH Medline Plus** – *http://www.nlm.nih.gov/medlineplus/immunization.html*;
  - **National Network for Immunization Information** – *http:/www.immunizationinfo.org* ;
  - **National Vaccine Program** - *http://www.hhs.gov/nvpo*;
  - **Office of Disease Prevention and Health Promotion** - *http://healthfinder.gov/FindServices/Organizations/Organization/HR2013/office-of-disease-prevention-and-health-promotion-us-department-of-health-and-human-services*;
  - **Partnership for Prevention** – *http://www.prevent.org*; and
  - **World Health Organization** – *http://www.who.int/en*

Beneficiary information

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

MLN Matters® Number: SE1523
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

NCD for screening for colorectal cancer using Cologuard™

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 9115 which announces effective October 9, 2014, the Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is sufficient to cover Cologuard™ – a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, aged 50 to 85 years.

Caution – what you need to know

CR 9115 instructs the MACs that effective for claims with dates of service on or after October 9, 2014, Medicare will recognize new Healthcare Common Procedure Coding System (HCPCS) code G0464, (Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (for example, KRAS, NDRG4 and BMP3)) as a covered service.

Only laboratories authorized by the manufacturer to perform the Cologuard™ test may bill for this service.

Go – what you need to do

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

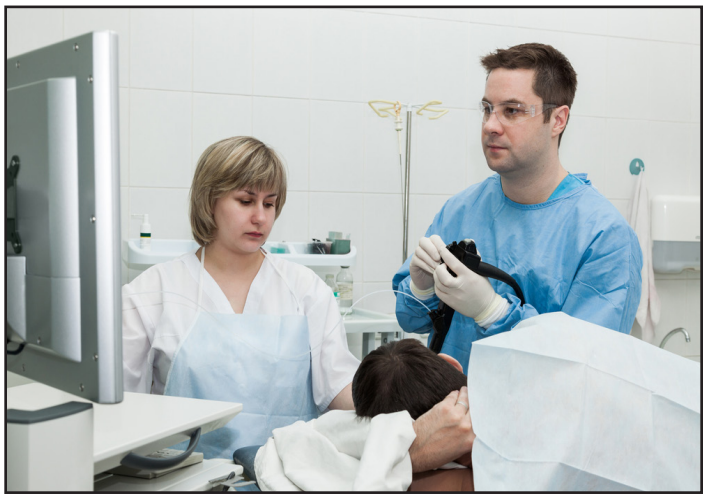
Background

The Social Security Act (the Act) (Sections 1861(s)(2)(R) and 1861(pp) - see *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm*) and regulations at 42 CFR 410.37 (see *http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-37.pdf*) authorize coverage for screening colorectal cancer (CRC) tests under Medicare Part B.

The statute and regulations authorize the Secretary to add other tests and procedures (and modifications to such tests and procedures for colorectal cancer screening) as the Secretary determines appropriate in consultation with appropriate experts and organizations.

As part of the CMS – Food and Drug Administration (FDA) Parallel Review Pilot Program, CMS finalized a NCD for screening for CRC using Cologuard™ – a multitarget stool DNA test.

After considering public comments and consulting with appropriate organizations, effective October 9, 2014,



CMS has determined that the evidence is sufficient to cover Cologuard™ – a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, who are ages 50 to 85 years.

Effective for claims with dates of service on or after October 9, 2014, MACs will recognize the new HCPCS code G0464 as a covered service. Be aware that claims for HCPCS code G0464 must also include ICD-9 diagnosis codes V76.41 and V76.51. Once ICD-10 is implemented, the claim must reflect ICD-10 diagnosis codes Z12.12 and Z12.11.

MACs will only pay for HCPCS code G0464 when it is submitted on types of bill (TOB) 13x hospital outpatient departments), 14x (hospital non-patient laboratories), or 85x (critical access hospitals). Payments will be made on TOB 13x and 14x based on the clinical laboratory fee schedule (CLFS). Payment for TOB 85x will be based on reasonable cost.

Note: HCPCS code G0464 is in the January 1, 2015 CLFS and integrated outpatient code editor (I/OCE) updates with an effective date of October 9, 2014. Therefore, MACs shall apply contractor pricing to claims containing HCPCS G0464 with dates of service October 9, 2014, through December 31, 2014.

You can refer to the revised Pub. 100-03, *Medicare NCD Manual*, Chapter 1, Section 210.3, Colorectal Cancer Screening Tests, for coverage policy. For claim processing instructions, refer to revised Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 60, Colorectal Cancer Screening. Both of these revised manuals are included as attachments to CR 9115.

Effective for dates of service on or after October 9, 2014, Medicare Part B will cover the Cologuard™ test once every three years for Medicare beneficiaries that meet all of the following criteria:

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- Age 50 to 85 years;
- Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test); and
- At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn's Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

There is no coinsurance or deductible for tests paid under the CLFS. Therefore, there is no coinsurance or deductible for HCPCS code G0464.

Medicare will pay for this service for eligible beneficiaries only once every three years. Next eligible dates will be displayed on all common working file (CWF) provider query screens. Subsequent claim lines for HCPCS code G0464 received in the same three-year period will be denied using the following:

- **Claim adjustment reason code (CARC) 119** – "Benefit maximum for this time period has been reached;"
- **Remittance advice remarks code (RARC) N386** – "This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD;" and
- **Group code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed advance beneficiary notice (ABN) is on file.

To be eligible for this service, beneficiaries must be aged 50-85 or the claim line item will be denied with the following messages:

- **CARC 6** – "The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **RARC N129** – "Not eligible due to the patient's age."
- **Group code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Failure to include the required ICD-9 or ICD-10 codes on the claim line will result in denial of the claim line with the following messages:

- **CARC 167** – "This (these) diagnosis(es) is (are) not covered. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **RARC N386** – "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered.

  A copy of this policy is available at *www.cms.gov/mcd/search.asp* on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- **Group code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Claim line items submitted on TOBs other than 13x, 14x, or 85x will be denied with the following messages:

- **CARC 170** – "Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **RARC N95** – "This provider type/provider specialty may not bill this service."
- **Group code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

All other indications for colorectal cancer screening not otherwise specified in the Act and regulations, or otherwise specified in Section 210.3 of the *NCD Manual*, remain nationally non-covered.

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Additional information

The official instruction, CR 9115, was issued to your MAC regarding this change via two transmittals.

The first updates the *Medicare National Coverage Determinations Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R183NCD.pdf*.

The second transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3319CP.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: MM9115
Related Change Request (CR) #: CR 9115
Related CR Release Date: August 6, 2015
Effective Date: October 9, 2014
Related CR Transmittal #: R183NCD and R3319CP
Implementation Date: September 8, 2015, for non-shared MAC edits; January 4, 2016, for shared systems changes

CMS conducts final successful Medicare FFS ICD-10 end-to-end testing week in July

From July 20 through 24, 2015, Medicare fee-for-service (FFS) health care providers, clearinghouses, and billing agencies participated in a third 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 final end-to-end testing week demonstrated that CMS systems are ready to accept and process ICD-10 claims. Approximately 1,200 providers and billing companies participated, and testers submitted over 29,000 test claims. *View the results*.

Overall, participants in the July 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 July was similar to the rates in *January* and *April*, but with an increase in the number of testers and test claims submitted. Most of the claim rejections that occurred were due to errors unrelated to ICD-9 or ICD-10.

Through its robust system release testing, CMS has ensured that the Medicare FFS claims processing systems changes for ICD-10 implementation have been thoroughly tested and validated.

CMS also has conducted an unprecedented additional level of testing to help providers prepare for ICD-10. This was the final end-to-end testing week, but providers are encouraged to participate in *acknowledgement testing*, which can be completed at any time prior to the implementation date.

Be prepared

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.

CMS has created a number of ICD-10 tools and resources for providers. 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 with implementation For more information, visit *Medicare FFS Provider Resources*.

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

Controlled substance monitoring and drugs of abuse testing – new Part A/B LCD

LCD ID number: L36393 (Florida/Puerto Rico/U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services' coverage and analysis department has created a national contractor medical director collaboration workgroup called the "local coverage determination (LCD) writers."

