Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

October 2015

In this issue

CMS releases 2016 inpatient prospective payment system and long-term care hospital PPS changes

Provider types affected

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

Provider action needed

Stop – impact to you

Policy changes for FY 2016 IPPS and LTCH PPS will cover services effective for hospital discharges occurring on or after October 1, 2015, through September 30, 2016, unless otherwise noted. Not adhering to these new policies could affect payment of Medicare claims.

Caution – what you need to know

New IPPS and LTCH PPS pricer software packages will be released prior to October 1, 2015, that will include updated rates that are effective for claims with discharges occurring on or after October 1, 2015, through September 30, 2016. The new revised pricer program will be installed in a timely manner to ensure accurate payments for IPPS and LTCH PPS claims.

Go – What you need to do

Make sure that your billing staffs are aware of these IPPS and LTCH PPS changes for FY 2016.

Background

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a PPS for Medicare payment of inpatient hospital services. In addition, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on

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Publication staff:

Terri Drury
Sofia Lennie
Martin Smith
Kathleen Storey
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications

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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.

Provider enrollment requirements for writing prescriptions for Medicare Part D drugs

Note: This article was revised October 20, 2015, to communicate changes to and the delayed enforcement of the Part D prescriber enrollment requirement until June 1, 2016, and to provide clarifying information regarding the enrollment process. All other information remains the same. This article was previously published in the December 2014 issue of Medicare A Connection, Pages 9-10.

Provider types affected

This *MLN Matters*® special edition is intended for physicians, dentists, and other eligible professionals who write prescriptions for Medicare beneficiaries for Medicare Part D drugs. The article is also directed to Medicare Part D plan sponsors.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) finalized CMS-4159-F, "Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs" on May 23, 2014. CMS later published CMS-6107-IFC, "Medicare Program; Changes to the Requirements for Part D Prescribers," an interim final rule with comment ("IFC"), that made changes to the Final Rule (CMS-4159-F), on May 6, 2015.

Together, these rules require virtually all physicians and other eligible professionals, including dentists, who write prescriptions for Part D drugs to be enrolled in an approved status or to have a valid opt-out affidavit on file for their prescriptions to be coverable under Part D, except in very limited circumstances. To allow sufficient time for the prescribers to enroll in Medicare and the Part D sponsors and the pharmacy benefit managers (PBMs) to make the complex system enhancements needed to comply with the prescriber enrollment requirements, CMS announced a delay in enforcement of this rule until June 1, 2016.

Nevertheless, prescribers of Part D drugs should submit their Medicare enrollment applications or opt-out affidavits to their Part B Medicare administrative contractors (MACs) by January 1, 2016, or earlier, to ensure that MACs have sufficient time to process the applications and opt-out affidavits and avoid their patients' prescription drug claims from being denied by their Part D plans, beginning June 1, 2016 (Enrollment functions for physicians and other prescribers are handled by MACs).

The purpose of these rules is to ensure that Part D drugs are prescribed only by physicians and eligible professionals who are qualified to do so under state law and under the requirements of the Medicare program and

who do not pose a risk to patient safety. By implementing these rules, CMS is improving the integrity of the Part D prescription drug program by using additional tools to reduce fraud, waste, and abuse in the Medicare program.

Prescribers who are determined to have a pattern or practice of prescribing Part D drugs that are abusive and represents a threat to the health and safety of Medicare enrollees or fails to meet Medicare requirements will have their billing privileges revoked under 42 USC 424.535 (a) (14).

Background

If you write prescriptions for covered Part D drugs and you are not already enrolled in Medicare in an approved status or have a valid record of opting out, you should submit an enrollment application or an opt-out affidavit to your MAC by January 1, 2016, or earlier, so that the prescriptions you write for Part D beneficiaries are coverable on and after June 1, 2016.

To enroll in Medicare for the limited purpose of prescribing: You may submit your enrollment application electronically using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) located at *https://www.cms.gov/medicare/provider-enrollment-andcertification/medicareprovidersupenroll/internetbasedpecos.html* or by completing the paper CMS-855O application, which is available at *https://www.cms.gov/Medicare/CMSForms/CMS-Forms/downloads/cms855o.pdf*, which must be submitted to the MAC that services your geographic area. Note that there is no application fee required for your application submission.

For step-by-step instructions, refer to the PECOS how-to guide, available at *http://go.cms.gov/orderreferhowtoguide* or watch an instructional video at *http://go.cms.gov/videotutorial*.

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The CMS-855O is a shorter, abbreviated form and takes minimal time to complete. While the CMS-855O form states it is for physicians and non-physician practitioners who want to order and certify, it is also appropriate for use by prescribers, who want to enroll to also prescribe Part D drugs. (CMS is in the process of updating the CMS-855O form).

If you do not see your specialty listed on the application, please select the *Undefined Physician/Non-Physician Type* option and identify your specialty in the space provided.

The average processing time for CMS-855O applications submitted online is 45 days versus paper submissions which is 60 days. However, your application could be processed sooner depending on the MAC's current workload.

To enroll to bill for services (and prescribe Part D drugs):

To enroll in Medicare to bill for your services, you may complete the CMS-855I application. The CMS-855R should also be completed if you wish to reassign your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries. All actions can be completed via PECOS or the paper enrollment application.

For more information on enrolling in Medicare to bill for services refer to *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf.*

If you are a physician or non-physician practitioner who wants to opt-out of Medicare, you must submit an opt-out affidavit to the MAC that services your geographic area. Physicians and non-physician practitioners should be aware that if they choose to opt-out of Medicare, they are **not** permitted to participate in a Medicare Advantage Plan.

In addition, once a physician or non-physician practitioner has opted out they are not permitted to terminate their opt-out affidavit early. Section 1802(b)(3)(B)(ii) of the Act establishes the term of the opt-out affidavit. The Act does not provide for early termination of the opt-out term.

Under CMS regulations, physicians and practitioners who have not previously submitted an opt-out affidavit under Section 1802(b)(3) of the Act, may choose to terminate their opt-out status within 90 days after the effective date of the opt-out affidavit, if the physician or practitioner satisfies the requirements of 42 CFR § 405.445(b). No other method of terminating opt-out status before the end of the two year opt-out term is available.

Prior to enactment of the Medicare Access and CHIP

Reauthorization Act of 2015 (MACRA), physician/practitioner opt-out affidavits were only effective for two years. As a result of changes made by MACRA, valid opt-out affidavits signed on or after June 16, 2015, will automatically renew every two years.

If physicians and practitioners that file affidavits effective on or after June 16, 2015, do not want their opt-out to automatically renew at the end of a two year opt-out period, they may cancel the renewal by notifying all Medicare administrative contractors (MACs) with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period.

Valid opt-out affidavits signed before June 16, 2015 will expire two years after the effective date of the opt out. If physicians and practitioners that filed affidavits effective before June 16, 2015, want to extend their opt-out, they must submit a renewal affidavit within 30 days after the current opt-out period expires to all MACs with which they would have filed claims absent the opt-out.

For more information on the opt-out process, refer to *MLN Matters*® article SE1311, titled "Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries," which is available at:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf

and

https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-06-25-eNews.html.

CMS would like to highlight the following limitations that apply to billing and non-billing providers:

- A resident is defined in 42 CFR § 413.75 as an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order

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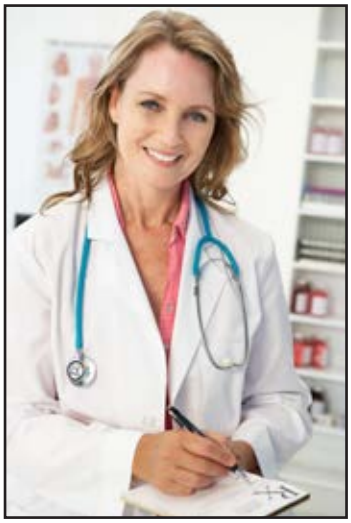
to become certified by the appropriate specialty board. Interns, residents, and fellows may enroll in Medicare to prescribe if the state licenses them. Licensure can include a provisional license or similarly- regulated credential. Unlicensed interns, residents, and fellows must specify the teaching physician who is enrolled in Medicare as the authorized prescriber on a prescription for a Part D drug (assuming this is consistent with state law).

Licensed residents have the option to either enroll themselves or use the teaching physician's name on prescriptions for Part D drugs, unless state law specifies which name is to be used. CMS strongly encourages teaching physicians and facilities to ensure that the NPI of the lawful prescriber under state law is included on prescriptions to assist pharmacies in identifying the correct prescriber and avoid follow up from the pharmacies, which experience rejected claims from Medicare Part D plans due to missing or wrong prescriber NPIs on the claims.



- The prescriber enrollment requirements also apply to physicians and non-physician practitioners who write prescriptions for Part D drugs and are employed by a Part A institutional provider (e.g., hospital, federally qualified health center (FQHC), rural health center (RHC)). Since Part A institutional providers may bill for services provided by an employed physician or non-physician practitioner, the physician or non-physician practitioner may not have separately enrolled, unless he or she is also billing for Part B services. Therefore, if the physician or non-physician practitioner prescribes Part D drugs as an employee of the institutional provider, he or she must be enrolled in an approved status for their prescriptions to be coverable under Part D beginning June 1, 2016.

"Other authorized prescribers" are exempt from the Medicare Part D prescriber enrollment requirement. In other words, prescriptions written by "other authorized prescribers are still coverable under Part D, even if the prescriber is not enrolled in or opted out of Medicare.

For purposes of the Part D prescriber enrollment requirement only, "other authorized prescribers" are defined as individuals other than physicians and eligible professionals who are authorized under state or other applicable law to write prescriptions but are not in a provider category that is permitted to enroll in or opt-out of Medicare under the applicable statutory language. CMS believes "other authorized prescribers" are largely pharmacists who are permitted to prescribe certain drugs in certain states, but based on the applicable statute, pharmacists are not able to enroll in or opt-out of Medicare.

If you believe you are an "other authorized prescriber" and are not a pharmacist, please contact *providerenrollment@cms.gov*.

In addition, CMS strongly recommends that pharmacists in particular make sure that their primary taxonomy associated with their NPI in the National Plan & Provider Enumeration System (NPPES) reflects that they are a pharmacist. To review and update your NPPES information, please go to the National Plan & Provider Enumeration System Web page at *https://nppes.cms.gov/NPPES/Welcome.do*.

Upon enforcement of the regulation, Part D plans will need to be able to determine if the prescriber is a pharmacist in order to properly adjudicate the pharmacy claim at point-of-sale.

In an effort to prepare the prescribers and Part D sponsors for the June 1, 2016 enforcement date, CMS has made available an enrollment file that identifies physician and eligible professional who are enrolled in Medicare in an approved or opt-out status. However, the file does not specify if a particular prescriber is eligible to prescribe, as prescribing authority is largely determined by state law. The enrollment file is available at *https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx*.

The file contains production data but is considered a test file since the Part D prescriber enrollment requirement is not yet applicable. An updated enrollment file will be generated every two weeks, with a purposeful goal of providing updates twice a week by the date of enforcement.

The file displays physician and eligible professional eligibility as of and after November 1, 2014, (i.e., currently enrolled, new approvals, or changes from opt-out to enrolled as of November 1, 2014). Any periods, prior to November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will not be displayed on the enrollment file.

However, any gaps in enrollment after November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will be reflected on the file with its respective effective and end dates

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for that given provider. For opted out providers, the opt-out flag will display a Y/N (Yes/No) value to indicate the periods the provider was opted out of Medicare. The file will include the provider's:

- (NPI);
- First and last names;
- Effective and end dates; and
- Opt-out flag

Example 1– Dr. John Smith's effective date of enrollment is January 1, 2014. Since he was enrolled prior to the generation of the test file, his effective date will display as November 1, 2014. Dr. Smith submits an enrollment application to voluntarily withdraw from Medicare effective December 15, 2014. Dr. Smith will appear on the applicable file as:

NPI	First name	Last name	Eff. date	End date	Opt-out flag
123456789	John	Smith	11/01/14	12/15/14	N

Example 2 - Dr. Mary Jones submits an affidavit to opt-out of Medicare, effective December 1, 2014. Since she has opted out after the generation of the test file, her effective date will display as December 1, 2014. After the two year opt-out period expires, Dr. Jones decides she wants to enroll in Medicare to bill, order, and certify, or to write prescriptions. The enrollment application is received on January 31, 2017, and the effective date issued is January 1, 2017. Dr. Jones will display on the applicable file as:

NPI	First name	Last name	Effective date	End date	Opt-out flag
987654321	Mary	Jones	12/01/14	12/01/16	Y
987654321	Mary	Jones	01/01/17	N	

After the enforcement date of June 1, 2016, the applicable effective dates on the file will be adjusted to June 1, 2016, and it will no longer be considered a test file. All inactive periods prior to June 1, 2016, will be removed from the file and it will only contain active and inactive enrollment or opt-out periods as of June 1, 2016, and after.

The file will continue to be generated every two weeks, with a purposeful goal of providing updates twice a week by the date of enforcement. Part D sponsors may utilize the file to determine a prescriber's Medicare enrollment or

opt-out status when processing Part D pharmacy claims. The file will not validate the provider's ability to prescribe under applicable laws. Please submit questions or issues encountered in accessing the file to *providerenrollment@cms.hhs.gov*.

Additional information

For more information on the enrollment requirements, visit *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*.

If you have questions and need to speak with the Part B contractor that handles your enrollment, you may find their toll-free number at MAC list on the CMS website.

For a list of frequency asked questions (FAQs) refer to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/CMS-4159_FAQs.pdf*.

Document history

- This article was revised December 5, 2014, to add language to emphasize that form CMS-855O is appropriate for use by prescribers.
- This article was revised October 20, 2015, to communicate changes to and the delayed enforcement of the Part D prescriber enrollment requirement until June 1, 2016, and to provide clarifying information regarding the enrollment process.

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Full implementation of edits on home health agency claims filed by ordering/referring providers

Note: This article was revised September 24, 2015, and October 21, 2015 to change the link to the "Ordering Referring Report" on the Centers for Medicare & Medicaid Services (CMS) website and to clarify legislative changes affecting providers who file Medicare opt-out affidavits with Medicare contractors. That link was changed to https://data.cms.gov on the Centers for Medicare & Medicaid Services website. For a complete list of any other changes to this article, please refer to the document history section. All other information remains the same. This article was previously published in the February 2014 issue of Medicare A Connection.

