Medicare A CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

December 2014

In this issue

Web tools hit the SPOT for veteran Medicare billing team

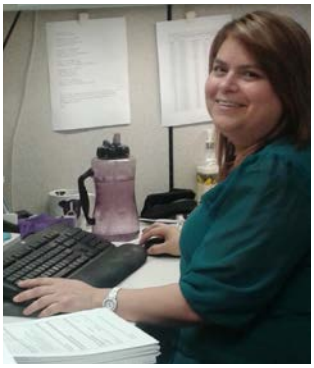
Kim Gonzales and her team of 12 medical claim billers see more than most. On an average day, Gonzales and the Medicare billing team at the Watson Clinic will work some aspect of the 10,400 active claims for medical services provided at the Lakeland, FL, clinic.

A veteran Medicare biller for more than 15 years, Gonzales says the addition of First Coast Service Options' secure provider portal, SPOT, has greatly enhanced the clinic's billing processes, making it easier to get claims paid.

"With my team, if they have a problematic claim, I will ask them if they checked it on SPOT," Gonzales said. "I know we can save 20-30 minutes working it through SPOT, rather than checking the status over the phone."

Accessing claims status information online is one of several features that became available to providers when First Coast launched the SPOT in August 2013. SPOT gives providers faster access to Medicare benefits and eligibility data, payment history, and analytical data reports.

At the Watson Clinic, Medicare beneficiaries represent 54 percent of the claims handled by the billing team.



These are comprised of services provided by more than 200 physicians and physician extenders from 40 different medical and surgical specialties.

The Watson Clinic has 17 offices located in three counties across Central Florida. Given this volume, the Medicare billing team is a critical component to successful business operations.

According to Gonzales, the biggest challenge for her team is working denied claims. "We spend a good amount of time working on denials and checking to see what is necessary to get the claim reprocessed. We started doing re-openings the first day it was offered by First Coast.

Now with online re-openings, we are trying to push everything to SPOT," Gonzales said.

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Contents

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

Publication staff:
Terri Drury
Kathleen Cruz Fuentes
Sofia Lennie
Martin Smith
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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.

General Information

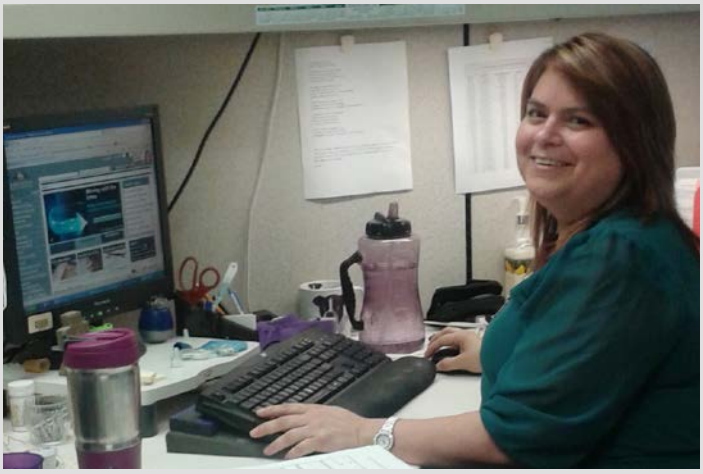
WEB TOOLS

From front page

First Coast added the online claim reopening feature to SPOT in September 2014. Providers may submit Part B clerical reopening requests and correct their claims on the SPOT, adjusting such claim elements as date(s) of service, procedure code, modifier, diagnosis code, or units billed.

SPOT represents a huge leap in helping the Watson Clinic and its Medicare billing. "I've seen the First Coast website grow and change. SPOT has been a really great addition," Gonzales said. "If it's something like a missed modifier, we can correct it right there in SPOT. If we can resolve it there, we'll determine if the claim is eligible for the next level of appeal."

"I've seen the First Coast website grow and change. SPOT has been a really great addition.



If you stay informed and use all of the tools, you will have clean claims and know exactly what to do should a claim get denied."

– Kim Gonzalez, Watson Clinic

Gonzales said while she had a system in place to track claim appeals, the new appeal verification tool offered by First Coast helps her prioritize claim appeals at the redetermination level. "With the appeals tool, we are able to make better decisions on what appeals to work," she said.

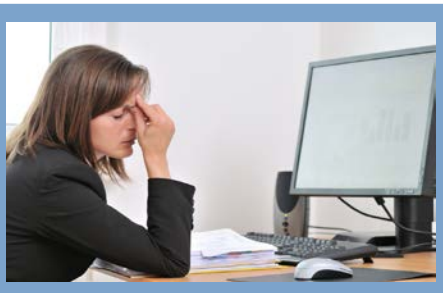
Gonzales says the seasonal residents of Florida can complicate matters with the variety of Medicare Advantage plans that cover their services. "With our snowbirds, we have to stay on top of their eligibility status," Gonzales says. "Many beneficiaries aren't aware they enrolled in a Medicare plan different from the traditional plan. They know they have Medicare and that's it."

Gonzales said having fast access to Medicare eligibility and secondary payer information greatly enhances their ability to file accurate claims and get reimbursed sooner.

"Our primary responsibility is to make sure our billing is appropriate and we get claims processed. We review denied claims and make sure the medical documentation we have is what First Coast has to get a claim paid," Gonzales said. "We look at each claim individually. We look to make sure there is an ABN (advance beneficiary notice) in place, if the claim needs to be transferred to another payer or if appropriate to what extent does the patient have responsibility for paying the claim."