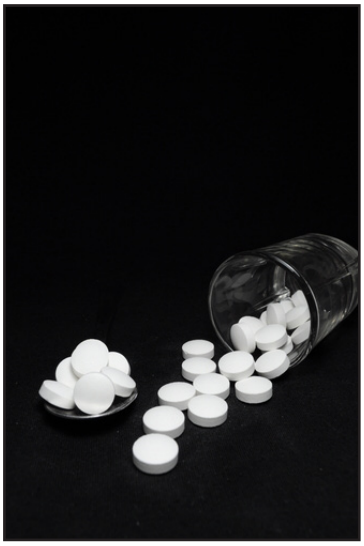
The workgroup includes medical directors from all of the A/B Medicare administrative contractors (MACs). One of the goals of all MACs is to collaborate with other contractors, and the development of consensus LCDs is one outcome of this collaboration.

In most cases, the contractor medical directors worked with the relevant specialty physicians in developing certain consensus draft LCDs.

When a consensus draft LCD has been adopted by a contractor, there are no major changes to the LCD development process, which includes a 45-day comment period, the finalization of the draft based on comments received from physicians representing their society and/or any stakeholder in the community, and a 45-day notice period.

The finalized LCD remains the local contractor's discretion and responsibility. In February 2014, the LCD titled "drugs of abuse testing" was published for a 45-day comment period.

This was a national consensus draft that was based on data analysis and claims review, which identified an over-utilization and a high risk for improper claim payment of HCPCS codes G0431 (drug screen, qualitative; multiple drug classes by high complexity test method [e.g., immunoassay, enzyme assay], per patient encounter) and G0434 (drug screen, other than chromatographic; any number of drug classes, by clinical laboratory improvement amendment [CLIA] waived test or moderate complexity test, per patient encounter). Post payment review further supported provider misuse.



Based on comments received following the 45-day comment period, it was decided this LCD would not be finalized and a new national consensus draft would be adopted during the October 2014 LCD cycle. This LCD has now been finalized with all the applicable 2015 HCPCS changes, and it also has revised the related coding articles to address the proper billing of the current HCPCS codes.

This new LCD has been developed to outline indications and limitations of coverage and/or medical necessity, procedure and diagnosis codes, documentation guidelines, and utilization guidelines for controlled substance monitoring and drugs of abuse testing.

Effective date

This new LCD is effective for services rendered **on or after October 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*.

LCD Revisions

Colorectal cancer screening – revision to the Part A LCD

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

The Centers for Medicare & Medicaid Services (CMS) determined evidence is sufficient to cover Cologuard™ a multitarget stool DNA test–as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, aged 50 to 85 years.

As a result, based on change request 9115, transmittal numbers 183 and 3319: National Coverage Determination (NCD) for Screening for Colorectal Cancer Using Cologuard™-A Multitarget Stool DNA Test, the "Indications and Limitations of Coverage and/or Medical Necessity" section of the local coverage determination (LCD) for colorectal cancer screening, was revised to add coverage criteria for screening for colorectal cancer using Cologuard™.

Effective date

This LCD revision is effective **for claims processed on or after September 08, 2015 for services rendered on or after October 09, 2014**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "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*.

Implantable infusion pump for the treatment of chronic intractable pain – revision to the Part A 'coding guidelines'

LCD ID number: L31249
(Florida, Puerto Rico/U.S. Virgin Islands)

Based on CR 9167 (Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes, the "coding guidelines" attachment has been revised to include HCPCS code Q9977 (compounded drug, not otherwise classified) . The effective date of this revision is based on the date of service.

Effective date

This revision to the LCD "coding guidelines" attachment 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.*

Noncovered services – revision to the Part A/B ICD-10-CM LCD 'coding guidelines' attachment

LCD ID number: L33777
(Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) "coding guidelines" attachment for noncovered services was revised to remove *Current Procedural Terminology®* (*CPT®*) code *82438* based on national coverage determination (NCD 190.5) editing being implemented by the Centers for Medicare & Medicaid Services (CMS).

Effective date

This revision to the LCD "coding guidelines" attachment is effective for services rendered **on or after October 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*.

G-CSF (Neupogen®, Granix™, Zarxio™) – revision to the Part A LCD

LCD ID number: L28845 (Florida)
LCD ID number L28878 (Puerto Rico/U.S. Virgin Islands)

Based on the United States Food and Drug Administration's (FDA) approval of filgrastim-sndz (Zarxio), a biosimilar of filgrastim (Neupogen), the local coverage determination (LCD) for G-CSF (Neupogen®, Granix™) has been revised. The "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD has been updated to add the new FDA-approved biosimilar filgrastim-sndz (Zarxio) for the same indications as filgrastim (Neupogen). The "*CPT*®/HCPCS Codes" section was also revised to add HCPCS code Q5101 and descriptor.

In addition, the LCD was revised to add diagnosis codes V07.8 (Other specified prophylactic or treatment measure) and V66.2 (Convalescence following chemotherapy) to the "ICD-9 Codes that Support Medical Necessity" section of the LCD making the ICD-9-CM coding congruent with the text of the LCD.

The "Sources of Information and Basis for Decision" section of the LCD was updated to support the above revisions.

Effective date

The LCD revision to add filgrastim-sndx (Zarxio) is effective **for claims processed on or after September 25, 2015**, for **services rendered on or after March 6, 2015**. The LCD revision to add diagnosis codes V07.8 and V66.2 is **effective for claims processed on or after September 25, 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*.

Spinal cord stimulation for chronic pain – corrected revision effective date to the Part A/B LCD

LCD ID number: L35648 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for spinal cord stimulation for chronic pain was revised. A correction was made to the effective date for the ICD-9 diagnosis codes 996.2, 996.63, and 996.75 that were previously added to support medical necessity for *CPT*® codes *63661-63664*, *63685*, and *63688* when the devices have complications and require removal, revision, or replacement.

Effective date

This LCD revision is effective for claims processed **on or after September 16, 2015**, for dates of service **on or after February 7, 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*.

Self-administered drug list – Part A: J3490/J3590/C9399

The Centers for Medicare & Medicaid Services (CMS) provides instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician's service.

The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore, not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs (SAD) incident to a physician's service are in the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 15, Section 50.2.

Effective for services rendered on or after September 28, 2015, the following drugs have been added to the MAC JN Part A SAD list.

- J3490/J3590/C9399 -- Injection, Dulaglutide (Trulicity™)
- J3490/J3590/C9399 -- Injection, Methotrexate Injection (Otrexup)
- J3490/J3590/C9399 -- Injection, Peginterferon beta-1a (PLEGRIDY®)
- J3490/J3590/C9399 -- Injection, Secukinumab (Cosentyx™)

Additionally, minor editorial changes were made to the SAD list. The evaluation of drugs for addition to the self-administered drug list is an ongoing process.

Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

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

Multiple Part A local coverage determinations being retired

LCD ID number: L28793, L28811, L28821, L28887, L28838, L29003 (Florida)

LCD ID number: L28798, L28818, L28854, L28909, L28871, L29035 (Puerto Rico/U.S. Virgin Islands)

The following local coverage determinations (LCDs) are being retired based on national coverage determination (NCD) editing being implemented by the Centers for Medicare & Medicaid Services (CMS).

- Cardiac Output Monitoring by Thoracic Electrical Bioimpedance
- Cryosurgical Ablation of the Prostate
- Diabetes Self-Management Training
- External Counterpulsation
- Hyperbaric Oxygen Therapy (HBO Therapy)
- Vagus Nerve Stimulation for Intractable Depression

Effective date

This retirement of these LCDs is **effective for services rendered on or after October 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*.

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.

Claims submission alternatives for providers who have difficulties submitting ICD-10 claims

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 offers physicians, providers, and suppliers information that will assist them in avoiding claims processing disruptions after implementation of International Classification of Diseases, Tenth Edition (ICD-10) on October 1, 2015. It provides information for providers who have difficulties submitting ICD-10 claims due to being unable to complete necessary systems changes or having issues with billing software, vendor(s), or clearinghouse(s).

Background

For FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) **are required to use ICD-10 code sets** adopted under HIPAA.