Provider types affected

This *MLN Matters*® special edition article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA), the Department of Defense (DoD), or the Public Health Service (PHS) who order or refer items or services for Medicare beneficiaries,
- Part B providers and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare administrative contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and
- Part A home health agency (HHA) services who submit claims to regional home health intermediaries (RHHIs), fiscal intermediaries (FIs, who still maintain an HHA workload), and Part A/B MACs.
- Optometrists may only order and refer DMEPOS products/services and laboratory and X-ray services payable under Medicare Part B.

Provider action needed

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare.

You can do this using the Internet-based provider enrollment, chain, and ownership system (PECOS) or by completing the paper enrollment application (CMS-855O). Review the background and additional information below and make sure that your billing staff is aware of these updates.

What providers need to know

Phase 1: Informational messaging began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication.

Phase 2: Effective January 6, 2014, CMS will turn on the edits to deny Part B clinical laboratory and imaging, DME, and Part A HHA claims that fail the ordering/referring provider edits.

Claims submitted identifying an ordering/referring provider and the required matching NPI is missing will continue to be rejected. Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit will not expose a Medicare beneficiary to liability.

Therefore, **an advance beneficiary notice is not appropriate in this situation**. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services, including home health, DMEPOS, imaging and clinical laboratory.

Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer.

Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare.

The edits will compare the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found at *https://data.cms.gov*. Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the ordering/referring fields.

All enrollment applications, including those submitted over the Internet, require verification of the information reported. Sometimes, Medicare enrollment contractors may request

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additional information in order to process the enrollment application. Waiting too long to begin this process could mean that your enrollment application may not be processed prior to the implementation date of the ordering/referring Phase 2 provider edits.

Background

The Affordable Care Act, Section 6405, "Physicians Who Order Items or Services are required to be Medicare Enrolled Physicians or Eligible Professionals," requires physicians or other eligible professionals to be enrolled in the Medicare program to order or refer items or services for Medicare beneficiaries.

Some physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program. Also, effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral.

Effective May 23, 2008, the unique identifier was determined to be the NPI. CMS has implemented edits on ordering and referring providers when they are required to be identified in Part B clinical laboratory and imaging, DME, and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:

- Claims from clinical laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures;
- Claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for ordered DMEPOS; and
- Claims from Part A home health agencies (HHA).

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

- Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.)
  - Physician assistants,
  - Clinical nurse specialists,
  - Nurse practitioners,
  - Clinical psychologists,

  - Interns, residents, and fellows,
  - Certified nurse midwives, and
  - Clinical social workers.

CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so.

Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Home health agency (HHA) services may only be ordered or referred by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Doctor of Podiatric Medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
- Optometrists may only order and refer DMEPOS products/services, and laboratory and X-ray services payable under Medicare Part B.

Questions and answers relating to the edits

1. What are the ordering and referring edits?

The edits will determine if the ordering/referring provider (when required to be identified in Part B clinical laboratory and imaging, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and contains a valid NPI (the name and NPI must

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match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. Why did Medicare implement these edits?

These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. How and when will these edits be implemented?

These edits were implemented in two phases:

Phase 1 – Informational messaging began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication. The informational messages used are identified below:

For Part B providers and suppliers who submit claims to carriers:

N264	Missing/incomplete/invalid ordering provider name
N265	Missing/incomplete/invalid ordering provider primary identifier

For adjusted claims, the claims adjustment reason code (CARC) code 16 (Claim/service lacks information which is needed for adjudication.) is used. DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future

For Part A HHA providers who order and refer, the claims system initially processed the claim and added the following remark message:

N272	Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 was used.

CMS has taken actions to reduce the number of informational messages. In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs. (NPIs were

added only when the matching criteria verified the NPI.)

On January 28, 2010, CMS made available to the public, via the *Downloads* section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the ordering referring report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner.

To keep the available information up to date, CMS will replace the Report twice a week. At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report and to download it, go to *https://data.cms.gov*.

Phase 2: Effective January 6, 2014, CMS will turn on the Phase 2 edits. In Phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral.

Below are the denial edits for Part B providers and suppliers who submit claims to Part A/B MACs, including DME MACs:

254D or 001L	Referring/ordering provider not allowed to refer/order
255D or 002L	Referring/ordering provider mismatch

CARC code 16 or 183 and/or the RARC code N264, N574, N575 and MA13 shall be used for denied or adjusted claims.

Claims submitted identifying an ordering/referring provider

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and the required matching NPI is missing (edit 289D) will continue to be rejected. CARC code 16 and/or the RARC code N265, N276 and MA13 shall be used for rejected claims due to the missing required matching NPI.

Below are the denial edits for Part A HHA providers who submit claims:

Reason code	The reason code will assign when:
37236	▪ The statement "From" date on the claim is on or after the date the phase 2 edits are turned on ▪ The type of bill is '32' or '33' ▪ Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code
37237	▪ The statement "From" date on the claim is on or after the date the phase 2 edits are turned on ▪ The type of bill is '32' or '33' ▪ The type of bill frequency code is '7' or 'F-P' ▪ Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

Effect of edits on providers

I order and refer. How will I know if I need to take any sort of action with respect to these two edits?

In order for the claim from the billing provider (the provider

who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, **you, the ordering/referring provider, need to ensure that**:

a) You have a current Medicare enrollment record.

- o If you are not sure you are enrolled in Medicare, you may:
  - i. Check the ordering referring report and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI;
  - ii. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or
  - iii. Use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare).
  - iv. If you choose iii, please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.

b) If you do not have an enrollment record in Medicare:

- o You need to submit either an electronic application through the use of internet-based PECOS or a paper enrollment application to Medicare.
  - i. For paper applications – fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor.
  - ii. For electronic applications – complete the online submittal process and either e-sign or mail a printed, signed, and dated certification

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statement and digitally submit any required supporting paper documentation to your designated Medicare enrollment contractor.

iii. In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated certification statement.

iv. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment Web page to learn more about the web-based system before you attempt to use it. Go to *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html,* click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the *Downloads* section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.

v. If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via Internet-based PECOS or .pdf for downloading from the CMS forms page (*http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html*).

c) You are an opt-out physician and would like to order and refer services. What should you do?

If you are a physician who has opted out of Medicare, you may order items or services for Medicare beneficiaries by submitting an opt-out affidavit to a Medicare contractor within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit).

Note: Prior to enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), physician/practitioner opt-out affidavits were only effective for two years. As a result of changes made by MACRA, valid opt-out affidavits signed on or after June 16, 2015, will automatically renew every two years. If physicians and practitioners that file affidavits effective on or after June 16, 2015, do not want their opt-out to automatically renew at the end of a two year opt-out period, they may cancel the renewal by notifying all Medicare administrative contractors (MACs) with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period.

d) You are of a type/specialty that can order or refer items or services for Medicare beneficiaries.

When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty (chiropractors are excluded) and only the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.

e) I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the ordering/referring provider edits?

- You need to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the ordering referring report described earlier in this article.
- Ensure you are correctly spelling the ordering/referring provider's name.
- If you furnished items or services from an order or referral from someone on the ordering referring report, your claim should pass the ordering/referring provider edits.
- The ordering referring report will be replaced twice a week to ensure it is current. It is possible that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the ordering referring report but who may be listed on the next report.

f) Make sure your claims are properly completed.

- On paper claims (CMS-1500), in item 17, only include the first and last name as it appears on the ordering and referring file found on *www.CMS.gov*.
- On paper claims (CMS-1450), you would capture the attending physician's last name,

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first name and NPI on that form in the applicable sections. On the most recent form it would be fields in FL 76.

- On paper claims (CMS-1500 and CMS-1450), do not enter "nicknames", credentials (e.g., "Dr.", "MD", "RPNA", etc.) or middle names (initials) in the Ordering/Referring name field, as their use could cause the claim to fail the edits.
- Ensure that the name and the NPI you enter for the ordering/referring provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral
- Make sure that the qualifier in the electronic claim (x12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer.

If there are additional questions about the informational messages, billing providers should contact their local A/B MAC, or DME MAC.

Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit shall not expose a Medicare beneficiary to liability. Therefore, **an advance beneficiary notice is not appropriate in this situation**.

This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services including home health, DMEPOS, imaging and clinical laboratory.

g) What if my claim is denied inappropriately? If your claim did not initially pass the ordering/referring provider edits, you may file an appeal through the standard claims appeals process or work through your A/B MAC or DME MAC.

h) How will the technical vs. professional components of imaging services be affected by the edits?

Consistent with the Affordable Care Act and 42 CFR 424.507, suppliers submitting claims for imaging services must identify the ordering or referring physician or practitioner. Imaging suppliers covered by this requirement include the following: IDTFs, mammography centers, portable x-ray facilities and radiation therapy centers.

The rule applies to the technical component of imaging services, and the professional component will be excluded from the edits. However, if billing globally, both components will be impacted by the edits and the entire claim will deny if it doesn't meet the ordering and referring requirements. It is recommended that providers and suppliers bill the global claims separately to prevent a denial for the professional component.

i) Are the Phase 2 edits based on date of service or date of claim receipt? The Phase 2 edits are effective for claims with dates of service on or after January 6, 2014.

A Medicare beneficiary was ordered a 13-month DME capped rental item. Medicare has paid claims for rental months one and two. The equipment is in the third rental month at the time the Phase 2 denial edits are implemented. The provider who ordered the item has been deactivated. How will the remaining claims be handled? Claims for capped rental items will continue to be paid for up to 13 months from the physician's date of deactivation to allow coverage for the duration of the capped rental period.

Additional guidance

1. **Terminology**: Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred, or certified an item or service reported in that claim. The final rule uses technically correct terms:
   a. a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and
   b. a provider "certifies" home health services to a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.
2. **Orders or referrals by interns or residents**: The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)).

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The final rule states that state-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if states provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with state law.

3. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense (DoD)/Tricare:** These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
4. **Orders or referrals by dentists:** Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional information

For more information about the Medicare enrollment process, visit *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html* or contact the designated Medicare contractor for your state.

Medicare provider enrollment contact information for each state can be found at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf*.

The *Medicare Learning Network*® (MLN) fact sheet titled, "Medicare Enrollment Guidelines for Ordering/Referring Provider," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_factSheet_ICN906223.pdf*.

Note: You must obtain a national provider identifier (NPI) prior to enrolling in Medicare. Your NPI is a required field

on your enrollment application. Applying for the NPI is a separate process from Medicare enrollment. To obtain an NPI, you may apply online at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*.

For more information about NPI enumeration, visit *http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html*.

Additional article updates

MLN Matters® article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7097.pdf*.

MLN Matters® article MM6417, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare administrative contractors (MACs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6417.pdf.*

MLN Matters® article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6421.pdf*;

MLN Matters® article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6129.pdf*.

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MLN Matters® article MM6856, "Expansion of the Current Scope for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) Claims processed by Medicare regional home health intermediaries (RHHIs), is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6856.pdf*.

MLN Matters® article SE1311, "Opting out of Medicare and/or Electing to Order and Refer Services" is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf* informs ordering and referring providers about the information they must provide in a written affidavit to their Medicare contractor when they opt-out of Medicare.

If you have questions, please contact your Medicare Carrier, Part A/B MAC, or DME MAC, at their toll-free numbers, which may be found *at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

Important information for physicians and non-physician practitioners who opt out of Medicare and/or elect to order and certify services to Medicare beneficiaries is available in *MLN Matters*® article SE1311 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1311.pdf*.

Document history

Date	Description
September 24, 2015	This article was revised to change the link to the "Ordering Referring Report" page. That link was changed to *https://data.cms.gov*.
January 26, 2015	This article was revised to include a link to article SE1311, which includes important information for physicians and non-physician practitioners who opt out of Medicare and/or elect to order and certify services to Medicare beneficiaries.
April 19, 2013	This article was previously revised add references to the CMS-1450 form and to add question H. on page 9. Previously, it was revised on April 3, 2013, to advise providers to not include middle names and suffixes of ordering/referring providers on paper claims. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid national provider identifier (NPI) and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found at *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html*.

MLN Matters® Number: SE1305 *Revised*
Related Change Request (CR) #: CRs 6421, 6417, 6696, 6856
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: R642OTN, R643OTN, R328PI, and R781OTN
Implementation Date: N/A

Claim processing MSP policy and procedures regarding ongoing responsibility for medicals

Provider types affected

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

Provider action needed

This article is based on change request (CR) 8984, through which the Centers for Medicare & Medicaid Services (CMS) outlines its Medicare claim processing requirements specific to ongoing responsibility for medicals (ORM) for liability insurance (including self-insurance), no-fault insurance, and workers' compensation in Medicare secondary payer (MSP) situations.

Liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans are required to report settlements, judgments, awards, or other payments to CMS, including ORM. The purpose of CR 8984 is to educate and instruct sure that your billing staffs are aware of these changes.

Note: MSP claims impacted by employer group health plan coverage will be not affected by this change.

Background

Pursuant to section 1862(b)(8) of the Social Security Act, "applicable plans" (liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans) are required to report settlements, judgments, awards or other payments involving individuals who are or were Medicare beneficiaries to CMS. The applicable plan is the "responsible reporting entity" (RRE) for this process.

The required reporting includes instances where the RRE has ORM associated with specified medical conditions. This information is collected to determine primary claims payment responsibility. Examples of ORM include, but are not limited to, a no-fault insurer agreeing to pay medical bills submitted to it until the policy in question is exhausted or a workers' compensation plan being required under a particular state law to pay associated medical costs until there is a formal decision on a pending workers' compensation claim.

The RRE may assume responsibility for ORM for one or more alleged injuries/illnesses without assuming ORM for all alleged injuries/illnesses in an individual's liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim. For example, if an individual is alleging both a broken leg and a back injury, the RRE might assume responsibility for the broken leg but continue to dispute the alleged back injury.

When ORM ends (for example, a policy limit is reached or a settlement occurs which terminates the RRE responsibility to pay on an ongoing basis), the RRE reports an ORM termination date, and this information is uploaded to Medicare's common working file (CWF) by the Benefit Coordination & Recovery Center (BCRC).