ICD-10 claim submission alternatives

If you have difficulties submitting ICD-10 claims due to being unable to complete the necessary systems changes or having issues with your billing software, vendor(s), or clearinghouse(s), the following claims submission alternatives are available:

- Free billing software;
- Provider internet portals;
- Direct data entry (DDE); and
- Paper claims.

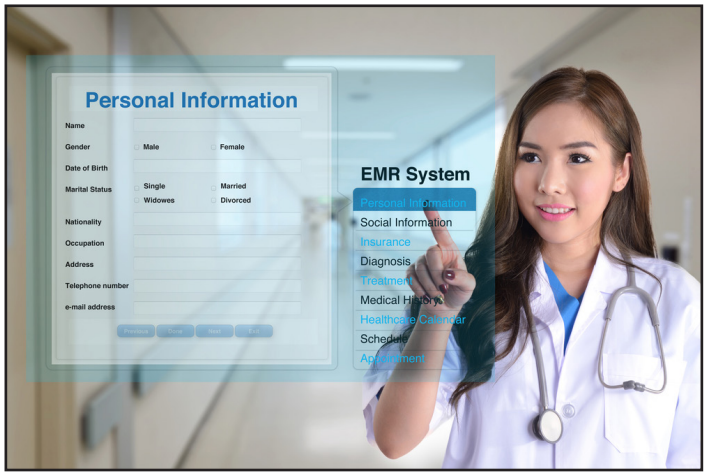
Each claims submission alternative is discussed in more detail below.

Please note that these claims submission alternatives REQUIRE THE USE OF ICD-10 code sets for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015.

Free billing software

Providers who submit claims to MACs

You may download the free billing software that the



Centers for Medicare & Medicaid Services (CMS) A/B MACs offer on their web pages. The software has been updated to support ICD-10 codes and requires either a network service vendor (NSV) or dial-up or both to transmit claims. The software download is free, but there may be fees associated with submitting claims through an NSV or dial-up. The MAC Web pages also provide information about NSVs.

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

Information about the free billing software is available on each of the CMS contractor websites. Please refer to the document that provides Web page access to all contractors titled *Contractors' ICD-10 claim submission alternatives Web pages*.

Please note that submitting electronic claims to Medicare using the free billing software does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service (on professional claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015. Any claims containing ICD-9 codes for FROM dates of service (on professional claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, will be rejected by Medicare.

Providers who submit claims to DME MACs

DME suppliers may download the free billing software that CMS offers via the *Common Electronic Data Interchange (CEDI)* website. The software has been updated to support ICD-10 codes and requires NSV connectivity to transmit Medicare DME claims to CEDI. The software download is free, but there may be fees associated with submitting

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claims through an NSV. The list of approved NSVs and an NSV frequently asked questions document is available at *http://www.ngscedi.com/nsv*. You must also have a CEDI trading partner/submitter ID to use the free billing software to submit claims to CEDI.

- If you currently do not have a CEDI trading partner ID (begins with A08, B08, C08, or D08) to submit claims directly to CEDI (for example, you submit claims through a clearinghouse or billing service), you will need to complete the necessary CEDI enrollment forms to obtain a CEDI trading partner ID.
- If you currently have a CEDI trading partner ID, you will use that to submit claims with the free billing software.

You can find CEDI enrollment forms at *http://www.ngscedi.com/forms/formsindex.htm*. You should submit the forms to CEDI as soon as possible, but no later than September 15, 2015, to allow CEDI time to process your request and for any testing you might want to do prior to the October 1, 2015, ICD-10 implementation. You will also need to allow for any additional time to sign up and establish connectivity to CEDI through the NSV that you choose. 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.

Information about the free billing software is available on each of the CMS contractor websites. Please refer to the document that provides Web page access to all contractors titled *Contractors' ICD-10 claim submission alternatives Web pages*.

Please note that submitting electronic claims to Medicare using the free billing software does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service on or after October 1, 2015. Any claims containing ICD-9 codes for FROM dates of service on or after October 1, 2015, will be rejected by Medicare.

Provider Internet portal

In some cases, you may be able to use your MAC's provider internet portal to submit ICD-10 compliant professional claims. All MACs offer the portals, and a subset of these MAC portals offer claims submission. Provider portal Internet claim submission is not available for institutional or supplier claims.

Information about registering for access to provider internet portals is available on each of the CMS contractor websites. Please refer to the document that provides Web page access to all contractors titled *Contractors' ICD-10 claim submission alternatives Web pages*.

Please note that claims submitted via our provider portal must contain ICD-10 codes for FROM dates of service on or after October 1, 2015. Those submitted containing ICD-9 codes for FROM dates of service on or after October 1, 2015, will be rejected through normal claim editing processes. ICD-9 codes will still be accepted for FROM dates prior to October 1, 2015.

DDE

Providers that bill institutional claims are also permitted to submit claims electronically via DDE screens. DDE requires a connectivity service provided by an external company to establish the connection.

Information about registering to submit claims via DDE and lists of DDE service vendors is available on each of the CMS contractor websites. Please refer to the document that provides Web page access to all contractors titled *Contractors' ICD-10 claim submission alternatives Web pages*.

Please note that claims submitted via DDE must contain ICD-10 codes for dates of DISCHARGE/THROUGH dates on or after October 1, 2015. Those submitted containing ICD-9 codes for dates of DISCHARGE/THROUGH dates on or after October 1, 2015, will be returned to provider (RTP).

Paper claims

In limited situations, you may submit paper claims with ICD-10 codes to Medicare. To find more information on when you may submit paper claims, visit *http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCAWaiver.html*.

Please note that to submit paper claims, you must meet the requirements to qualify for a waiver of the Administrative Simplification Compliance Act (ASCA) provisions.

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Information about submitting paper claims and ordering claim forms is available on each of the CMS contractor websites. Please refer to the document that provides web page access to all contractors titled *Contractors' ICD-10 claim submission alternatives Web pages*.

Waivers subject to MAC evaluation

Providers must apply for and **meet all** of the following requirements to qualify for a waiver of the ASCA provisions:

- Your software vendor is not ICD-10 ready, and it will cause a financial hardship for you to switch to another vendor; **or**
- Your software is not ICD-10 ready, and it will cause a financial hardship for you to switch to new software; **and**
- Your MAC's provider Internet portal does not support electronic claims submissions; **and**
- It would cause financial hardship for you to procure the services of a billing agent/clearinghouse.

It is the provider's responsibility to submit all of the following documentation to the MAC to establish the validity of a waiver request:

- A letter from the vendor stating that their software is not ICD-10 compliant; **or**
- Attestation from the provider stating that your software is not ready for ICD-10; **and**
- Attestation of provider financial hardship; **and**
- Acknowledgement that paper claims must be submitted in a machine scannable format.

If the MAC determines that the waiver request meets the criteria described above and proper documentation has been provided, the MAC will grant the waiver request.

Corrective action plan (CAP)

A provider who qualifies for a waiver to submit paper claims will be placed on a CAP not to exceed 120 days and must submit a CAP detailing the steps, with associated timelines, being taken to become ICD-10 compliant.

Please note that submitting paper claims to Medicare, even if approved for an ASCA waiver, does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015. Any paper claims containing ICD-9 codes for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, will be returned as unprocessable by Medicare.

Information and resources

Visit the following Web pages to find information and resources that will assist you in submitting 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 provider resources including claim processing and billing, coding, unspecified ICD-10-CM codes, home health provider information, NCDs and LCDs, testing and results, features and benefits, and calls and background: *https://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*.

MLN Matters® Number: SE1522
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

CMS clarifies correcting coding edits for respiratory ventilation procedure

Provider types affected

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

Provider action needed

Change request (CR) 9117 informs MACs about changes related to the correct coding of ICD-10-CM procedure code 5A1955Z, Respiratory ventilation, greater than 96 consecutive hours. The Centers for Medicare & Medicaid Services (CMS) is revising the MCE edit for procedure inconsistent with length of stay (LOS) due to the implementation of ICD-10. Make sure that your billing staffs are aware of these changes.