Note: An ORM report is not a guarantee that medicals will be paid indefinitely or through a particular date.

Pursuant to Section 1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment "has been made, or can reasonably be expected to be made…" under liability insurance (including self-insurance), no-fault insurance, or a workers' compensation law or plan, hereafter, referred to as non-group health plan (NGHP).

Where ORM has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted.

CR 8984 includes modifications to Medicare systems to automate the fact that ORM responsibility is assumed, exists, or did exist for a particular period of time. All MACs shall reference the modified CWF MSPD screen to determine if ORM exists in association with MSPD (No-Fault – 14), E (Workers Compensation -15), and L (Liability - 47) records for the date(s) of service at issue.

When claims are processed, Medicare will compare the diagnosis code(s) on the claim with the diagnosis code(s) associated with the ORM record.

All MACs shall deny claims where the ORM indicator is present for the period covered by the claim and the

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diagnosis code(s) match(es) (or match(ed)) within the family of diagnosis codes). As stated, documentation from the RRE that the ORM terminated or is otherwise exhausted may require that the previously denied claim be reprocessed. (Any claim will also process for a potential Workers' Compensation Medicare Set-Aside (WCMSA) denial where there is no denial based upon the ORM indicator.)

As stated above, MACs shall deny payment for claim lines with open ORM for the date of service for the associated diagnosis code(s) or family of diagnosis codes. The prompt payment rules do not override this requirement; therefore, a conditional payment cannot be made to providers when ORM exists for the item or service in question.

However, as stated, the reported ORM is not a guarantee that medicals will be paid indefinitely or through a particular date.

Consequently, if a claim is denied on the basis of ORM and the MAC receives information that the policy limit has been appropriately exhausted -- even though the claim in question is for services prior to the ORM termination date -- the claim may be paid if it is otherwise covered and reimbursable. This type of situation could occur where there has been a delay in billing to the RRE or where part of a group of claims submitted to the RRE was sufficient to exhaust the policy.

When Medicare denies claims due to the ORM indicator, the remittance advice for the denied claim will reflect one of the following claims adjustment reason codes (CARC) and remittance advice remarks codes (RARC):

- **CARC 19** – "This is a work-related injury/illness and thus the liability of the Workers' Compensation Carrier." Also, RARC N728 – "A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis"—will appear. (Note: To be used with group code PR.)
- **CARC 20** – "This injury/illness is covered by the liability carrier." Also, RARC N725 – "A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis" —will appear. (NOTE: To be used with group code PR.)
- **CARC 21** – "This injury/illness is the liability of the no-fault carrier." Also, RARC N727 – "A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis" —will appear. (**Note**: To be used with group code PR.)

However, Medicare payment will be made for services if the following codes and conditions are met (assumption: primary payer did not pay for an acceptable reason; for example, benefits appropriately exhausted, or benefits no longer covered due to state imposed limits, etc.):

- Any of the following CARCs are found on the ORM claim: 26, 27, 31, 32, 35, 49, 50, 51, 53, 55, 56, 60, 96, 119, 149, 166, 167, 170, 184, 200, 201, 204, 242, 256, B1 (if a Medicare covered visit), B14; and
- The service is covered and otherwise reimbursable by Medicare.

Additional information

Important: Providers, physicians, and other suppliers should know that CMS is implementing use of the ORM indicator on a gradual basis, beginning in January 2016. Appeal rights apply to all claims denied due to ORM as part of MSP claims processing.

The official instruction, CR 8984, was issued to your MAC regarding this change via two transmittals. The first transmittal is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R114MSP.pdf* and the second transmittal is at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3358CP.pdf*.

You may find further information about the mandatory reporting required by liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans by going to *http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html*.

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: MM8984
Related Change Request (CR) #: CR 8984
Related CR Release Date: September 18, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R114MSP and R3358CP
Implementation Date: October 5, 2015

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ICD-10 conversion and coding infrastructure revisions to NCDs – third maintenance update

Provider types affected

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

What you need to know

Change request (CR) 9252 is the third maintenance update of ICD-10 conversions/updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs.

Specifically, they were contained in CR 7818, CR 8109, CR 8197, CR 8691, and CR 9087. Related *MLN Matters*® articles are *MM7818*, *MM8109*, *MM8197*, *MM8691*, and *MM9087*. Some are the result of revisions required to other NCD-related CRs released separately that included ICD-10 coding.

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly updates as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

Background

CR 9252 creates and updates NCD editing, both hard-coded shared system edits as well as local MAC edits that contain ICD-10 diagnosis/procedure codes, plus all associated coding infrastructure such as HCPCS/*CPT*® codes, reason/remark codes, frequency edits, place of service (POS), type of bill (TOB), provider specialties, and so forth.

The requirements described in CR 9252 reflect the operational changes that are necessary to implement the conversion of the Medicare local and shared system diagnosis and procedure codes specific to the 26 Medicare NCD spreadsheets, which are available at *http://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9252.zip*.

NCD policies may contain specific covered, non-covered and/or discretionary diagnosis and procedure coding. These 26 spreadsheets are designated as such and are based on current NCD policies and their corresponding edits.

You should be aware that nationally covered and non-covered diagnosis code lists are finite and cannot be revised without a subsequent CR. Discretionary code lists are to be regarded as CMS' compilation of discretionary codes based on current analysis/interpretation. MACs

may or may not expand discretionary lists based on their individual local authority within their respective jurisdictions. Some coding details are as follows:

1. Your MAC will use default Council for Affordable Quality Healthcare (CAQH) Committee on operating rules for information exchange (CORE) messages, where appropriate:
   - **Remittance advice remark code (RARC) N386** (This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered), along with
   - **Claim adjustment reason code (CARC) 50** (These are non-covered services because this is not deemed a "medical necessity" by the payer),
   - **CARC 96 (Non-covered charge(s).** At least one remark code must be provided [may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT]), and/or
   - **CARC 119** (Benefit maximum for this time period or occurrence has been reached).
2. When denying claims associated with the NCDs in the 26 spreadsheets, except where otherwise indicated, your MACs will use:
   - **Group code PR** (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 (advance beneficiary notice), or with occurrence code 32 and a GA modifier (The provider or supplier has provided an advance beneficiary notice (ABN) to the patient), indicating a signed ABN is on file).
   - **Group code CO** (contractual obligation) assigning financial liability to the provider (if a claim is

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January 2016 changes to the laboratory national coverage determination edit software

Provider types affected

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

Provider action needed

Change request (CR) 9352 informs MACs about the changes that will be included in the January 2016 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

Background

The national coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in Medicare's claims processing systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective April 1, 2003.

CR 9352 communicates requirements to Medicare's shared system maintainers (SSMs) and MACs notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for January 2016. Changes are being made to the NCD code lists as follows:

- Add ICD-10-CM codes N131 and N132 to the list of ICD-10-CM codes that are covered by Medicare for the Urine Culture, Bacterial (190.12) NCD.
- Add ICD-10-CM code I481 to the list of ICD-10-CM codes that are covered by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.
- Add ICD-10-CM code S069X0A to the list of ICD-10-CM codes that are covered by Medicare for the prothrombin time (PT) (190.17) NCD.
- Add ICD-10- ICD-10-CM code I481 to the list of ICD-10-CM codes that are covered by Medicare for the thyroid testing (190.22) NCD.

These changes are effective for services furnished on or after January 1, 2016.

Additional information

The official instruction, CR 9352, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3366CP.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: MM9352
Related Change Request (CR) #: CR 9352
Related CR Release Date: October 2, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3366CP
Implementation Date: January 4, 2016

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received with a GZ modifier (The provider or supplier expects a medical necessity denial; however, did not provide an advance beneficiary notice (ABN) to the patient), indicating no signed ABN is on file)

- For modifier GZ, your MAC will use CARC 50.

Additional information

The official instruction, CR 9252, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1537OTN.pdf*.

MLN Matters® Number: MM9252
Related Change Request (CR) #: CR 9252
Related CR Release Date: October 5, 2015
Effective Date: October 1, 2015
Implementation Date: January 4, 2016, Exceptions: FISS will implement the following NCDs April 4, 2016: 260.1, 80.11, 270.6, 160.18, 110.10, 110.21, 250.5, 100.1, 160.24
Related CR Transmittal #: R1547OTN

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

Evaluation and management services in a nursing facility – new LCD

LCD ID number: L 36230 (Florida, Puerto Rico/U.S. Virgin Islands)

This new local coverage determination (LCD) was developed based on data analysis by the Program Safeguards Communication Group (PSCG), as well as issues identified in medical review related to excessive utilization of evaluation and management (E/M) services in a skilled nursing facility/nursing facility setting in Florida.

Data demonstrated a marked increase in the number of daily or every other day visits in the absence of documented medical necessity. In addition, many Florida providers continue to bill E/M services (across one or more place of service) in medically unbelievable daily patterns. Data analysis continues to identify providers who were allowed services in excess of 16 hours per day, and some who were allowed services in excess of 24 hours per day.

This LCD has been developed to outline indications and limitations of coverage and/or medical necessity, *CPT*® codes, documentation guidelines, and utilization guidelines for evaluation and management services in a nursing facility.

Effective date

The LCD revision is effective for services rendered **on or after November 15, 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*.

Special histochemical stains and immunohistochemical stains – new Part A-B LCD

LCD ID number: L36234 (Florida, Puerto Rico/U.S. Virgin Islands)

This local coverage determination (LCD) is based on issues identified by Palmetto GBA in their administration of molecular pathology services in several jurisdictions.

The Palmetto draft was discussed in a national contractor medical director (CMD) workgroup and adopted by jurisdiction N (JN) and other Medicare administrative contractors (MACs), as a draft and posted for a 45-day comment period. This LCD outlines indications and limitations of coverage and/or medical necessity, *CPT*® code, ICD-10-CM diagnosis codes, documentation guidelines, and utilization guidelines.

Effective date

This LCD revision for ICD-9 diagnosis codes is effective **for services rendered on or after December 6, 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*.

Diagnostic evaluation and medical management of moderate-severe dry eye disease (DED) – new LCD

LCD ID number: L36232
(Florida/Puerto Rico/U.S. Virgin Islands)

The Local Coverage Determination (LCD) for diagnostic evaluation and medical management of moderate-severe DED has been created to address the limited indications for a rapid point-of-care (POC) diagnostic test and to further clarify providers eligible to perform this procedure. *Current Procedural Terminology*® (*CPT*®) code *83516* [Immunoassay analysis (MMP-9)] is billed for a rapid POC diagnostic test to aid in the diagnosis of DED.

In addition, data analysis identified an increase in utilization of microfluidic analysis (tear osmolarity), *CPT*® code *83861*. The Medicare Part B Extraction Summary System (BESS) statistical medical data obtained for dates of service July 01, 2014 through December 31, 2014 indicated a Carrier to Nation Ratio for Florida at 2.32 for procedure code *83861* (between 100-150 percent above the national average) (**Note**: data for Puerto Rico and the U.S. Virgin Islands was below the national average for the applicable code). Due to the risk for a high dollar claim payment error the limited indications of *CPT*® code *83861* was also addressed in the LCD.

Furthermore, First Coast took this opportunity to incorporate the current lacrimal punctal plugs LCD in the new LCD to address both the diagnostic evaluation and medical management of moderate–severe DED. Therefore, the lacrimal punctal plugs LCD will be retired **November 22, 2015** when this new LCD is implemented.

This LCD outlines indications and limitations of coverage and/or medical necessity, *CPT*® code, ICD-10-CM diagnosis codes, documentation guidelines, and utilization guidelines for diagnostic evaluation and medical management of moderate-severe DED. In addition, an article was created and attached to the LCD to provide instructions on coding and billing.

Though stakeholders for both emerging diagnostic tests (both tear osmolarity test *CPT*® code *83861* and MMP-9 protein *CPT*® code *83516*) addressed in this LCD for DED have adequate support given analytical and clinical validity, the clinical utility, the likelihood that the test, (by implementing an intervention), will result in improved health outcome, has not been well established in the Medicare population.

If future peer reviewed literature suggests alternative approaches to the evaluation of moderate to severe DED, these tests will be evaluated for added limitations or non-coverage. As clearly outlined in the LCD, test results must be used for individual patient treatment decisions as a predictive marker (patient likely to respond to a given therapy). And, testing of patients without signs or symptoms is screening and not a covered service.

Effective date

The LCD is effective **for services rendered on or after November 22, 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*. Articles 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*.

Magnetic resonance angiography and magnetic resonance imaging LCDs – clarification related to ICD-10-CM diagnosis codes

Due to multiple inquires received related to MRA and MRI local coverage determinations (LCDs) not including ICD-10-CM diagnosis codes, this article is being published to provide clarification. .During the ICD-9-CM to ICD-10-CM conversion of the First Coast Service Options (First Coast) (LCDs) for MRA/MRI a determination was made to leave out the ICD-10-CM diagnosis codes from these LCDs.

Moving forward, certain LCDs may be revised to include the appropriate ICD-10-CM diagnosis codes, based on data analysis of these services. If First Coast determines to add the diagnoses, the LCD would be taken through a 45-day comment and 45-notice period, given this would further restrict the LCD by adding diagnosis codes and associated editing.

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

LCD Revisions

Bone mineral density studies – revision to the Part A/B LCD

LCD ID number: L36356 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for bone mineral density studies was revised to include the Center for Medicare & Medicaid Services (CMS) nationally covered diagnoses.

Although these national diagnoses were not included in the LCD, they were included in the system editing. The revised LCD will be visible to the provider community within the next couple of weeks.

Effective date

The LCD revision 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*.

Biofeedback – revision to the Part A and Part B LCD

LCD ID number: L 33615 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for biofeedback was revised to add ICD-9-CM diagnosis codes 564.00, 564.01, 564.02, 564.09 and 564.6 for procedure code *90911* to the "ICD-9 Codes that Support Medical Necessity" section of the LCD.

The ICD-10-CM diagnosis codes were also revised to include K59.00, K59.01, K59.02, K59.09 and K59.4 for procedure code *90911* to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision for ICD-9 diagnosis codes is effective **for services rendered on or after April 1, 2015**. This LCD revision for ICD-10 diagnosis codes 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*.