Background

Currently, MCE has an edit for ICD-9-CM procedure code 96.72 (Continuous invasive mechanical ventilation for 96 consecutive hours or more) when it is inconsistent with the LOS. For this code to be reported correctly, a patient must have received continuous mechanical ventilation for 96 hours or more. This equates to a patient being hospitalized for at least a four day LOS and having received continuous invasive mechanical ventilation for a minimum of four days.

However, the description of the ICD-10-CM procedure code for mechanical ventilation, 5A1955Z, differs from the ICD-9-CM procedure code. To ensure correct coding of ICD-10-CM procedure code 5A1955Z, Respiratory ventilation, greater than 96 consecutive hours, a revision to the MCE edit for procedure inconsistent with LOS is necessary. For this code to be reported correctly, a patient must have received continuous mechanical ventilation for more than 96 hours. This equates to a patient being hospitalized for at least a five day LOS.

Under ICD-10, claims received with ICD-10 procedure code 5A1955Z with less than a five day stay (based on days remaining between the 'from' and 'through' dates and outside occurrence span code 74) will be returned to the provider with reason code W2054 indicating a LOS conflict with the procedure code.

Your MAC will determine that the days remaining between the from and through dates, including the from and through dates, regardless of the patient status and outside of each occurrence span code 74, if present, have at least five consecutive days when ICD-10-PCS procedure code 5A1955Z is present on the claim.

Previously, the discharge date was not counted as one of the days to establish the required four consecutive inpatient days when ICD-9-CM procedure code 96.72 was present. To correct this issue, MACs will allow adjustments to claims that you submitted with ICD-9-CM procedure

code 96.72 with four or more consecutive days including the date of discharge, that were returned to you, when brought to their attention for claims with discharge dates on or after October 1, 2012.

In addition, MACs will mass adjust claims to recoup overpayments due to an error in the process of counting consecutive days. Claims with the following parameters will be adjusted by November 16, 2015:

- TOB – 11x;
- Discharge date - On or after 10/1/12 occurrence span code 74 present;
- Procedure code 96.72; and
- Length of stay greater than four days.

Additional information

The official instruction, CR 9117 issued to your MAC regarding this change is available at *http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1495OTN.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: MM9117
Related Change Request (CR) #: CR 9117
Related CR Release Date: August 19, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R1495OTN
Implementation Date: October 5, 2015

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) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 9270 instructs MACs to update systems based on the CORE 360 uniform use of claim adjustment reason code (CARC) and remittance advice remark code (RARC) rule publication. These system updates are based on the CORE code combination list to be published on or about October 1, 2015.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) committee on operating rules for information exchange (CORE) electronic funds transfer (EFT) and electronic remittance advice (ERA) operating rule set, required by January 1, 2014, by the Affordable Care Act.

CR 9270 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 October 1, 2015.

This update is based on July 1, 2015, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website. (Visit *http://www.wpc-edi.com/reference* for CARC and RARC updates and *http://www.caqh.org/CORECodeCombinations.php* for CAQH CORE defined code combination updates.)

Additional information

The official instruction, CR 9270, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3335CP.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: MM9270
Related Change Request (CR) #: CR 9270
Related CR Release Date: August 21, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3335CP
Implementation Date: January 4, 2016

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.

What you need to know

Change request (CR) 9276 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 September/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/*. The Committee has decided to allow the industry six months for implementation of newly added or changed codes.

All code changes approved during the September/October 2015 committee meeting will be posted on those sites on or about November 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 9276.

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 9276.

Additional information

The official instruction, CR 9276, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3344CP.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: MM9276
Related Change Request (CR) #: CR 9276
Related CR Release Date: August 28, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3344CP
Implementation Date: January 4, 2016

2016 annual clotting factor furnishing fee update

Provider types affected

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

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. For 2016, the clotting factor furnishing fee is $0.202 per unit.

Caution – what you need to know

Change request (CR) 9295 announces the update to the clotting factor furnishing fee for 2016. A furnishing fee for items associated with clotting factor is required by Section 1842(o)(5)(C) of the Social Security Act, as added by section 303(e)(1) of the Medicare Modernization Act.

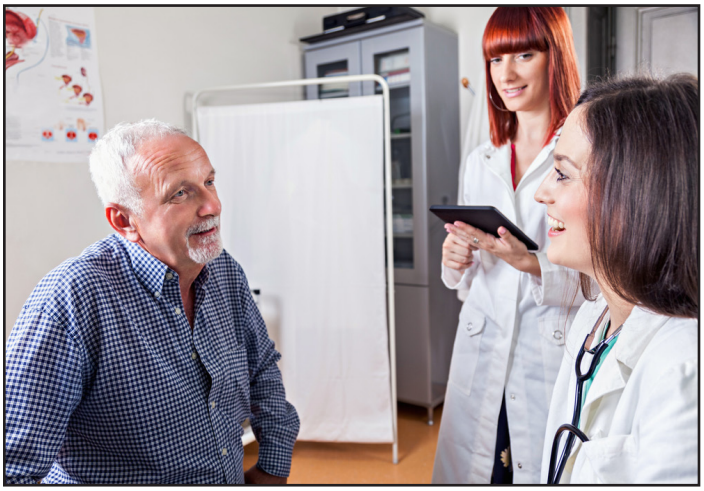
Go – what you need to do

Make sure that your billing staffs are aware of this update to the annual clotting factor furnishing fee for 2016.

Background

CMS includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. When the national payment limit for a clotting factor is not included on the average sales price (ASP) Medicare Part B drug pricing file or the not otherwise classified (NOC) pricing file, the MACs must make payment for the clotting factor as well as make payment for the furnishing fee.

Effective for dates of service from January 1, 2016, through December 31, 2016, the clotting factor furnishing fee of $0.202 per unit is included in the published payment limit for clotting factors and shall be added to the payment for a clotting factor when no payment limit for the clotting factor is published either on the ASP or NOC drug pricing files.



Additional information

The official instruction, CR 9295, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3340CP.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: MM9295
Related Change Request (CR) #: CR 9295
Related CR Release Date: August 21, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3340CP
Implementation Date: January 4, 2016

CMS issues inpatient PPS update for 2016

Provider types affected

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

Provider action needed

Change request (CR) 9305 identifies changes that are required as part of the annual IPF PPS update from the IPF prospective payment system fiscal year 2016 final rule, displayed on July 31, 2015. These changes are applicable to IPF discharges occurring during the fiscal year October 1, 2015, through September 30, 2016.

Background

On November 15, 2004, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a final rule that established the prospective payment system for inpatient psychiatric facilities (IPF) under the Medicare program in accordance with provisions of Section 124 of Public Law 106-113, the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA).

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

CMS is required to make updates to this prospective payment system annually.

Market basket update

For FY 2016, CMS is using the newly adopted 2012-based IPF market basket to update the IPF PPS payments (that is, the federal per diem base rate and electroconvulsive therapy (ECT) payment per treatment). The 2012-based IPF market basket update for FY 2016 is 2.4 percent. However, this 2.4 percent is subject to two reductions required by the Social Security Act (the Act), as described below.

Section 1886(s)(2)(A)(ii) of the Social Security Act requires the application of an "Other Adjustment" that reduces any update to the IPF market basket update by percentages specified in Section 1886(s)(3) of the Act for rate year (RY) beginning in 2010 through the FY beginning in 2019. For the FY beginning in 2015 (that is, FY 2016), Section 1886(s)(3)(C) of the Act requires the reduction to be 0.2 percentage point. CMS implemented that provision in the FY 2016 IPF PPS final rule.

In addition, section 1886(s)(2)(A)(i) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPF PPS for the RY beginning in 2012 (that is, an RY that coincides with a FY), and each subsequent FY.

For the FY beginning in 2015 (that is, FY 2016), the reduction is 0.5 percentage point. CMS implemented that provision in the FY 2016 IPF PPS Final Rule.

CMS updated the IPF PPS base rate for FY 2016 by applying the adjusted market basket update of 1.7 percent (which includes the 2012-based IPF market basket update of 2.4 percent, an Affordable Care Act required 0.2 percent reduction to the market basket update, and an Affordable Care Act required productivity adjustment reduction of 0.5 percent) and the wage index budget neutrality factor of 1.0041 to the FY 2015 federal per diem base rate of $728.31 to yield a FY 2016 federal per diem base rate of $743.73.

Similarly, applying the adjusted market basket update of 1.7 percent and the wage index budget neutrality factor of 1.0041 to the FY 2015 ECT payment per treatment of $313.55 yields an ECT payment per treatment of $320.19 for FY 2016.

Inpatient psychiatric facilities quality reporting program (IPFQR)

Section 1886(s)(4) of the Act requires the establishment of a quality data reporting program for the IPF PPS beginning in FY 2014. CMS finalized new requirements for quality reporting for IPFs in the "Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates" final rule (August 31, 2012) (77 FR 53258, 53644 through 53360).

Section 1886(s)(4)(A)(i) of the Act requires that, for FY 2014 and each subsequent fiscal year, the Secretary shall reduce any annual update to a standard federal rate for discharges occurring during the FY by two percentage points for any IPF that does not comply with

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the quality data submission requirements with respect to an applicable year. Therefore, a two percentage point reduction is applied to the federal per diem base rate and the ECT payment per treatment as follows:

- For IPFs that fail to submit quality reporting data under the IPFQR program, a -0.3 percent annual update (a negative update consisting of 1.7 percent reduced by 2.0 percentage points in accordance with section 1886(s)(4)(A)(ii) of the Act) and the wage index budget neutrality factor of 1.0041 is applied to the FY 2015 federal per diem base rate of $728.31, yielding a federal per diem base rate of $729.10 for FY 2016.
- Similarly, a -0.3 percent annual update and the 1.0041 wage index budget neutrality factor is applied to the FY 2015 ECT payment per treatment of $313.55, yielding an ECT payment per treatment of $313.89 for FY 2016.

Pricer updates: IPF PPS fiscal year 2016 (October 1, 2015 – September 30, 2016):

- The federal per diem base rate is $743.73 for IPFs that complied with quality data submission requirement
- The federal per diem base rate is $729.10 when applying the two percentage point reduction, for IPFs that failed to comply with quality data submission requirements.
- The fixed dollar loss threshold amount is $9,580.00.
- The IPF PPS wage index is based on the FY 2015 pre-floor, pre-reclassified acute care hospital wage index, which includes updated CBSA delineations from the Office of Management and Budget (OMB). Please see the section below entitled, “FY 2016 IPF PPS Wage Index,” for more details on the FY 2016 IPF PPS wage index.
- The labor-related share is 75.2 percent.
- The non-labor related share is 24.8 percent.
- The ECT payment per treatment is $320.19 for IPFs that complied with quality data submission requirements.
- The ECT payment per treatment is $313.89 when applying the two percentage point reduction, for IPFs that failed to comply with quality data submission requirements.

MS-DRG update

The adjustment factors are unchanged for the FY 2016 IPF PPS. However, CMS adopted the ICD-10-CM/PCS code set as of October 1, 2015. Diagnosis codes were converted from ICD-9-CM/PCS to ICD-10-CM/PCS in the FY 2015 IPF PPS final rule, published August 06, 2014.

FY 2016 IPF PPS wage index

The FY 2016 IPF PPS final rule adopts the most recent OMB statistical area delineations for use in determining the IPF PPS wage index. For FY 2016, CMS adopted these updated OMB CBSAs using a one-year transition with a blended wage index for all providers.

The FY 2016 IPF PPS wage index for each provider consists of a blend of 50 percent of the FY 2015 wage index using the current OMB delineations and 50-percent FY 2015 wage index using the revised OMB delineations. The FY 2016 final IPF PPS transitional wage index is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html*.

Cost-to-charge ratio for the IPF prospective payment system fiscal year 2016

Cost to charge ratio	Median	Ceiling
Urban	0.4650	1.7339
Rural	0.6220	1.9041

CMS is applying the national cost-to-charge ratios (CCRs) to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, CMS is using these national ratios until the facility’s actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
- The IPFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the fiscal intermediary obtains inaccurate or incomplete data with which to calculate

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either an operating or capital CCR or both.

COLA adjustment for the IPF prospective payment system fiscal year 2016

The cost of living adjustment (COLA) factors are unchanged for Alaska and Hawaii for the FY 2016 IPF PPS as represented in the following table:

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

Rural adjustment

Due to the OMB CBSA changes, several rural IPFs will have their status changed to “urban” as of FY 2016. As a result, these rural IPFs will no longer be eligible for the 17 percent rural adjustment which is part of the IPF PPS. Rather than ending the adjustment abruptly, CMS is phasing out the adjustment for these providers over a three-year period.

In FY 2016, the adjustment for these newly-urban providers is two-thirds of 17 percent, or 11.3 percent. For FY 2017, the adjustment for these providers will be one-third of 17 percent, or 5.7 percent. No rural adjustment will be given to these providers after FY 2017.

Additional information

The official instruction, CR 9305 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3332CP.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: MM9305
Related Change Request (CR) #: CR 9305
Related CR Release Date: August 21, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3332CP
Implementation Date: October 5, 2015

2016 annual update of HCPCS codes for skilled nursing facility consolidated billing update

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice (HH&H) MACs and durable medical equipment (DME) MACs, for services provided to Medicare beneficiaries who are in a Part A covered skilled nursing facility (SNF) stay.

Provider action needed

Stop – impact to you

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in change request (CR) 9340 could impact your payments.

Caution – what you need to know

CR 9340 provides the 2016 annual update of Healthcare Common Procedure Coding System (HCPCS) codes for SNF consolidated billing (SNF CB) and explains how the updates affect edits in Medicare claim processing systems. By the first week in December 2015, the new code files for Part B processing, and the new Excel and PDF files for Part A processing will be available at *http://www.cms.gov/SNFConsolidatedBilling*; and become effective on January 1, 2016.

Go – what you need to do

It is important and necessary for the provider community to read the *General Explanation of the Major Categories* PDF file located at the bottom of each year's MAC update in order to understand the major categories, including additional exclusions not driven by HCPCS codes.

Background

The common working file (CWF) currently has edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. These edits allow only those services that are excluded from consolidated billing to be separately paid.

Changes to HCPCS codes and Medicare physician fee schedule designations are used to revise these edits to allow MACs to make appropriate payments in accordance with policy for SNF CB, found in the *Medicare Claims Processing Manual*, Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Sections 20.6 and 110.4.1. You may view this manual at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf*.

Additional information

The official instruction, CR 9340, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3349CP.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: MM9340
Related Change Request (CR) #: CR 9340
Related CR Release Date: September 11, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3349CP
Implementation Date: January 4, 2016

Skilled nursing facility consolidated billing and erythropoietin (EPO, Epoetin Alfa)

***Note**: This article was revised September 11, 2015, to reflect the updated regulation reference in the first paragraph of the "Background" section of the article and to update several Web addresses. All other information remains the same. This information was previously published in the 2005 Third Quarter Edition of Medicare A Connection, Pages 108-109.*

Provider types affected

Skilled nursing facilities (SNF), physicians, suppliers, and providers.

Provider action needed

This special edition article describes SNF consolidated billing (CB) as it applies to erythropoietin (EPO, epoetin alfa) and related services.

Background

The original Balanced Budget Act of 1997 list of exclusions from the PPS and consolidated billing for SNF Part A residents specified the services described in Section 1861(s)(2)(O) of the Social Security Act — the Part B erythropoietin (EPO) benefit.

This benefit covers EPO and items related to its administration for those dialysis patients who can self-administer the drug, subject to methods and standards established by the Secretary for its safe and effective use (see 42 CFR 494.80(a)(2) and (a)(4), 494.90(a)(4), and 494.100). (See *MLN Matters*® article SE0431 for an overview of SNF CB and a list of "excluded services.")

Regulations at 42 CFR 414.335 describe payment for EPO and require that EPO be furnished by either a Medicare approved end-stage renal disease (ESRD) facility or a supplier of home dialysis equipment and supplies.

The amount that Medicare pays is established by law. Thus, the law and implementing regulations permit a SNF to unbundle the cost of the Epogen® drug when it is furnished by an ESRD facility or an outside supplier, which can then bill for it under Part B.