Doxorubicin HCl – revision to the Part A/B LCD

LCD ID number: L33990 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for doxorubicin HCl was revised to add ICD-10-CM diagnosis codes C82.00-C82.99, C85.10-C85.99, C91.40-C91.42, C96.0, C96.2, C96.4, C96.A, C96.Z, and C96.9 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD. In addition, diagnosis code range C84.60-C84.79 was changed to diagnosis range C84.00-C84.99 and diagnosis range C86.5-C86.6 was changed to diagnosis range C86.0-C86.6 in the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

The LCD revision 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*.

Rituximab (Rituxan®) – revision to the Part A-B LCD

LCD ID number: L33746 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for rituximab (Rituxan®) was revised to add ICD-10-CM diagnosis codes C83.00-C83.99 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

The LCD revision 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*.

Visual field examination – revision to the Part A-B LCD

LCD ID number: L33766 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for visual field examination was revised to add ICD-10-CM diagnosis codes H40.001-H40.009, H40.011, H40.012, H40.013, H40.021, H40.022, H40.023, H40.031, H40.032, H40.033, H40.041, H40.042, H40.043, H40.051, H40.052, H40.053, H40.061, H40.062, and H40.063 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

The LCD revision 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*.

Physician and non-physician practitioners' use of scribes

Physicians and non-physician practitioners (NPPs) may utilize the services of a scribe to assist with documentation during a clinical encounter, which may be in an office or facility setting, between the physician/NPP and the patient.

A scribe can be an NPP, a nurse, clinical assistant, or other ancillary personnel allowed by the physician/NPP, to document his/her services in the patients' medical record.

A scribe's core responsibility is to capture an accurate and detailed description (handwritten, electronic, or otherwise) of the patient encounter in a timely manner. Scribes are clerical in nature and are not permitted to make independent decisions or translations while capturing or entering information into the health record beyond what is directed by the physician/NPP.

Some practices utilize clinical staff to perform scribe functions, so it is important to clearly define and differentiate their clinical duties from their scribe duties. Even though it's acceptable for a physician/NPP to use a scribe, current Medicare documentation guidelines must be followed. The physician is ultimately accountable for the documentation and should sign and notate after the scribe's entry that the documentation accurately reflects the work done by the physician.

Documentation of scribed services should indicate who performed the service and who recorded the service. The scribe's note should include "written by [name and title of scribe], acting as scribe for Dr./NPP [name of physician/NPP]," and the date and time of entry into the medical record. The physician should legibly co-sign (either hard copy or electronic) and date the entry, indicating that the note accurately reflects work and decisions made and dictated by him/her.

Record entries made by a scribe should be made upon dictation by the physician and should document clearly the level of service provided at that encounter. This requirement is no different from any other encounter's documentation requirement.

Medicare pays for medically necessary and reasonable services and expects the person receiving payment to be the one delivering the services and creating the record. The scribe should not act independently, and there is no payment for the services of the scribe.

Sources: *American Academy of Professional Coders – Use Scribes Appropriately*
American Health Information Management Association – Using Medical Scribes in a Physician Practice
American College of Emergency Physicians Scribe FAQ
The Joint Commission Scribe FAQ
Ensuring Proper Use of Electronic Health Record Features and Capabilities: A Decision Table

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

Note: This article was revised October 13, 2015, to correct a code in the modified codes – RARC table. The code of N109 is now shown in that table, instead of the incorrect code of M109. All other information remains the same. This article was previously published in the August 2015 edition of *Medicare A Connection, Pages 14-15*.

Provider types affected

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

Provider action needed

Stop – Impact to You

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your MAC for a *Current Procedural Terminology* (*CPT*®) code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

Caution – what you need to know

Change request (CR) 9278 updates the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists and also instructs Medicare system maintainers to update Medicare remit easy print (MREP) and PC print software used by some providers.

Go – What you need to do

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

Background

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

The CARC and RARC changes that impact Medicare are usually requested by staff of the Centers for Medicare & Medicaid Services (CMS), in conjunction with a policy change. MACs are notified about these changes in the corresponding instructions from the specific

CMS component that implements the policy change,

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

If any new or modified code has an effective date past the implementation date specified in CR 9278, MACs must implement on the effective date found at the WPC website.

The discrepancy between the dates may arise because the Washington Publishing Company (WPC) website gets updated only three times per year and may not match the CMS release schedule. CR 9278 lists only the changes that have been approved since the last code update by CR 9125, issued April 13, 2015, and does not provide a complete list of codes for these two code sets.

The WPC website has four listings available for both CARC and RARC. Those listings are available at *http://www.wpc-edi.com/Reference* on the WPC website.

Changes in RARC list since CR 9125

New codes – RARC

Code	Modified narrative	Effective date
N753	Missing/Incomplete/Invalid attachment control number.	07/01/2015
N754	Missing/Incomplete/Invalid referring provider or other source qualifier on the 1500 claim form.	07/01/2015
N755	Missing/Incomplete/Invalid ICD Indicator on the 1500 Claim Form.	07/01/2015
N756	Missing/Incomplete/Invalid point of drop-off address,	07/01/2015

See **RARC**, next page

RARC

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Code	Modified narrative	Effective date
N757	Adjusted based on the federal indian fees schedule (MLR).	07/01/2015
N758	Adjusted based on the prior authorization decision.	07/01/2015
N759	Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013.	07/01/2015

Modified codes – RARC

Code	Modified narrative	Effective date
M47	Missing/Incomplete/Invalid payer claim control number. Other terms exist for this element including, but not limited to, internal control number (ICN), claim control number (CCN), document control number (DCN).	07/01/2015
MA74	Alert: This payment replaces an earlier payment for this claim that was either lost, damaged or returned.	07/01/2015
N432	Alert: Adjustment based on a recovery audit.	07/01/2015
N22	Alert: This procedure code was added/changed because it more accurately describes the services rendered.	07/01/2015
M39	Alert: The patient is not liable for payment of this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	07/01/2015
N109	Alert: This claim/service was chosen for complex review.	07/01/2015
M38	Alert: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges.	07/01/2015
N381	Alert: Consult our contractual agreement for restrictions/billing/ payment information related to these charges.	07/01/2015
MA91	Alert: This determination is the result of the appeal you filed.	07/01/2015

Deactivated codes - RARC

Code	Current narrative	Effective date
N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.	07/01/2016

***N735- This RARC is not included in the list of deactivated codes because CMS did not add this code during the previous release when it was included on the WPC website. The RARC was previously added to the WPC website erroneously.**

Changes in CARC list since CR 9125

New code – CARC

Code	Modified narrative	Effective date
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.	07/01/2015

Modified code – CARC

Code	Modified narrative	Effective date
45	Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement. Note: This must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with group codes PR or CO depending upon liability.)	11/01/2015

There have been no **deactivated** CARC codes since CR 9125. In case of any discrepancy in the code text as

See **RARC**, next page

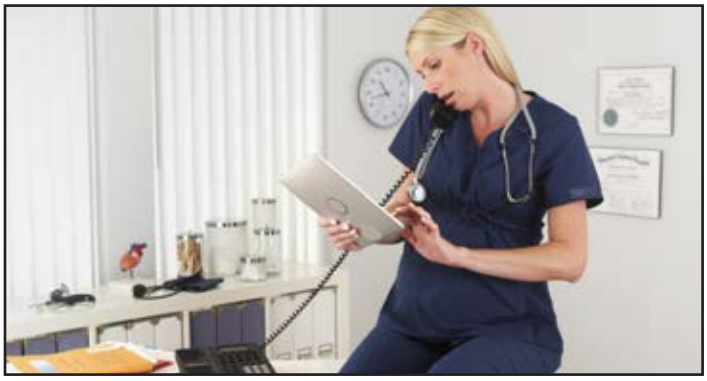
Billing clarification for IPF and LTCH PPS claims that span October 1, 2015

The Centers for Medicare & Medicaid Services (CMS) has received inquiries concerning inpatient psychiatric facility (IPF) and long term care hospital (LTCH) claims returning to providers when the claim's dates of service span October 1, 2015, and benefits exhaust date (Occurrence Code A3) with a date prior to October 1, 2015, exists on the same claim.

As a reminder, in accordance with previous instruction in *change request 5474*, IPF and LTCH prospective payment system (PPS) providers must split these claims using the following example as guidance:

- A provider submits a claim with dates of service September 25, 2015 through October 5, 2015. In good faith, the provider did not know that benefits would exhaust on the claim and used appropriate coding valid on and after October 1, 2015. The claim goes to common working file (CWF) and benefits are exhausted on September 25, 2015. Since the benefits exhaust date is considered the discharge date, FISS will edit the claim and suspend with a Medicare code error (MCE).

The Medicare administrative contractors (MAC) will return the claim to the provider to have the provider split the bill.



- The first claim should be a bill type 112 with a date of service September 25, 2015, through September 28, 2015, with a patient status 30.
- The next and final claim should be bill type 110 with dates of service September 29, 2015, through October 5, 2015, with the appropriate discharge patient status. Providers should resubmit the split claims with the appropriate coding based on dates of service.

Providers may review *MLN Matters® article MM5474* for additional clarification.

RARC

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posted on the WPC website and as reported in any CR, the WPC version should be implemented.

Additional information

The official instruction, CR 9278, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3298CP.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: MM9278 *Revised*
Related Change Request (CR) #: CR 9278
Related CR Release Date: August 6, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3298CP
Implementation Date: October 5, 2015

October 2015 Medicare physician fee schedule database update

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit claims to Medicare administrative contractors (MACs) for services subject to the Medicare physician fee schedule database (MPFSDB) that are provided to Medicare beneficiaries.

What you need to know

Changes included in the October update to the 2015 MPFSDB are effective for dates of service on and after January 1 (unless otherwise stated). The key change is to the malpractice relative value units (RVU) of the following *CPT*®/HCPCS codes: *33471, 33606, 33611, 33619, 33676, 33677, 33692, 33737, 33755, 33762, 33764, 33768, 33770, 33771, 33775, 33776, 33777, 33778, 33779, 33780, 33781, 33783, 33786, 33803, 33813, 33822, 33840*, and *33851*; and the work RVUs for G0105 and G0121.

The RVU changes for these codes are retroactive to January 1, 2015. In addition, effective January 1, 2015, codes *76641*, *76641*-TC, *76641*-26, *76642*, *76642*-TC, *76642*-26, *95866*, *95866*-TC, and *95866*-26 have a revised bilateral surgery indicator = 3.

Also, effective October 1, 2015, *CPT*®/HCPCS code Q9979 is assigned a procedure status indicator of E (Excluded from the PFS by regulation. These codes are for items and services that CMS has excluded from the PFS by regulation. No payment may be made under the PFS for these codes and generally, no RVUs are shown.).

Background

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

Payment files were issued to the MACs based upon the 2015 Medicare physician fee schedule (MPFS) final rule, published in the *Federal Register* December 19, 2014,

to be effective for services furnished between January 1, 2015, and December 31, 2015.

Additional information

The official instruction, CR 9266 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R3364CP.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: MM9266
Related Change Request (CR) #: CR 9266
Related CR Release Date: September 29, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R3364CP
Implementation Date: October 5, 2015

CMS releases October 2015 integrated outpatient code editor specifications

This article was revised on September 24, 2015, to reflect the revised change request (CR) 9290 issued September 23. In the article, the table below has been updated to include the modification to edit 68 for HCPCS code Q5101 and to clarify the entry in that table regarding edit 87. In addition, the CR release date, transmittal number, and the Web address for accessing the CR are revised. all other information remains the same.

Provider types affected

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

Provider action needed

Stop – impact to you

Be aware that the integrated/outpatient code editor (I/OCE) is being updated for October 1, 2015. CR 9290 details those changes.

Caution – what you need to know

CR 9290 provides the instructions and specifications for the I/OCE to be used under the outpatient prospective payment system (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the home health prospective payment system (PPS) or to a hospice patient for the treatment of a non-terminal illness. This notification applies to Chapter 4, Section 40.1 of the *Medicare Claims Processing Manual*, which is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

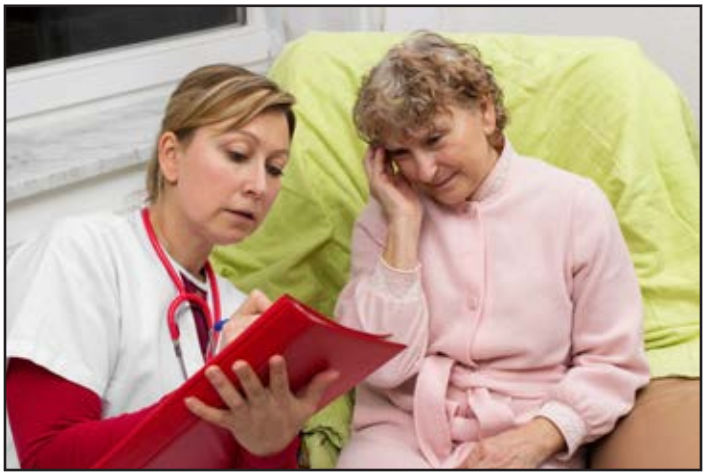
Go – what you need to do

Make sure that your billing staffs are aware of the updated I/OCE for October 1, 2015.

Background

CR 9290 provides the I/OCE instructions and specifications for the Integrated OCE that will be utilized under the OPPS and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the home health PPS or to a hospice patient for the treatment of a non-terminal illness. The I/OCE specifications will be posted online and can be found at *http://www.cms.gov/OutpatientCodeEdit/.*

The modifications of the I/OCE for the October 2015



release (V16.3) are summarized in the table below. Some I/OCE modifications in this update may be retroactively added to prior releases. If so, the retroactive date appears in the "Effective Date" column.

Effective date	Edits affected	Modification
9/3/2015	68	Implement mid-quarter national coverage determination (NCD) edit effective date for HCPCS Q5101.
10/1/2015	87	Modify the program logic to not ignore skin substitute product code(s) present with line item action flag 2 in order to process edit 87. Corrects effective date to 10/1/2015 from erroneous date in program logic of 4/1/2015. No change to documentation.
10/1/2015	87	Update to the skin substitute product list (move HCPCS Q4151 from List A to List B – Appendix P, list E of CR9290).
10/1/2015	88, 89	Modify the program logic to not assign edits 88 and 89 for federally qualified health center (FQHC) PPS claims when only FQHC non-covered services are present with edit 91 (page 11; Appendix M processing steps and flowchart).