An SNF that elects to furnish EPO to its Part A resident itself cannot be separately reimbursed over and above the Part A SNF PPS per diem payment amount for the Epogen® drug. As explained above, the exclusion of EPO from CB and the SNF PPS applies only to those services that meet the requirements for coverage under the separate Part B EPO benefit, i.e., those services that are furnished and billed by an approved ESRD facility or an outside dialysis supplier.

By contrast, if the SNF itself elects to furnish EPO services

(including furnishing the Epogen® drug) to a resident during a covered Part A stay (either directly with its own resources, or under an "arrangement" with an outside supplier in which the SNF itself does the billing), the services are no longer considered Part B EPO services, but rather, become Part A SNF services.

Accordingly, they would no longer qualify for the exclusion of Part B EPO services from CB, and would instead be bundled into the PPS per diem payment that the SNF receives for its Part A services.

Note: EPO (Epoetin Alfa, trade name Epogen®) and DPA (Darbepoetin Alfa, trade name Aranesp®) are not separately billable when provided as treatment for any other illness or condition. In this case, the SNF is responsible for reimbursing the supplier. The SNF should include the charges on the Part A bill filed for that beneficiary.

Additional information

MLN Matters® SE0431, containing the list of services excluded from SNF CB, can be found at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0431.pdf*.

The *Medicare Renal Dialysis Facility Manual*, Chapter II, Coverage of Services can be found at *http://www.cms.gov/manuals/downloads/pub_29.zip*.

Also, you can find the *Medicare Benefit Policy Manual* Chapter 11 regarding billing and payment details for EPO and DPA at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c11.pdf*.

The CMS consolidated billing can be found at *https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html*.

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Updates to the list of Medicare DRGs subject to the IPPS replaced devices offered without cost or with a credit policy

Provider types affected

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

Provider action needed

Change request (CR) 9121 adds the following Medicare severity diagnosis-related groups (MS-DRGs) to the list of MS-DRGs subject to the policy for replaced devices offered without cost or with a credit:

- MS-DRG 266 (Endovascular Cardiac Valve Replacement w/ Major Complication or Comorbidity (MCC))
- MS DRG 267 (Endovascular Cardiac Valve Replacement w/o MCC)
- MS-DRG 268 (Aortic and Heart Assist Procedures except Pulsation Balloon with MCC)
- MS-DRG 269 (Aortic and Heart Assist Procedures except Pulsation Balloon without MCC)
- MS-DRG 270 (Other Major Cardiovascular Procedures with MCC)
- MS-DRG 271 (Other Major Cardiovascular Procedures with CC)
- MS-DRG 272 (Other Major Cardiovascular Procedures without CC/MCC)

In addition, MS-DRG 237 and MS-DRG 238 have been removed from the list of MS-DRGs subject to the policy for replaced devices offered without cost or with a credit.

Make sure that your billing staffs are aware of the following changes.

Background

A specified (or certain) number of the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) procedure codes that previously grouped to MS-DRGs 216-221 (Cardiac Valve & Other Major Cardiothoracic Procedure with and without Cardiac Catheterization, with major complication or comorbidity (MCC), with complication or comorbidity (CC), without CC/MCC, respectively), and were subject to the policy for the inpatient prospective payment system (IPPS) reimbursement of replaced devices offered without cost or with a credit, have been reassigned to new MS-DRGs 266 and 267 effective October 1, 2014.

The Centers for Medicare & Medicaid Services (CMS) also determined that MS-DRGs 266 and 267 were omitted from the list of MS-DRGs subject to the final policy for the IPPS reimbursement of replaced devices offered without cost or with a credit for FY 2015.

Effective October 1, 2015, MS-DRGs 237 and 238 (Major Cardiovascular Procedures with and without MCC, respectively) will be deleted. Procedures that were previously assigned to those MS-DRGs will be reassigned to new MS-DRGs 268 and 269 (Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC and without MCC, respectively) as well as, new MS-DRGs 270-

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BILLING

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It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

Lastly, the CMS skilled nursing facility prospective payment system (SNF PPS) can be found at *http://www.cms.gov/SNFPPS/05_ConsolidatedBilling.asp*.

MLN Matters® Number: SE0434 *Revised*
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

REPLACED

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272 (Other Major Cardiovascular Procedures with MCC, with CC, and without CC/MCC, respectively). New MS-DRGs 268-272 will be subject to the policy for replaced devices offered without cost or with a credit effective with discharges on or after October 1, 2015.

CR 5860 instructed providers to bill the amount of the credit for a replaced device if the hospital receives a credit that is 50 percent or greater than the cost of the device effective for discharges on or after October 1, 2008.

Medicare will reduce the hospital reimbursement, for one of the applicable MS-DRGs listed in the CR 5860, by the full or partial credit a provider received for a replaced device. You may review the *MLN Matters*® article (MM5860) corresponding to CR 5860 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5860.pdf*.

CR 9121 adds MS-DRG 266 and MS-DRG 267 to the list of MS-DRGs subject to the policy for replaced devices offered without cost or with a credit and MS-DRGs 237 and 238 have been removed and replaced by new MS-DRGs 268-272.

The complete list of MS-DRGs, including the existing MS-DRGs and the new MS-DRGs subject to the policy for replaced devices offered without cost or with a credit, is displayed in the table attached to CR 9121.

Note that MACs will revise current edits for replaced devices offered without cost or with a credit based on that table of MS-DRGs subject to the policy. Also, MACs will use the statement covers through date to determine if the MS-DRG is subject to the reduction for replaced devices offered without cost or with a credit.

MACs will adjust claims with discharge dates on or after October 1, 2014, with MS-DRGs 266 & 267, which are being added in CR 9121, if you bring such claims to their attention. To expedite processing in view of timely filing edits, MACs shall ensure that hospitals reference CR 9121 in the remarks section of applicable adjustments.

Additional information

The official instruction, CR 9121, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1494OTN.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: MM9121
Related Change Request (CR) #: CR 9121
Related CR Release Date: August 19, 2015
Effective Date: October 1, 2014; October 1, 2015
Related CR Transmittal #: R1494OTN
Implementation Date: October 5, 2015

Inpatient rehabilitation facility PPS changes for 2016

Provider types affected

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

Provider action needed

Change request (CR) 9236 provides updated rates used to pay IRF prospective payment system (PPS) claims for fiscal year (FY) 2016. A new IRF pricer software package will be released prior to October 1, 2015, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2015, through September 30, 2016. Make sure your billing staff are aware of these changes.

Background

On August 7, 2001, the Centers for Medicare & Medicaid Services (CMS) published a final rule in the *Federal Register* (see *http://www.gpo.gov/fdsys/pkg/FR-2001-08-07/pdf/01-19313.pdf*), that established the IRF PPS, as authorized under the Social Security Act (Section1886(j); see *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm*).

The FY 2016 IRF PPS final rule was issued on August 6, 2015, and it sets forth the prospective payment rates applicable for IRFs for FY 2016. You can review the FY 2016 IRF PPS final rule at *http://www.gpo.gov/fdsys/pkg/FR-2015-08-06/pdf/2015-18973.pdf*.

Transition wage index

For FY 2016, all IRFs will receive a one-year transition policy that consists of a blended wage index (50 percent of their FY 2016 wage index based on the new Office of Management and Budget (OMB) delineations and 50 percent of their FY 2016 wage index based on the OMB delineations used in FY 2015).

This transition policy is effective for discharges occurring on or after October 1, 2015, and on or before September 30, 2016. The transition is designed to mitigate some of the negative impact for IRFs that experience a decrease in the wage index.

For FY 2016, some IRFs may have a special core-based statistical area (CBSA) code to capture the transition wage index appropriate for their state and county combination. Please refer *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html* for state and county combinations with a special CBSA code in the 50,000 series for some areas.

Phase out of rural adjustment

CMS will implement a three year budget neutral phase out of the rural adjustment for those IRFs that meet the

definition in 42 CFR §412.602 as rural in FY 2015 and will become urban under the FY 2016 CBSA-based designations. You can review 42 CFR §412.602 *at http://www.ecfr.gov/cgi-bin/textidx?SID=c97ad2145949e2eebff1357120689 2d4&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_1602.*

CMS will afford a three year phase out to existing IRFs that were:

1. Designated in FY 2015 as rural IRFs (pursuant to 42 CFR §412.602), and
2. Re-designated as an urban facility in FY 2016 (pursuant to 42 CFR §412.602). This will be done in order to mitigate the payment effect upon a rural facility that is redesignated as an urban facility (effective FY 2016) and thereby loses the rural adjustment of 1.149. This adjustment will be in addition to the one-year blended wage index for all IRFs. pricer updates for IRF PPS FY 2016

The updated rates used to correctly pay IRF PPS claims for FY 2016 are shown in the following table:

Pricer updates for IRF PPS FY 2016 - (October 1, 2015 – September 30, 2016)	
Standard federal rate	$15,478
Adjusted standard federal rate	$15,174
Fixed loss amount	$8,658
Labor-related share	0.710
Non-labor related share :	0.290
Urban national average cost to charge ratio (CCR)	0.435
Rural national average CCR	0.562

See **REHAB**, next page

REHAB

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Pricer updates for IRF PPS FY 2016 - (October 1, 2015 – September 30, 2016)	
Low income patient (LIP) adjustment	0.3177
Teaching adjustment	1.0163
Rural adjustment	1.149

Two percentage point reduction

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

The mandated reduction will be applied in FY 2016 for IRFs that failed to comply with the data submission requirements during the data collection period January 1, 2014, through December 31, 2014. Thus, in compliance with Section 1886(j)(7)(A)(i) of the Social Security Act, CMS will apply a two percentage point reduction to the applicable FY 2016 market basket increase factor (2.4 percent) in calculating an adjusted FY 2016 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements.

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

Note: The adjusted FY 2016 standard payment conversion factor that will be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the period from January 1, 2014, through December 31, 2014, will be $15,174.

Additional information

The official instruction, CR 9236, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3331CP.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: MM9236
Related Change Request (CR) #: CR 9236
Related CR Release Date: August 21, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3331CP
Implementation Date: October 5, 2015

Online Medicare refreshers

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

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

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October 2015 update of the hospital outpatient prospective payment system

Provider types affected

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

Provider action needed

Change request (CR) 9298 describes changes to and billing instructions for various payment policies implemented in the October 2015 outpatient prospective payment system (OPPS) update. Make sure that your billing staffs are aware of these changes.

Background

The October 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 9298. The October 2015 revisions to I/OCE data files, instructions, and specifications are provided in the October 2015 I/OCE CR 9290.

A related *MLN Matters*® article, MM9290 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9290.pdf*.

Key changes to and billing instructions for various payment policies implemented in the October 2015 OPPS update are as follows:

New separately payable procedure code

Effective October 1, 2015, a new HCPCS code C9743 has been created. See Table 1 below which provides the short and long descriptors and the APC placement for this new code.

Table 1 – New separately payable procedure code effective October 1, 2015

Effective June 30, 2015, modifier JF (Compounded drug) was discontinued and replaced with HCPCS code Q9977 (Compounded drug, not otherwise classified) effective July 1, 2015. HCPCS code Q9977 should be used to report compounded drug combinations.

Revised coding guidance for intraocular or periocular injections of combinations of anti- inflammatory drugs and antibiotics

Intraocular or periocular injections of combinations of anti-inflammatory drugs and antibiotics are being used with increased frequency in ocular surgery (primarily cataract surgery).

One example of combined or compounded drugs includes triamcinolone and moxifloxacin with or without vancomycin.

Such combinations may be administered as separate injections or as a single combined injection. Because such injections may obviate the need for post-operative anti-inflammatory and antibiotic eye drops, some have referred to cataract surgery with such injections as “dropless cataract surgery.”

As stated in the 2015 *National Correct Coding Initiative (NCCI) Policy Manual* (Chapter VIII, Section D,

HCPCS code	Short description	Long description	OPPS SI	OPPS APC	Effective date
C9743	Bulking/ spacer material impl	Injection/ implantation of bulking or spacer material (any type) with or without image guidance (not to be used if a more specific code applies)	S	0310	10/01/2015

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Compounded drugs

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Item 20; see *http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/*), injection of a drug during a cataract extraction procedure or other ophthalmic procedure is not separately reportable.

Specifically, no separate procedure code may be reported for any type of injection during surgery or in the perioperative period. Injections are a part of the ocular surgery and are included as a part of the ocular surgery and the HCPCS code used to report the surgical procedure.

According to the *Medicare Claims Processing Manual* (Chapter 17, Section 90.2; see *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf*), the compounded drug combinations described above and similar drug combinations should be reported with HCPCS code Q9977, regardless of the site of service of the surgery, and are packaged as surgical supplies in both the hospital outpatient department (HOPD) and the ambulatory surgical center (ASC) Although these drugs are a covered part of the ocular surgery, no separate payment will be made. In addition, these drugs and drug combinations may not be reported with HCPCS code C9399.

According to the *Medicare Claims Processing Manual* (Chapter 30, Section 40.3.6; see *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf*), physicians or facilities should not give advance beneficiary notices (ABNs) to beneficiaries for either these drugs or for injection of these drugs because they are fully covered by Medicare.

Physicians or facilities are not permitted to charge the patient an extra amount (beyond the standard copayment for the surgical procedure) for these injections or the drugs used in these injections because they are a covered part of the surgical procedure. Also, physicians or facilities cannot circumvent packaged payment in the HOPD or ASC for these drugs by instructing beneficiaries to purchase and bring these drugs to the facility for administration.

Drugs, biologicals, and radiopharmaceuticals

a. Drugs and biologicals with payments based on average sales price (ASP) effective October 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 October 1, 2015, and drug price restatements can be found in the October 2015 update of the OPPS Addendum A and Addendum B at *http://www.cms.gov/HospitalOutpatientPPS/*.

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

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files.

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

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

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

HCPCS code	Long descriptor	APC	Status indicator
C9456	Injection, isavuconazonium sulfate, 1 mg	9456	G

See **OUTPATIENT**, next page

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HCPCS code	Long descriptor	APC	Status indicator
C9457	Injection, sulfur hexafluoride lipid microsphere, per ml	9457	G

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

Effective October 1, 2015 a new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. This new code is listed in Table 3 below.

Table 3 – New HCPCS code effective for certain drugs, biologicals, and radiopharmaceuticals

2015 HCPCS code	2015 Long descriptor	2015 SI	2015 APC
Q9979	Injection, alemtuzumab, 1 mg	K	1809

e. Corrected dosage descriptor for HCPCS code Q9976

The correct dosage descriptor for Q9976 is 0.1 mg of iron. The short and long descriptor are included in Table 4 below.

Table 4 – Corrected dosage descriptor for HCPCS code Q9976

HCPCS code	Revised short descriptor	Revised long descriptor
9976	Inj Ferric Pyrophosphate Cit	Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron

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

One existing skin substitute product has been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. This product is listed in Table 5 below.

Table 5 – Updated skin substitute product - Assignment to high cost status effective October 1, 2015

HCPCS code	Short descriptor	Status indicator	Low/ high cost status
Q4151	AmnioBand, guardian 1 sq cm	N	High

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

CR 9298 is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3333CP.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: MM9298
Related Change Request (CR) #: CR 9298
Related CR Release Date: August 21, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3333CP
Implementation Date: October 5, 2015

Educational Events

Provider outreach and educational events – October - December 2015

2015 Quarterly payment system updates for IPFs, IRFs, and hospitals

When: Tuesday, October 27
Time: 10:00 a.m. - 11:30 a.m. ET – Delivery language: English
Type of Event: webinar
http://medicare.fcso.com/Events/0302371.asp

Medicare Part A changes and regulations

When: Tuesday, December 15
Time: 10:00 a.m. -11:30 a.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/0302306.asp

Two easy ways to register

1. **Online** – Visit *www.fcsouniversity.com*, logon to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**. First-time user?** Set up an account by completing "Request a New Account" online. Providers with no national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.
2. **Fax** – Providers without Internet access may request a fax registration form through our Registration Hotline at 904-791-8103. Class materials will be faxed to you the day of the event.