See **I/OCE**, next page

I/OCE

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Effective date	Edits affected	Modification
10/1/2015	2, 3, 86	Update the diagnosis/age and diagnosis/sex conflict, and manifestation edits based on the official ICD-10-CM diagnosis code editing content for the MCE.
10/1/2015		Modify the diagnosis code content to replace all preliminary ICD-10-CM content with the official ICD-10-CM code content effective for 10/1/2015; restrict the use of ICD-9-CM code content for historical claims with from dates through 9/30/2015.
10/1/2015		Updates to FQHC non-covered procedures and flu/PPV vaccine lists (see quarterly data file changes).
10/1/2015		Make Healthcare Common Procedure Coding System (HCPCS)/ Ambulatory Payment Classification (APC)/Status Indicator (SI) changes as specified by CMS (data change files).
10/1/2015	20, 40	Implement version 21.3 of the NCCI (as modified for applicable institutional providers).
10/1/2015		Update the IOCE PC product User and Installation Manual for removal of support for Microsoft® Windows® versions 2000, XP and Vista; add support for Microsoft® Windows® version 8.1.
10/1/2015		Update page 3 and Table 1 (OCE Control Block) to indicate ICD-10-CM diagnosis codes as the primary diagnosis code set with ICD-9-CM diagnosis codes remaining for historical claims.

Note: Readers should also read through the entire CR 9290 document and note the highlighted sections, which also indicate changes from the prior release of the software. A full summary of data changes in I/OCE V16.3, including diagnosis, HCPCS, *Current Procedural Terminology* (*CPT*®) and APC codes, is attached to the CR.

Additional information

The official instruction, CR 9290, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3359CP.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: MM9290 *Revised*
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or after October 1, 2002. The Centers for Medicare & Medicaid Services (CMS) is required to make updates to these prospective payment systems annually.

Change request (CR) 9253 outlines those changes for FY 2016. The following policy changes for FY 2016 were displayed in the *Federal Register* on July 31, 2015, with a publication date of August 17, 2015. CR 9253 is effective for hospital discharges occurring on or after October 1, 2015, through September 30, 2016, unless otherwise noted.

A. FY 2016 IPPS rates and factors

The FY 2016 IPPS rates and factors and operating rates are in the following table along with Figure 1 and Figure 2 on the following page:

Rate	Factor
Standardized amount applicable percentage increase	▪ 1.017 if quality = '1' and EHR = 'blank' in PSF; or ▪ 1.011 if quality = '0'and EHR = 'blank' in PSF; or ▪ 1.005 if quality = '1'and EHR = 'Y' in PSF; or ▪ 0.999 if quality = '0'and EHR = 'Y' in PSF
Common fixed loss cost outlier threshold	$22,539
Federal capital rate	$438.75
Puerto Rico capital rate	$212.55

Figure 1 – Operating rates for wage index > 1

B. Pricer logic changes

Pricer now applies the rural floor wage index policy to the Puerto Rico specific wage index for Puerto Rico providers. It compares each Puerto Rico provider's Puerto Rico specific core based statistical area (CBSA) wage index to the rural Puerto Rico CBSA (" 4*") wage index. If the rural Puerto Rico specific wage index is higher than the provider's Puerto Rico specific CBSA wage index, Pricer uses the rural Puerto Rico specific wage index for the provider.

C. MS-DRG grouper and Medicare code editor (MCE) changes

The grouper contractor, 3M Health Information Systems (3M-HIS), developed the new ICD-10 MS-DRG grouper, version 33.0, software package effective for discharges on or after October 1, 2015.

The grouper assigns each case into a MS-DRG on the basis of the reported diagnosis and procedure codes and demographic information (that is, age, sex, and discharge status). The ICD-10 MCE version 33.0, which is also developed by 3M-HIS, uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after October 1, 2015.

For discharges occurring on or after October 1, 2015, the fiscal intermediary standard system (FISS) calls the appropriate grouper based on discharge date. For discharges occurring on or after October 1, 2015, the MCE selects the proper internal code edit tables based on discharge date.

CMS created the following new MS-DRGs:

- MS-DRG 268 (Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC)

	Hospital submitted quality data and is a meaningful EHR user (update = 1.7 percent)		Hospital did NOT submit quality data and is a meaningful EHR user (update = 1.1 percent)		Hospital submitted quality data and is NOT a meaningful EHR user (update = 0.5 percent)		Hospital did NOT submit quality data and is NOT a meaningful EHR user (update = -0.1 percent)	
	Labor	**Non-labor**	**Labor**	**Non-labor**	**Labor**	**Non-labor**	**Labor**	**Non-labor**
National	$3,805.30	$1,662.09	$3,782.85	$1,652.28	$3,760.40	$1,642.48	$3,737.95	$1,632.67
PR national	$3,805.30	$1,662.09	$3,805.30	$1,662.09	$3,805.30	$1,662.09	$3,805.30	$1,662.09
Puerto Rico specific	$1,650.00	$960.77	$1,650.00	$960.77	$1,650.00	$960.77	$1,650.00	$960.77

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Figure 2 – Operating rates for wage index < 1

	Hospital submitted quality data and is a meaningful EHR user (update = 1.7 percent)		Hospital did NOT submit quality data and is a meaningful EHR user (update = 1.1 percent)		Hospital submitted quality data and is NOT a meaningful EHR user (update = 0.5 percent)		Hospital did not submit quality data and is NOT a meaningful EHR user (update = -0.1 percent)	
	Labor	**Non-labor**	**Labor**	**Non-labor**	**Labor**	**Non-labor**	**Labor**	**Non-labor**
National	$3,389.78	$2,077.61	$3,369.78	$2,065.35	$3,349.79	$2,053.09	$3,329.78	$2,040.84
PR National	$3,389.78	$2,077.61	$3,389.78	$2,077.61	$3,389.78	$2,077.61	$3,389.78	$2,077.61
Puerto Rico Specific	$1,618.68	$992.09	$1,618.68	$992.09	$1,618.68	$992.09	$1,618.68	$992.09

- 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)
- MS-DRG 273 (Percutaneous Intracardiac Procedures with MCC) and
- MS-DRG 274 (Percutaneous Intracardiac Procedures without MCC).

CMS deleted the following MS-DRGs:

- MS-DRG 237 (Major Cardiovascular Procedures with MCC) and
- MS-DRG 238 (Major Cardiovascular Procedures without MCC).

D. Post-acute transfer and special payment policy

The changes to MS-DRGs for FY 2016 have been evaluated against the general post-acute care transfer policy criteria using the FY 2014 MedPAR data according to the regulations under Section 412.4 (c). As a result of this review the following MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy and special payment policy:

- 273 and 274 (Percutaneous Intracardiac Procedures with and without MCC, respectively)

See corrected Table 5 of the *FY 2016 IPPS/LTCH PPS Final Rule* and subsequent correction notice for a listing of all post-acute and special post-acute MS-DRGs. Then click on the link on the left side of the screen titled, "FY 2016 IPPS Final Rule Home Page" or "Acute Inpatient Files for Download".

E. New technology add-on

The following items will continue to be eligible for new-technology add-on payments in FY 2016:

1. Name of approved new technology: Argus

- Maximum add on payment: $72,028.75;
- MACs will identify and make new technology add-on payments with ICD-10-PCS procedure code 08H005Z or 08H105Z.

2. Name of approved new technology: Kcentra

- Maximum add on payment: $1,587.50;
- MACs will identify and make new technology add-on payments with ICD-10-PCS procedure code 30283B1;
- MACs will **not** make this payment if one of the following diagnosis codes are on the bill: D66, D67, D68.1, D68.2, D68.0, D68.311, D68.312, D68.318, D68.32, and D68.4.

3. Name of approved new technology: MitraClip® system

- Maximum add on payment: $15,000;
- MACs will identify and make new technology add-on payments with ICD-10-PCS procedure code 02UG3JZ.

4. Name of approved new technology: RNS® system

- Maximum add on payment: $18,475;
- MACs will identify and make new technology add-on payments with ICD-10-PCS procedure code 0NH00NZ in combination with 00H00MZ

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Following are the items that are eligible for new-technology add-on payments in FY 2016:

5. Name of approved new technology: Blinatumomab (BLINCYTO™)

- Maximum add on payment: $27,017.85;
- MACs will identify and make new technology add-on payments with ICD 10 PCS procedure code XW03351 or XW04351.

6. Name of approved new technology: LUTONIX® Drug Coated Balloon (DCB) Percutaneous Transluminal Angioplasty (PTA) and IN.PACT™**Admiral™ Pacliaxel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter**

- Maximum add on payment: $1,035.72;
- MACs will identify and make new technology add-on payments with any of the following ICD-10-PCS procedure codes: 047K041, 047K0D1, 047K0Z1, 047K341, 047K3D1, 047K3Z1, 047K441, 047K4D1, 047K4Z1, 047L041, 047L0D1, 047L0Z1, 047L341, 047L3D1, 047L3Z1, 047L441, 047L4D1, 047L4Z1, 047M041, 047M0D1, 047M0Z1, 047M341, 047M3D1, 047M3Z1, 047M441, 047M4D1, 047M4Z1, 047N041, 047N0D1, 047N0Z1, 047N341, 047N3D1, 047N3Z1, 047N441, 047N4D1, and 047N4Z1.

F. Cost of living adjustment update for IPPS PPS

The IPPS incorporates a cost of living adjustment (COLA) for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2016, and are the same COLAs established for FY 2014. For reference, a table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2014, can be found in the FY 2016 IPPS/LTCH PPS final rule and is also displayed in Table 2 in attachment 1 of CR 9253.

G. FY 2016 wage index changes and issues

1. New wage index labor market areas and transitional wage indexes

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

In order to mitigate potential negative payment impacts due to the adoption of the new OMB delineations, CMS adopted a one-year transition for FY 2015 for hospitals that are experiencing a decrease in their wage index exclusively due to the implementation of the new OMB delineations. This transition adjustment expired effective October 1, 2015, and is not applicable in FY 2016.

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

That is, for FYs 2015, 2016, and 2017, assuming no other form of wage index reclassification or re-designation is granted, these hospitals are assigned the area wage index value of the urban CBSA in which they were geographically located in FY 2014. Note that for hospitals that are receiving the three-year hold-harmless wage index, the transition is only for the purpose of the wage index and does not affect the hospital's urban or rural status for any other payment purposes.

2. Treatment of certain providers re-designated under Section 1886(d)(8)(B) of the Social Security Act (or The Act)

42 CFR 412.64(b)(3)(ii) implements Section 1886(d)(8)(B) of the Act, which re-designates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as "Lugar counties".)

Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are re-designated. A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes.

3. Section 505 hospital (out-commuting adjustment)

Section 505 of the Medicare Modernization Act of 2003 (MMA), also known as the "outmigration adjustment," is an adjustment that is based primarily on commuting patterns and is available to hospitals that are not reclassified by the Medicare geographic classification review board (MGCRB).

H. Treatment of certain urban hospitals reclassified as rural hospitals under Section 412.103

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An urban hospital that reclassifies as a rural hospital under Section 412.103 is considered rural for all IPPS purposes. **Note**: hospitals reclassified as rural under Section 412.103 are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see Section 412.320(a)(1)).

I. Multi-campus hospitals with inpatient campuses in different CBSAs

Beginning with the FY 2008 wage index, CMS instituted a policy that allocates the wages and hours to the CBSA in which a hospital campus is located when a multi-campus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility at which the discharge occurred. Also note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA. In general, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers.

J. Updating the provider specific file (PSF) for wage index, re-classifications, and re-designations

CR 9253 provides MACs with instructions for updating their PSF with appropriate wage index based on policies mentioned above.

K. Medicare-dependent, small rural hospital program

The Medicare dependent hospital (MDH) program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. The MDH program is currently effective through September 30, 2017, as provided by Section 205 of the Medicare Access and CHIP Reauthorization Act of 2015. Provider Types 14 and 15 continue to be valid through September 30, 2017.

L. Hospital specific rate factors for sole community hospitals and MDHs

For FY 2016, the hospital specific (HSP) amount in the PSF for sole community hospitals (SCH) and MDHs will continue to be entered in FY 2012 dollars. pricer will apply the cumulative documentation and coding adjustment factor for FYs 2011 through 2014 of 0.9480 and apply all of the updates and DRG budget neutrality factors to the HSP amount for FY 2013 and beyond.

M. Low-volume hospitals – criteria and payment adjustments for FY 2016

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, expanded the definition of a low-volume hospital and

modified the methodology for determining the payment adjustment for hospitals meeting that definition. Section 204 of the Medicare Access and CHIP Reauthorization Act of 2015 extended the temporary changes to the low-volume hospital payment adjustment through September 30, 2017.

In order to qualify as a low-volume hospital in FY 2016, a hospital must be located more than 15 road miles from another “subsection (d) hospital” and have less than 1600 Medicare discharges (which includes Medicare Part C discharges and is based on the latest available MedPAR data). The applicable low-volume percentage increase is determined using a continuous linear sliding scale equation that results in a low-volume hospital payment adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more Medicare discharges.

For FY 2016, qualifying low-volume hospitals and their payment adjustment are determined using Medicare discharge data from the March 2015 update of the FY 2014 MedPAR file. Attachment 9 of CR 9253 is the corrected Table 14 of the *FY 2016 IPPS/LTCH PPS final rule* and subsequent correction notice, which will be available and lists the “subsection (d)” hospitals with fewer than 1,600 Medicare discharges based on the March 2015 update of the FY 2014 MedPAR file and their low-volume hospital payment adjustment for FY 2016 (if eligible). CMS notes that the list of hospitals with fewer than 1,600 Medicare discharges in Table 14 does not reflect whether or not the hospital meets the mileage criterion (that is, the hospital is located more than 15 road miles from any other subsection (d) hospital, which, in general, is an IPPS hospital).

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

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

To receive a low-volume hospital payment adjustment under Section 412.101 for FY 2016, a hospital must have made a written request for low-volume hospital status that is received by its MAC no later than September 1, 2015, in order for the applicable low-volume hospital payment adjustment to be applied to payments for discharges occurring on or after October 1, 2015.

Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment in FY 2015 may continue to receive a low-volume hospital payment adjustment for FY 2016 without reapplying if it continues to meet the Medicare discharge criterion established for FY 2016 (as shown in corrected Table 14 of the FY 2016 IPPS/LTCH PPS Final Rule and subsequent correction notice) and the mileage criterion.

However, the hospital must have sent a written verification that was received by its MAC no later than September 1, 2015, stating that it continues to be more than 15 miles from any other "subsection (d)" hospital. This written verification could be a brief letter to the MAC stating that the hospital continues to meet the low-volume hospital distance criterion as documented in a prior low-volume hospital status request.

If a hospital's written request for low-volume hospital status for FY 2016 was received after September 1, 2015, and if the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital's FY 2016 discharges, effective prospectively within 30 days of the date of its low-volume hospital status determination.

The MAC will determine, based on the most recent data available, if the hospital qualifies as a low-volume hospital, so that the hospital will know in advance whether or not it will receive a payment adjustment for the FY. The MAC and CMS may review available data, in addition to the data the hospital submits with its request for low-volume hospital status, in order to determine whether or not the hospital meets the qualifying criteria.

N. Hospital quality initiative

The hospitals that will receive the quality initiative bonus are listed at *www.qualitynet.org* on the Internet. Should a provider later be determined to have met the criteria

after publication of this list, they will be added to the website, and MACs will update their file as needed. A list of hospitals that will receive the statutory reduction to the annual payment update for FY 2016 under the hospital inpatient quality reporting (IQR) program was provided to the MACs.

O. Hospital-acquired condition reduction program

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

Under the HAC reduction program, a 1-percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital's discharges for the specified fiscal year.

The HAC reduction program adjustment amount (that is, the 1-percent payment reduction) is calculated after all other IPPS per discharge payments, which includes adjustments for DSH (including the uncompensated care payment), IME, outliers, new technology, readmissions, VBP, low-volume hospital payments, and capital payments. This amount will be displayed in the HAC 'PAYMENT AMT' field in the IPPS pricer output record. For SCHs and MDHs, the HAC reduction program adjustment amount applies to either the federal rate payment amount or the hospital-specific rate payment amount, whichever results in a greater operating IPPS payment.

A list of providers subject to the HAC reduction program for FY 2016 was not publicly available in the final rule because the review and correction process was not yet completed. CMS provided the MACS with a preliminary list of hospitals subject to the HAC reduction program.

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Updated hospital level data for the HAC reduction program will be made publicly available following the review and corrections process.

P. Hospital value based purchasing

Section 3001 of the Affordable Care Act added Section 1886(o) to the Social Security Act, establishing the hospital value-based purchasing (VBP) program. This program began adjusting base operating DRG payment amounts for discharges from subsection (d) hospitals, beginning in FY 2013.

Under its current agreement with CMS, Maryland hospitals are not subject to the hospital VBP program for the FY 2016 program year. The regulations that implement this provision are in Subpart I of 42 CFR Part 412 (Section 412.160 through Section 412.162).

Under the hospital VBP program, CMS reduces base operating DRG payment amounts for subsection (d) hospitals by the applicable percent defined in statute. The applicable percent for payment reductions for FY 2016 is 1.75 percent. This percent is gradually increasing each fiscal year from 1.0 in FY 2013 to 2.0 percent in FY 2017.

These payment reductions fund value-based incentive payment to hospitals that meet or exceed performance standards on the measures selected for the program.

By law, CMS must base value-based incentive payments on hospitals' performance under the hospital VBP program, and the total amount available for value-based incentive payments must be equal to the amount of payment reductions, as estimated by the Secretary of Health and Human Services.

CMS calculates a total performance score (TPS) for each hospital eligible for the hospital VBP program. CMS then uses a linear exchange function to convert each hospital's TPS into a value-based incentive payment.

Based on that linear exchange function's slope, as well as an individual hospital's TPS, the hospitals' own annual base operating DRG payment amount and the applicable percent reduction to base operating DRG payment amounts, CMS calculates a value-based incentive payment adjustment factor that will be applied to each discharge at a hospital, for a given fiscal year.

For FY 2016, CMS will implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2016. CMS expects to post the value-based incentive payment adjustment factors for FY 2016 in the near future in Table 16B of the FY 2016 IPPS/LTCH PPS final rule, which will be available on the CMS website. (MACs received subsequent communication of the value-based incentive payment adjustment factors for FY 2016 in Table 16B.)

Q. Hospital readmissions reduction program

For FY 2016, the readmissions adjustment factor is the higher of a ratio or 0.97 (-3 percent). The readmissions adjustment factor is applied to a hospital's "base operating DRG payment amount" that is, the wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable), to determine the reduction amount under the hospital readmissions reduction program.

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

For FY 2016, the portion of a MDH's payment reduction due to excess readmissions that is based on 75 percent difference between payment under the hospital-specific rate and payment under the federal rate will be determined at cost report settlement.

Consequently, in determining the claim payment, the pricer will continue to only apply the readmissions adjustment factor to a MDH's wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable) to determine the payment reduction due to excess readmissions.

The readmissions payment adjustment factors for FY 2016 are in Table 15 of the FY 2016 IPPS/LTCH PPS final rule, which will be available on the CMS website. Hospitals that are not subject to a reduction under the hospital readmissions reduction program in FY 2016 (such as Maryland hospitals) have a readmission adjustment factor of 1.0000. For FY 2016, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.

Note: Hospitals located in Maryland (for FY 2016) and in Puerto Rico are not subject to the hospital readmissions reduction program, and therefore, are not listed in Table 15.

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R. Medicare disproportionate share hospitals program

Section 3133 of the Affordable Care Act modified the Medicare disproportionate share hospital (DSH) program beginning in FY 2014. Starting in FY 2014, hospitals received 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH.

The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured.

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

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

The total uncompensated care payment amount to be paid to the Medicare DSH hospitals was finalized in the FY 2016 IPPS Final Rule. The uncompensated care payment will be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2016.

The estimated per claim amount is determined by dividing the total uncompensated care payment by the average number of claims from the most recent three years of claims data (FY 2012-2014). CMS is issued a correction notice to the FY 2016 IPPS final rule, which changed each provider's uncompensated care payment per claim amounts.

Attachment 3 of CR 9253 includes the updated estimated per discharge uncompensated care payment amounts per claim to be used for updating the PSF, which will be displayed in the corrected Medicare DSH supplemental data file for the corrected notice to the FY 2016 IPPS Final rule on the CMS website.

The estimated per discharge uncompensated care payment amount will be included in the outlier payment determinations.

In addition the estimated per discharge uncompensated care payment amount will be included as a federal payment for SCHs to determine if a claim is paid under

the hospital-specific rate or federal rate and for Medicare dependent hospitals to determine if the claim is paid 75 percent of the difference between payment under the hospital-specific rate and payment under the federal rate.

The total uncompensated care payment amount finalized in the correction notice to the FY 2016 IPPS Final Rule will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis.

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

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

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

In the second year after a hospital loses urban status, the hospital will receive an additional payment that equals one third of the difference between the DSH payments applicable to the hospital before its re-designation from urban to rural and the DSH payments otherwise applicable to the hospital subsequent to its re-designation from urban to rural.

This adjustment will be determined at cost report settlement. In determining the claim payment, the pricer will only apply the DSH payment adjustment based on its urban/rural status according to the re-designation.

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S. Recalled devices

A hospital's IPPS payment is reduced, for specified MS-DRGs, when the implantation of a device is replaced without cost or with a credit equal to 50 percent or more of the cost of the replacement device.

New MS-DRGs are added to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they are formed from procedures previously assigned to MS-DRGs that were already on the list.

MS-DRGs 266 and 267 (Endovascular Cardiac Valve Replacement with MCC and Endovascular Cardiac Valve Replacement without MCC, respectively) were inadvertently omitted from the list of MS-DRs subject to the policy for FY 2015; therefore they are being added to the list with an effective date retroactive to October 1, 2014.

For FY 2016, MS-DRGs 237 and 238 (Major Cardiovascular Procedures with MCC and without MCC, respectively) will be deleted.

The following MS-DRGs will be added:

- 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)
- MS-DRG 273 (Percutaneous Intracardiac Procedures with MCC)
- MS-DRG 274 (Percutaneous Intracardiac Procedures without MCC)

The complete list of MS-DRGs subject to the IPPS policy for replaced devices offered without cost or with a credit and their effective and termination dates is displayed in *CR 9121.*

LTCH PPS FY 2016 update

A. FY 2016 LTCH PPS rates and factors

FY 2016 LTCH PPS rates and factors are in the following table:

Table - FY 2016 LTCH PPS rates and factors

Rate	Factor
LTCH PPS standard federal rates	Rates based on successful reporting of quality data. ▪ Full update (quality indicator on PSF = 1): $41,762.85 ▪ Reduced update (quality indicator on PSF = 0 or blank): $40,941.55
Labor share	62.0 percent
Non-labor share	38.0 percent
High-cost outlier fixed-loss amount for standard federal rate discharges	$16,423
High-cost outlier fixed-loss amount for site-neutral rate discharges	$22,539

The LTCH PPS pricer has been updated with the version 33.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2015, and on or before September 30, 2016.

1. Application of the site neutral payment rate

Section 1206(a) of Public Law 113–67 amended Section 1886(m) of the Act to establish patient-level criteria for payments under the LTCH PPS for implementation for cost reporting periods beginning on or after October 1, 2015.

This revision to payments under the LTCH PPS established a dual-rate payment structure, under which discharges are paid based on either of the following:

- The LTCH PPS standard federal payment rate (that is, generally consistent with the payment amount determined under the LTCH PPS prior to the amendments made by Public Law 113–67) for LTCH cases meeting the specified patient criteria upon discharge; or
- The site neutral payment rate (that is, the lesser of an "IPPS-comparable" payment amount determined under Section 412.529(d)(4), including a high cost outlier payment under Section 412.525(a) as applicable, or 100 percent of the estimated cost of the case as determined under Section 412.529(d)(2)) for those cases not the meeting specified patient criteria upon discharge.

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In order to be paid at the LTCH PPS standard federal rate amount, the following criteria must be met:

- The discharge must not have a principal diagnosis in the LTCH of a psychiatric diagnosis or rehabilitation as indicated by the grouping of the discharge into one of 15 "psychiatric and rehabilitation" MS-LTC-DRGs (that is, MS-LTC-DRGs 876, 880, 881, 882, 883, 884, 885, 886, 887, 894, 895, 896, 897, 945, and 946).
- The discharge must have been immediately preceded by an IPPS hospital discharge ("immediately preceded" is defined as the LTCH admission occurring within one day of the IPPS hospital discharge based on the admission date on the LTCH discharge claim and the discharge date on the IPPS hospital claim).
- The patient discharged from the LTCH must have spent three days in the ICU during the immediately preceding IPPS hospital stay (discharges meeting this criteria will be identified by the use of revenue center codes 020x and 021x on the IPPS hospital discharge claim) or have received at least 96 hours of respiratory ventilation services during the LTCH stay (which will generally be identified by the use of ICD-10-PCS procedure code 5A1955Z on the LTCH claim).

The site neutral payment rate amount will be paid for patients discharged from the LTCH that do not meet the above criteria. The application of the site neutral payment rate is codified in the regulations at Section 412.522.

Additional information on the final policies implementing the application of the site neutral payment rate are in the FY 2016 Final Rule (80 FR 49601-49623). Information on the requirements implementing the application of the site neutral payment rate are in CR 9015. A related *MLN Matters*® article, *MM9015*, is available on the CMS website.

Existing LTCH PPS policies, such as the short-stay outlier (SSO) policy (for discharges paid the LTCH PPS standard federal rate) and the interrupted stay policy, will continue to apply in determining the applicable payment amount (that is, site neutral payment rate or standard Federal payment rate) under the LTCH PPS.

2. Transition blended payment rate for 2016 and 2017

Public Law 113-67 establishes a transitional payment method site neutral payment rate for LTCH discharges occurring in cost reporting periods beginning during FY 2016 or FY 2017. The blended payment rate is comprised of 50 percent of the site neutral payment rate for the discharge and 50 percent of the LTCH PPS standard federal payment rate that would have applied to the discharge if the provisions of Public Law 113-67 had not been enacted.

Under new Section 412.522(c)(1), the site neutral payment rate is the lower of the IPPS comparable per diem amount determined under Section 412.529(d)(4), including any applicable outlier payments under Section 412.525(a), or 100 percent of the estimated cost of the case determined under Section 412.529(d)(2).

For purposes of the blended payment rate, the payment rate that would otherwise be applicable had the provisions of Public Law 113-67 not been enacted, is the LTCH PPS standard federal payment determined under Section 412.523 (that is, the LTCH PPS standard federal payment rate that is applicable to discharges that meet the criteria for exclusion from the site neutral payment rate under new Section 412.522(a)(2)).

Under the blended payment rate at Section 412.522(c)(3), for LTCH discharges occurring in cost reporting periods beginning on or after October 1, 2015, and on or before September 30, 2017 (that is, discharges occurring in cost reporting periods beginning during FYs 2016 and 2017), the portions of the payment amounts determined under Section 412.522(c)(1) (the site neutral payment rate) and under Section 412.523 (the LTCH PPS standard federal rate) include any applicable adjustments, such as HCO payments, as applicable, consistent with the requirements under Section 412.523(d).

For example, the portion of the blended payment for the discharge that is based on the site neutral payment rate includes 50 percent of any applicable site neutral payment rate HCO payment under our revised HCO payment policy under Section 412.525(a).

Similarly, the portion of the blended payment for the discharge that is based on the LTCH PPS standard federal payment rate includes any applicable HCO payment under existing Section 412.525(a).

3. Subclause (II) LTCHs

In the FY 2015 IPPS Final Rule, CMS established a payment adjustment under the LTCH PPS at Section 412.526 for hospitals "classified under subclause (II) of subsection (d)(1)(B)(iv)" of the Act (referred to as "subclause (II) LTCHs), effective for cost reporting periods

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beginning on or after October 1, 2014, (that is, federal FY 2015 and beyond). Under this payment adjustment, payments to subclause (II) LTCHs are adjusted so that their LTCH PPS payments are generally equivalent to an amount determined under the reasonable cost-based reimbursement rules for both operating and capital-related costs. \Consequently, the application of the site neutral payment rate at Section 412.522 is not applicable to subclause (II) LTCHs.

Currently there is only one hospital meeting the statutory definition of a subclause (II) LTCH, which is located in New York. The FY 2016 LTCH PPS pricer includes logic to determine the claim payment amount for discharges from the subclause (II) LTCH that does not include the application of the site neutral payment rate in accordance with these policies.

B. Average length of stay calculation

Consistent with the amendments made by Public Law 113–67, beginning with cost reporting periods starting on or after October 1, 2015, for LTCHs which were classified as such by December 10, 2013, Medicare advantage (MA) discharges and discharges paid the site neutral payment rate will not be included in the calculation of an LTCH's average length of stay (ALOS) for the purposes of a hospital's payment classification as an LTCH under Section 412.23(e). All other requirements for calculating an LTCH's ALOS remain unchanged.

C. Discharge payment percentage

For all LTCHs' FY 2016 or later cost reporting periods, the statute requires LTCHs to be notified of their "discharge payment percentage" (DPP). The DPP is the ratio (expressed as a percentage) of the LTCHs' FFS discharges which received LTCH PPS standard federal rate payment to the LTCHs' total number of LTCH PPS discharges.

The LTCH's total number of LTCH PPS discharges for a cost reporting period and discharges which were paid at the LTCH PPS standard federal payment rate are to be determined at cost report settlement using data from the provider statistical and reimbursement report (PS&R). (Additional information regarding the identification of the discharge counts used in this calculation is forthcoming.)

To calculate the DPP, divide the number of discharges paid at the LTCH PPS standard federal payment rate by total LTCH PPS discharges. The percent equivalent of that result is the DPP. MACs will provide notification to the LTCH of its DPP upon final settlement of the cost report, beginning with cost reporting periods beginning on or after October 1, 2015. MACs may use the form letter in Attachment 2 of CR 9253 to notify LTCHs of their DPP.

D. LTCH quality reporting (LTCHQR) program

Section 3004(a) of the Affordable Care Act requires the establishment of the LTCH quality reporting (LTCHQR) program. For FY 2016, the annual update to a standard Federal rate will continue to be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance with the LTCHQR program for that year.

E. Provider specific file (PSF)

CR 9253 provides instructions for MACs to use in updating relevant fields in their PSF.

F. Cost of living adjustment under the LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2016, and are the same COLAs established in the FY 2014 IPPS/LTCH PPS final rule. For reference, a table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2015, is in the FY 2016 IPPS/LTCH PPS final rule and is also shown in Table 2 in Attachment 1 of CR 9253.

Additional information

The official instruction, *CR 9253 (R3373CP)* regarding this change is available on the CMS website.

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

MLN Matters® Number: MM9253
Related Change Request (CR) #: CR 9253
Related CR Release Date: October 14, 2015
Implementation Date: October 1, 2015
Related CR Transmittal #: R3373CP
Effective Date: October 5, 2015

2016 annual update for the health professional shortage area bonus payments

Provider types affected

This *MLN Matters*® article is intended for physicians submitting claims to Medicare administrative contractors (MACs) for services provided in health professional shortage areas (HPSAs) to Medicare beneficiaries.

Provider action needed

Change request (CR) 9342 alerts you that the annual HPSA bonus payment file for 2016 will be made available by the Centers for Medicare & Medicaid Services (CMS) to your MAC and will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2016, through December 31, 2016.

You should review physician bonuses webpage at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses* each year to determine whether you need to add modifier AQ to your claim in order to receive the bonus payment, or to see if the ZIP code in which you rendered services will automatically receive the HPSA bonus payment. Make sure that your billing staffs are aware of these changes.

Background

Section 413(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 mandated an annual update to the automated HPSA bonus payment file. CMS automated HPSA ZIP code file shall be populated using the latest designations as close as possible to November 1 of each year.

The HPSA ZIP code file shall be made available to contractors in early December of each year. MACs will implement the HPSA ZIP code file and for claims with dates of service January 1 to December 31 of the following year, shall make automatic HPSA bonus payments to physicians providing eligible services in a ZIP code contained on the file.

Additional information

The official instruction, CR 9342 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3370CP.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: MM9342
Related Change Request (CR) #: CR 9342
Related CR Release Date: October 9, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3370CP
Implementation Date: January 4, 2016

2016 amounts in controversy required to sustain appeal rights for an ALJ hearing or Federal District Court review

Section 1869(b)(1)(E) of the Social Security Act (the Act), as amended by Section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires an annual reevaluation of the dollar amount in controversy required for an administrative law judge (ALJ) hearing or federal district court review.

The amount that must remain in controversy for ALJ hearing requests filed on or before December 31, 2015, is $150. This amount will remain at $150 for ALJ hearing requests filed on or after January 1, 2016.

The amount that must remain in controversy for review in federal district court requested on or before December 31, 2015, is $1,460. This amount will increase to $1,500 for appeals to federal district court filed on or after January 1, 2016. Click *here* for more information regarding when to file an appeal.

CMS releases January 2016 drug pricing files and revisions for Medicare Part B drugs

Provider types affected

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

Provider action needed

Medicare will use the January 2016 quarterly average sales price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2016, with dates of services from January 1, 2016, through March 31, 2016.

Change request (CR) 9351, from which this article is taken, instructs MACs to implement the January 2016 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised October 2015, July 2015, and April 2015, and January 2015 files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the *Medicare Claims Processing Manual*, Chapter 4, Section 50, outpatient code editor (OCE).

The following table shows how the files will be applied.

Files	Effective for dates of service
January 2016 ASP and ASP NOC	January 1, 2016, through March 31, 2016
October 2015 ASP and ASP NOC	October 1, 2015, through December 31, 2015
July 2015 ASP and ASP NOC	July 1, 2015, through September 30, 2015

Files	Effective for dates of service
April 2015 ASP and ASP NOC	April 1, 2015, through June 30, 2015
January 2015 ASP and ASP NOC	January 1, 2015, through March 31, 2015

Additional information

The official instruction, CR 9351, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3354CP.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: MM9351
Related Change Request (CR) #: CR 9351
Related CR Release Date: September 18, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3354CP
Implementation Date: January 4, 2016

Applying therapy caps to Maryland hospitals

Note: This article was revised October 8, 2015, to reflect the revised change request (CR) 9223 issued October 7. In the article, the CR release date, transmittal number, and the Web address for accessing CR 9223 are changed. All other information remains the same. This article was previously published in the August 2015 edition of Medicare A Connection, Page 22.

Provider types affected

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

Provider action needed

Stop – impact to you

Change request (CR) 9223 revises original Medicare systems to ensure therapy services provided in Maryland hospitals are subject to the outpatient therapy per-beneficiary caps.

Caution – what you need to know

In earlier CRs, the therapy cap provisions were inadvertently not applied to Maryland hospitals when Section 3005 of the Middle Class Tax Relief and Job Creation of 2012 (MCTRJCA) applied them to other outpatient hospitals described in Section 1833(a)(8)(B) of the Social Security Act. CR 9223 corrects this oversight. It also includes corrections and clarifications to various sections of Chapter 5 of the *Medicare Claims Processing Manual*.

Go – what you need to do

Make sure that your billing staffs are aware of these system revisions related to therapy services provided in Maryland hospitals.

Background

Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) required Original Medicare to temporarily apply the therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital.

These provisions have been extended several times by additional legislation. They were implemented by CR 7785, effective October 1, 2012. (MM7785 can be viewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7785.pdf.*)

To account for future extensions of the effective dates, in January 2013, CR 7881 created a mechanism that MACs use to update a screen of 'legislation effective' indicators in their claims processing systems. (MM7881 can be viewed at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7881.pdf*.)

In those earlier CRs, the therapy cap provisions were inadvertently not applied to Maryland hospitals when MCTRJCA applied them to other outpatient hospitals described at section 1833(a)(8)(B) of the Social Security Act. CR 9223 corrects that oversight.

Key points

CR 9223 implements the following policies:

- Original Medicare pays outpatient therapy services furnished in Maryland hospitals at rates established under the Maryland all-payer model.
- The therapy caps and related provisions described at Section 1833(g) apply to hospitals paid under the Maryland all-payer model.
- Medicare will use the rates established under the all-payer model to count the therapy services of Maryland hospitals toward the therapy caps and threshold total of beneficiaries.

Additional information

The official instruction, CR 9223 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3367CP.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: MM9223
Related Change Request (CR) #: CR 9223
Related CR Release Date: October 7, 2015
Implementation Date: January 1, 2016
Effective Date: January 4, 2016
Related CR Transmittal #: R3367CP

Implementation of long-term care hospital prospective payment system based on specific clinical criteria

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on change request (CR) 9015, which informs you that Section 1206(a) of Public Law 113–67 (2013 Bipartisan Budget Act) amended Section 1886(m) of the Social Security Act (the Act) to establish patient-level criteria for standard payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015.

Caution – what you need to know

This revision to payments under the existing LTCH PPS will establish two separate payment categories for LTCH patients: standard and site neutral. See the *Background and Policy Sections* below for details.

Go – what you need to do

Make sure that your billing staffs are aware of the updated I/OCE for October 1, 2015.

Background

Medicare currently pays for inpatient hospital services for LTCH discharges under the LTCH PPS.

- Under this payment system, the Centers for Medicare & Medicaid Services (CMS) largely sets payment rates prospectively for inpatient stays based on the patient's diagnosis and severity of illness. A hospital generally receives a single payment for the case based on the payment classification, that is, the MS-LTC-DRGs assigned at discharge.
- LTCHs are required to meet the same Medicare conditions of participation (COPs) as acute care hospitals that are paid under the inpatient prospective payment system (IPPS). Under existing law, the primary criteria for a hospital to be designated as an LTCH for Medicare payment purposes is a "greater than 25 day average length of stay" requirement.

Until the enactment of the 2013 Bipartisan Budget Act (Public Law 113-67), however, there were no clinical criteria concerning the patients treated in LTCHs. Specifically, Section 1206 of this Act establishes two distinct payment categories under the LTCH PPS:

- "Standard" payments for patient discharges meeting specific clinical criteria; and
- "Site Neutral" payments for those discharges that do not meet the specified clinical criteria.

This revision to payments under the existing LTCH PPS will establish two separate payment categories for LTCH patients:

- Upon discharge, LTCH cases meeting specific clinical criteria will be paid a standard LTCH PPS payment (that is, what is generally paid under existing LTCH PPS policy); and
- Upon discharge, those cases not meeting specific clinical criteria will be paid based on a "site neutral" basis, which is the lesser of an "IPPS-comparable" payment amount or 100 percent of the estimated cost of the case.

In order to be paid at the standard LTCH PPS amount, an LTCH patient must either:

- Have been admitted directly from an IPPS hospital during which at least three days were spent in an intensive care unit (ICU) or coronary care unit (CCU), but the discharge must not be assigned to a psychiatric or rehabilitation MS-LTC-DRG in the LTCH; or
- Have been admitted directly from an IPPS hospital and the LTCH discharge includes the procedure code for ventilator services of at least 96 hours (ICD-10-CM procedure code 5A1955Z) but must not be assigned to a psychiatric or rehabilitation MS-LTC-DRG in the LTCH.

Existing LTCH PPS policies, such as the short-stay outlier (SSO) policy and the interrupted stay policy, will continue to apply in determining the standard LTCH PPS payment

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for those discharges meeting specific clinical criteria.

The "**site neutral**" amount will be paid for patients discharged from the LTCH that do not meet one or both of the above criteria. Where a site neutral payment is made, MACs will place remittance advice remarks code N741 (This is a site neutral payment.) on the remittance advice.

Site neutral payments shall not change the beneficiary's out of pocket costs. Coinsurance, if applicable, is payable by the beneficiary for the number of days used. The hospital subtracts the coinsurance amount from the Medicare payment. Days after benefits are exhausted are not charged against the beneficiary's utilization whether or not the hospital receives the full MS-LTC-DRG payment.

If there is at least one day of utilization left at the time of admission and that day is also a day of entitlement (for example, a day before the beneficiary discontinued voluntary Part A entitlement by not paying the premium), if a site neutral payment is made, the remaining "inlier" days of the stay will be considered covered until the site neutral high cost outlier is reached even though the beneficiary is not using any Medicare covered days.

The beneficiary shall not be responsible for non-utilization days. Once the beneficiary reaches the site neutral high cost outlier threshold, the beneficiary may choose to use life-time reserve days.

Additional information

The official instruction, CR 9015, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1544OTN.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: MM9015
Related Change Request (CR) #: CR 9015
Related CR Release Date: September 22, 2015
Effective Date: Discharges in cost reporting periods on or after October 1, 2015
Related CR Transmittal #: R1544OTN
Implementation Date: October 5, 2015

October 2015 update of the hospital outpatient prospective payment system

***Note**: This article was revised September 17, 2015, to reflect the revised change request (CR) 9298, issued September 15. In the article, information on Healthcare Common Procedure Coding System (HCPCS) code Q5101 has been added in subsection 'g'. and Table 6 on page 47.*

Also, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This article was previously published in the September 2015 edition of Medicare A Connection, Pages 35-37.

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

CR 9298 describes changes to and billing instructions for various payment policies implemented in the October 2015 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:

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

HCPCS code	Short desc	Long desc	OPPS SI	OPPS APC	Eff. date
C9743	Bulking/ spacer material impl	Injection/ implant-ation of bulking or spacer material (any type) with or without image guidance (not to be used if a more specific code applies)	S	0310	10/01/15

Compounded drugs

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, 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.

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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.