Please note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking the *Education* section of our website, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit *medicare.fcso.com*, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to our live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. Our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Explore our catalog of online courses and learn more at *www.fcsouniversity.com*.

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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 August 20, 2015

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- MLN Connects National Provider Call: Countdown to ICD-10 — Last Chance to Register
- Use of Unspecified Codes in ICD-10-CM
- List of Valid ICD-10-CM Codes
- ICD-10 Clinical Concepts Guides for SpecialtiesVideo Slideshow from June 18 MLN Connects ICD-10 Call Available

MLN Connects® National Provider Calls and Events

- National Partnership to Improve Dementia Care and QAPI Call — Register Now
- Overview of the 2014 Annual Quality and Resource Use Reports Webcast — Register Now

CMS Events

- Webinar for Comparative Billing Report on CT of the Abdomen and Pelvis for Referring Providers
- Hospital Quality Reporting Program Webinars: Impact of FY 2016 Payment Rule
- Hospital Quality Reporting Webinar Series: Early Management Bundle, Severe Sepsis/Septic Shock

Announcements

- Additional Participants in Pilot Project to Improve Care and Reduce Costs for Medicare
- CMS Implements Changes in its Medical Review Education and Enforcement Strategies
- ESRD QIP PY 2016 Preview Period Extended
- Get Ready for DMEPOS Competitive Bidding

Claims, Pricers, and Codes

- Claims Hold for Diabetic Test Strips and Other Supply Items

Medicare Learning Network® Educational Products

- "National Site Visit Verification (NSV) Initiative" MLN Matters Article — Released
- "Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims" MLN Matters Article — Released
- "PECOS Technical Assistance Contact Information" Fact Sheet — Revised

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- Get ICD-10 Answers in One Place
- ICD-10 Resources
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
- Claims that Span the ICD-10 Implementation Date
- ICD-10-CM POA Exempt Codes for FY 2016 Available
- MS-DRG Grouper and MCE Software Available
- Video Slideshow from June 18 MLN Connects ICD-10 Call Available

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- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call — Registration Now Open
- New MLN Connects National Provider Call Audio Recordings and Transcripts

Other CMS Events

- PQRS Webinars: Public Reporting of 2014 Measures

Announcements

- Medicare ACOs Continue to Improve Quality of Care, Generate Shared Savings
- Registration Now Open for Round 1 2017 DMEPOS Competitive Bidding

Medicare Learning Network® Educational Products

- "Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet – Revised
- New Medicare Learning Network Educational Web Guides Fast Fact

MLN Connects® Provider eNews for September 3, 2015

MLN Connects® Provider eNews for September 3, 2015
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Countdown to ICD-10

- Access the ICD-10 Code Set
- List of Valid ICD-10-CM Codes
- "General Equivalence Mappings Frequently Asked Questions" Booklet – Revised
- "ICD-10-CM/PCS ICD-10-CM/PCS Myths and Facts" Fact Sheet – Revised
- "ICD-10-CM Classification Enhancements" Fact Sheet — Revised
- "ICD-10-CM/PCS The Next Generation of Coding" Fact Sheet – Revised
- Get Ready Now: Assess How ICD-10 Will Affect Your Practice
- Prepare for ICD-10 with MLN Connects Videos

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- Overview of the 2014 Annual Quality and Resource Use Reports Webcast – Register Now
- Hospital Inpatient and LTCH PPS FY 2016 Final Rule Call – Registration Now Open
- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call – Register Now

Announcements

- CMS to Extend Initiative to Improve Care for Nursing Facility Residents
- DMEPOS Competitive Bidding Program: Prepare for Round 1 2017
- New ST PEPPER Available
- EHR Incentive Programs: Determine Broadband Speed in Your Area

Claims, Pricers, and Codes

- October 2015 Average Sales Price Files Now Available

Medicare Learning Network® Educational Products

- "837P and Form CMS-1500" Web-Based Training Course – Revised

MLN Connects® Provider eNews for September 10, 2015

MLN Connects® Provider eNews for September 10, 2015
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In this edition:

Countdown to ICD-10

- Updated Results for ICD-10 End-to-End Testing Week in July
- ICD-10 Coding and Clinical Documentation Resources
- New Webcasts Cover Dental, Lab, Pharmacy, and Radiology Services
- Audio Recording and Written Transcript from August 27 MLN Connects Call Available
- Finding ICD-10 Information Online Just Got Easier
- Revised ICD-10 Products Now Available in Hard Copy Format

MLN Connects® National Provider Calls and Events

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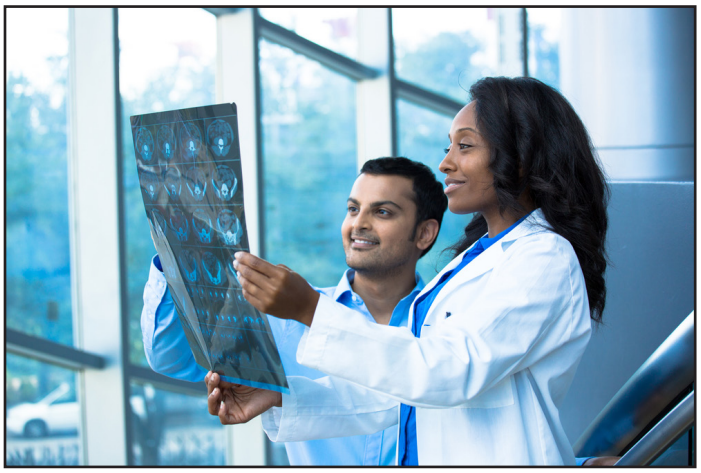
- Hospital Inpatient and LTCH PPS FY 2016 Final Rule Call – Register Now
- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call – Register Now
- Dialysis Facility Compare: Rollout of Five Star Rating Call – Registration Now Open
- 2014 Supplemental QRUR Physician Feedback Program Call – Registration Now Open



Announcements

- HIV Screening for Older Adults and Others with Medicare
- 2014 Annual Quality and Resource Use Reports Available Soon
- CMS to Release CBR on Orthopedic Surgeons' Use of Modifiers 24 and 25 in September

Claims, Pricers, and Codes

- Delay in Implementing Single Chamber and Dual Chamber Cardiac Pacemakers

Medicare Learning Network® Educational Products

- "Skilled Nursing Facility (SNF) Consolidated Billing (CB)" Web-Based Training Course – Revised
- "HIPAA EDI Standards" Web-Based Training Course – Revised

MLN Connects® Provider eNews for September 17, 2015

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- Physician Orders for Lab, Radiology Services, and Other Services after ICD-10 Implementation
- Use of Unspecified Codes in ICD-10-CM
- Get ICD-10 Answers in One Place

MLN Connects® National Provider Calls and Events

- Hospital Inpatient and LTCH PPS FY 2016 Final Rule Call — Last Chance to Register
- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call — Last Chance to Register
- Dialysis Facility Compare: Rollout of Five Star Rating Call — Register Now
- 2014 Supplemental QRUR Physician Feedback Program Call — Register Now
- Improving Medicare Post-Acute Care Transformation Act — Registration Now Open

Other CMS Events

- Physician Compare Public Reporting Information Sessions
- Medicare Learning Network Webinar: Medicare Basics for New Providers Part Three: Medicare Claim Review Programs, POE, and Protecting the Medicare Trust Fund

Announcements

- Medicare-Covered Cardiovascular Disease Preventive Services
- Healthy Aging Month — Discuss Preventive Services with your Patients
- CMS Releases Plan to Address Health Equity in Medicare
- Early Flu Treatment Reduces Hospitalization Time, Disability Risk in Older People
- 2016 PQRS Payment Adjustment and Informal Review Process
- Million Hearts: Cardiovascular Disease Risk Reduction Model Application Deadline Extension

Claims, Pricers, and Codes

- Delay in Implementing Single Chamber and Dual Chamber Cardiac Pacemakers

Medicare Learning Network® Educational Products

- "Medicare-Required SNF PPS Assessments" Educational Tool — Released
- "Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries" MLN Matters Article — Revised

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

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