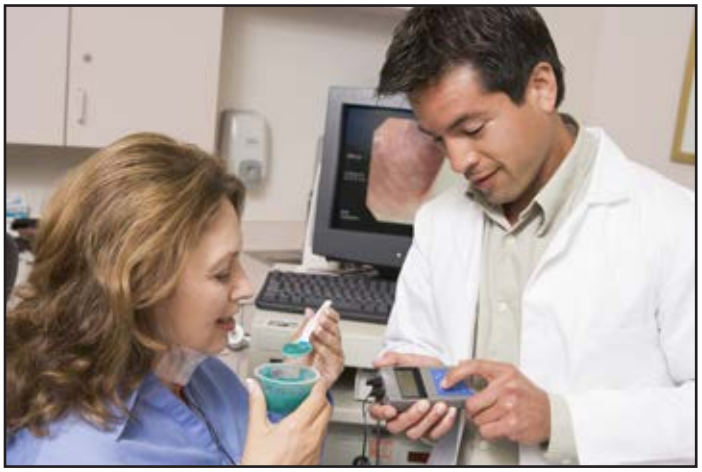
Also, physicians or facilities cannot circumvent packaged payment in the HOPD or ASC for these drugs by instructing beneficiaries to purchase and bring these drugs to the facility for administration.

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
C9457	Injection, sulfur hexafluoride lipid microsphere, per ml	9457	G

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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
Q9976	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

g. Revised status indicator for HCPCS code Q5101

Effective September 3, 2015, the status indicator for HCPCS code Q5101 (Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram) will change from SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (Paid under OPPS; separate APC payment). APC 1822 is assigned to Q5101 as shown in Table 6 below. If you had claims for Q5101 for dates of service on or after September 3, 2015, that were processed prior to the installation of the October 2015 OPPS pricer, your MAC will adjust those claims if you bring them to the attention of your MAC.

Table 6 – Drug and biological with revised status indicator effective September 3, 2015

HCPCS code	Long descriptor	APC	Status indicator
Q5101	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	1822	K

Coverage determinations

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

Additional information

The official instruction, CR 9298, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3352CP.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: September 15, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3352CP
Implementation Date: October 5, 2015

Physicians and non-physician practitioners reported on Part A critical access hospital claims

***Note**: This article was revised September 24, 2015, to change the link to the ordering referring report. That link was changed to https://data.cms.gov on the CMS website. For a complete list of any other changes to this article, please refer to the document history section. All other information remains the same. This information was previously published in the May 2015 Medicare A Connection, Page 42.*

Provider types affected

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

Provider action needed

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

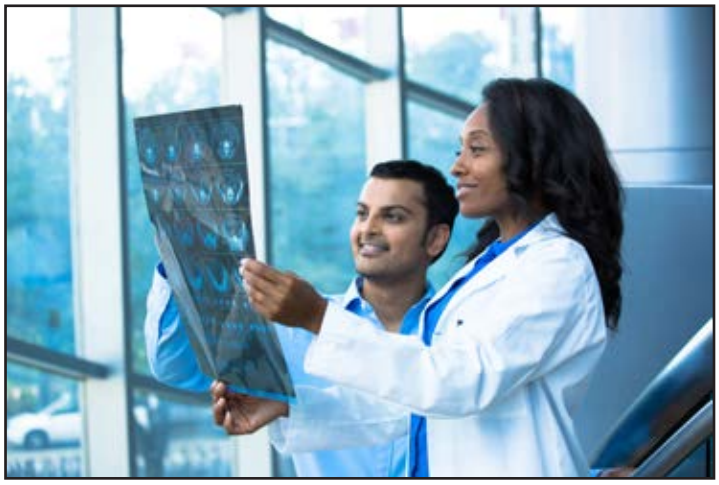
Background

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

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

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

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



System (PECOS) located at *https://pecos.cms.hhs.gov/pecos/login.do* or by completing the paper CMS-855I or CMS- 855O application, which is available at *http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html*.

Note that an application fee is not required as part of the physician's or non-physician practitioner's application submission. Only physicians and certain types of non-physician practitioners are eligible as attending or rendering providers on CAH Method II claims. Those providers are as follows:

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

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

See **OUTPATIENT**, next page

OUTPATIENT

From previous page

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

Additional information

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

When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the attending and rendering file available at *https://data.cms.gov*.

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

Document history

Date	Description
September 24, 2015	This article was revised to change the link to the ordering referring report. That link was changed to *https://data.cms.gov*.

MLN Matters® Number: SE1505 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A Related CR
Transmittal #: N/A
Implementation Date: N/A

Mass adjustments of IRF PPS claims that require a special wage index

The Centers for Medicare & Medicaid Services (CMS) discovered a system error when calculating payments for inpatient rehabilitation facility (IRF) providers that require a special wage index under the fiscal year (FY) 2016 IRF prospective payment system (PPS).

A system fix will be implemented around October 26, 2015.

Your Medicare administrative contractor (MAC) will mass adjust affected IRF PPS claims with dates of service on or after October 1, 2015.

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.

Educational Events

Provider outreach and educational events – November – December 2015

Ask-the-contractor Teleconference (ACT): An ICD-10 Update

When: Wednesday, November 18
Time: 11:30 a.m. - 1:00 p.m. ET – Delivery language: English
Type of Event: webinar
http://medicare.fcso.com/Events/0302471.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*.

MLN Connects®

CMS MLN Connects® Provider eNews

The Centers for Medicare & Medicaid Services (CMS) *MLN Connects*® Provider eNews is an official *Medicare Learning Network*® (*MLN*) – branded product that contains a week's worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the e-News to their membership as appropriate.

MLN Connects® Provider eNews for September 24, 2015

MLN Connects® Provider eNews for September 24, 2015

View this edition as a PDF

In this edition:

Countdown to ICD-10

- Use ICD-10 to Successfully Bill for Your Services
- Clarifying Questions and Answers Related to the CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities – Update
- Access the ICD-10 Code Set
- List of Valid ICD-10-CM Codes
- Claims that Span the ICD-10 Implementation Date
- Coding for ICD-10-CM: Continue to Report *CPT*®/ HCPCS Modifiers for Laterality
- Get ICD-10 Answers in One Place

MLN Connects® National Provider Calls and Events

- 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 – Register Now
- New MLN Connects® National Provider Event Audio Recording and Transcript

Other CMS Events

- *Medicare Learning Network*® Webinar: Medicare Basics for New Providers Part Three: Medicare Claim Review Programs, POE, and Protecting the Medicare Trust Fund
- Long-Term Care Hospital Quality Reporting Program Provider Training

Announcements

- September is Prostate Cancer Awareness Month
- Prepare for DMEPOS Competitive Bidding Round 1 2017: Three Steps to Get Ready
- EHR Incentive Program 2016 Payment Adjustment Fact Sheet for Hospitals Available

Medicare Learning Network® Educational Products

- "PECOS for Physicians and Non-Physician Practitioners" Fact Sheet – Revised
- *Medicare Learning Network*® Product Available In Electronic Publication Format

Take the time to 'chat' with the website team

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

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

MLN Connects® Provider eNews for October 1, 2015

MLN Connects® Provider eNews for October 1, 2015

View this edition as a PDF

In this edition:

ICD-10

- Coding around the Compliance Date
- Physician Orders for Lab, Radiology Services, and Other Services after ICD-10 Implementation
- Access the ICD-10 Code Set
- Finding ICD-10 Information Online

MLN Connects® National Provider Calls and Events

- Dialysis Facility Compare: Rollout of Five Star Rating Call – Last Chance to Register
- 2014 Supplemental QRUR Physician Feedback Program Call – Register Now
- Improving Medicare Post-Acute Care Transformation Act – Register Now
- New MLN Connects® Event Video Slideshows, Audio Recordings, and Transcripts

MLN Connects Videos

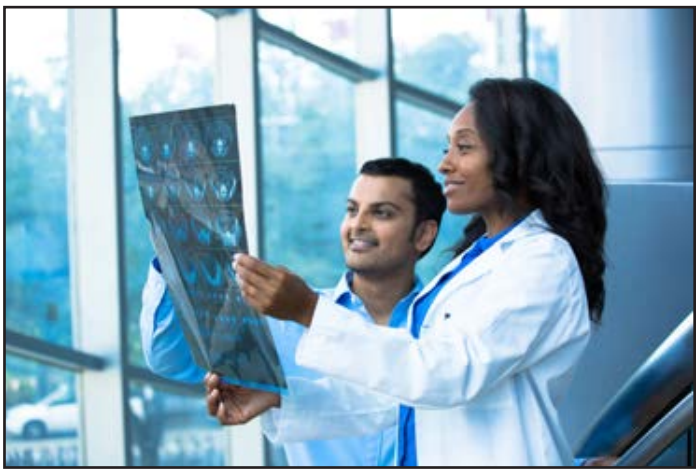
- Video Available on PQRS and VM: What You Need to Know in 2015

Other CMS Events

- Webinar for Comparative Billing Report on Modifiers 24 and 25: Orthopedic Surgeons

Announcements

- Talk to Your Patients about Mental Illness and Depression
- CMS Proposes New Medicare Clinical Diagnostic Laboratory Tests Fee Schedule
- HHS Announces $685 Million to Support Clinicians Delivering High Quality, Patient-Centered Care
- CMS Awards $110 Million to Continue Improvements in Patient Safety



- 2014 Supplemental Quality and Resource Use Reports Available
- MACRA: New Opportunities for Medicare Providers through Innovative Payment Systems
- Getting Started with the Hospice Item Set: Updated Fact Sheet Available
- Access Ordering and Referring Report through *data.cms.gov*
- Change in Cost Report Appeals Support Contractor for Part A Providers
- New EHR Web Page for Past Program Requirements and Resources
- Guidance on Switching EHR Vendors
- 2016 PQRS Payment Adjustment and Informal Review Process

Medicare Learning Network® Educational Products

- "Medicare Enrollment and Claim Submission Guidelines" Booklet – Revised
- "Medicare Enrollment for Institutional Providers" Fact Sheet – Revised
- New *Medicare Learning Network*® Educational Web Guides Fast Fact

MLN Connects® Provider eNews for October 8, 2015

MLN Connects® Provider eNews for October 8, 2015

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In this edition:

ICD-10

- Get ICD-10 Answers in One Place
- 5 Ways to Check Your Claim Status

MLN Connects® National Provider Calls and Events

- 2014 Supplemental QRUR Physician Feedback Program Call — Last Chance to Register
- Improving Medicare Post-Acute Care Transformation Act — Register Now
- New MLN Connects National Provider Call Audio Recordings and Transcripts

Other CMS Events

- MACRA Request for Information Webinars

Announcements

- DMEPOS Competitive Bidding Round 1 2017 Bidding Starts October 15
- HHS Issues Rules to Advance Electronic Health Records with Added Simplicity and Flexibility
- Physician Compare Preview Period Open through November 6
- DMEPOS Fee Schedule PUF Formats and Rural Zip Code File
- October Quarterly Provider Update Available
- Technical Correction to FY 2015 IPF Final Rule
- Participation in EHR Incentive Programs: Updated FAQs

Claims, Pricers and Codes

October 2015 OPPS Pricer File Available

Medicare Learning Network® Educational Products

- "How to Access and Use the Medicare Learning Network Learning Management and Product Ordering System (LM/POS)" Fact Sheet — Released
- "Safeguard Your Identity and Privacy Using PECOS" Fact Sheet — Revised
- "DMEPOS Information for Pharmacies" Fact sheet — Revised
- Medicare Learning Network Products Available in Electronic Publication Format

MLN Connects® Provider eNews for October 15, 2015

MLN Connects® Provider eNews for October 15, 2015

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In this edition:

ICD-10

- Use ICD-10 Now
- ICD-10 Ombudsman and ICD-10 Coordination Center Support Your Transition Needs
- Qualifiers for ICD-10 Diagnosis Codes on Electronic Claims

MLN Connects® National Provider Calls and Events

- Improving Medicare Post-Acute Care Transformation Act Call — Last Chance to Register
- Stay Informed about Medicare Program Changes

Other CMS Events

- Long-Term Care Hospital Quality Reporting Program Provider Training

Announcements

- CMS Launches New ACO Dialysis Model
- New Medicare Utilization and Payment Data Available for Medical Equipment, Supplies
- Primary Care Makes Strides in Improving Quality and Costs
- CMS to Release a Comparative Billing Report on Optometry Services in October
- EHR Incentive Program: 2016 Payment Adjustments and Reconsiderations

Medicare Learning Network® Educational Products

- "Medicare Quarterly Provider Compliance Newsletter [Volume 6, Issue 1]" Educational Tool — Released
- Medicare Learning Network Products Available in Hard Copy Format
- Medicare Learning Network Product Available In Electronic Publication Format

MLN Connects® Provider eNews for October 22, 2015

MLN Connects® Provider eNews for October 22, 2015

View this edition as a PDF

In this edition:

ICD-10

- Learn How to Assign an ICD-10-CM Diagnosis Code with MLN Connects Videos
- Video Slideshow from August 27 MLN Connects Call Available
- 5 Ways to Check Your Claim Status
- Contact List for ICD-10 Questions

MLN Connects® National Provider Calls and Events

- Clinical Diagnostic Laboratory Test Payment System Proposed Rule Call — Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

Other CMS Events

- EHR Incentive Programs: Recording from Final Rule Webinar Available

Announcements

- HHS Awards more than $240 Million to Expand the Primary Care Workforce
- HHS Awards up to $22.9 Million in Planning Grants for Certified Community Behavioral Health Clinics
- 2016 Value Modifier: Informal Review Request Period Open through November 9
- 2016 PQRS Payment Adjustment: Informal Review Request Period Open through November 9
- IRF Quality Reporting Program Data Submission Deadline: November 15
- LTCH Quality Reporting Program Data Submission Deadline: November 15

- MACRA Request for Information: Comments Accepted through November 17
- Dialysis Facility Compare: Submit your Comments through December 4
- New Survey Process for Duodenoscopes/ Endoscopes/ Reusable Medical Devices
- Hospice Quality Reporting Program: New Training Modules Available

Claims, Pricers, and Codes

- Mass Adjustments of IRF PPS Claims that Require a Special Wage Index

Medicare Learning Network® Educational Products

- “Infection Control: Environmental Safety” Web-Based Training Course — Released
- “Infection Control: Injection Safety” Web-Based Training Course — Released
- “PECOS for Provider and Supplier Organizations” Fact Sheet — Revised

Correct your claims on the ‘SPOT’

The SPOT offers registered users the time-saving advantage of not only viewing claim data online but also the option of correcting clerical errors on their eligible Part B claims quickly, easily, *and securely – online.*

Save time – correct your claims online!

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