To accomplish all of this, she uses most all of the tools and updates available through the First Coast website.

"We love the E/M worksheet. We have three certified coders who do audits to find the right code. Other important tools include PDS reports, the fee schedule and local coverage determination lookups. "We used PDS quite a bit. If there is something funky we come across in our remittances, we will check a PDS. However, we don't need them as much as we have solved or limited billing problems using the tools," Gonzales said.



Puzzled about your enrollment status?

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

CMS releases 'Program Integrity Manual' updates

Provider types affected

This *MLN Matters*® article is intended for all providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What you need to know

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8810 to make several clarifications to Chapter 15 of the *Medicare Program Integrity Manual*. Most of these changes were editorial in nature to clarify other Medicare manuals being referenced in Chapter 15. The revised Chapter 15 is attached to CR 8810.

Additional information

The official instruction, CR 8810, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R556PI.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: MM8810
Related Change Request (CR) #: CR 8810
Related CR Release Date: November 26, 2014
Effective Date: December 29, 2014
Related CR Transmittal #: R556PI
Implementation Date: December 29, 2014

CMS announces timeline for the DMEPOS competitive bidding round two and national mail-order recompete

Bidding timeline

DMEPOS competitive bidding – bidder education program begins

CMS has announced the *bidding timeline* for the round two recompete and the national mail-order recompete of the Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program.

Bidder education program

CMS has also launched a comprehensive bidder education program. This program is designed to ensure that DMEPOS suppliers interested in bidding receive the information and assistance they need to submit complete bids in a timely manner.

The CBIC is the official information source for bidders and the focal point for bidder education. The CBIC website features an array of important and helpful information for suppliers, including bidding rules, user guides, fact sheets, checklists, and bid preparation worksheets.

The education program also includes a new video series to assist and guide bidders through the entire bidding process. The short – but helpful and engaging – *instructional videos* are posted on the CBIC website. When a new video is posted, the CBIC will announce its availability through a CBIC e-mail update. To sign up to receive video announcements and other key registration and bidding information, subscribe *to CBIC E-Mail Updates*.

Background

In addition to viewing the information on the CBIC website, suppliers are encouraged to call the CBIC customer service center toll-free, at 1-877-577-5331, with questions. During registration and bidding periods, the customer service center will be open from 9 a.m. to 9 p.m. ET.

For more information

Press release

Fact sheet

Policy updates for 2015 rural health clinics and federally qualified health centers

Provider types affected

This *MLN Matters*® article is intended for rural health clinics (RHCs) and federally qualified health centers (FQHCs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 8981 advises MACs of updates to Chapter 13 of the *Medicare Benefit Policy Manual*. These updates include new and clarifying information on the FQHC prospective payment system (PPS) rate, adjustments, payment codes, and qualifying visits; RHC employment requirements; RHC and FQHC preventive health services; and other issues related to RHC and FQHC billing and services.

Background

The Centers for Medicare & Medicaid Services (CMS) has released an update to the *Medicare Benefit Policy Manual*, Chapter 13, rural health clinic (RHC) and federally qualified health center (FQHC) Services." Some of the key section updates as a result of CR 8981 are as follows:

Section 10.1 - RHC General Information

Clarification - A provider-based CMS certification number is not an indication that the RHC has a provider-based determination for purposes of an exception to the payment limit.

Section 10.2 - FQHC General Information

New - On or after October 1, 2014, FQHCs began to transition to the FQHC PPS as required by Section 10501(i)(3)(B) of the Affordable Care Act.

Section 30.1.1 – RHC Requirements

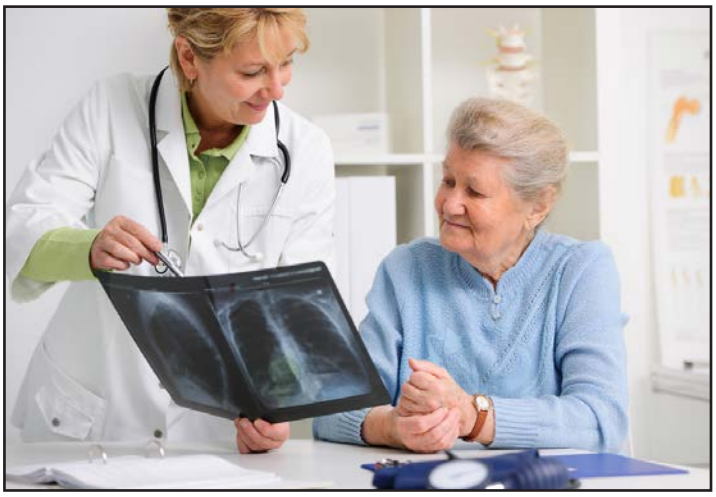
Clarification - An advanced practice registered nurse who is not a nurse practitioner (NP), or physician assistant (PA), or a NP or PA who is working as a substitute in an arrangement similar to a locum tenens physician, would not satisfy the RHC employment requirements.

New - As of July 1, 2014, RHCs may contract with NPs, PAs, certified nurse midwives, clinical psychologists, or clinical social workers as long as at least one NP or PA is employed by the RHC (subject to the waiver provision for existing RHCs set forth at Section 1861(aa)(7) of the Social Security Act).

Section 40 - RHC and FQHC Visits

New - A list of qualifying visits for FQHCs paid under the PPS is located on the FQHC PPS webpage at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html*.

Section 40.3 - Multiple visits on same day and exceptions



Clarification- Except as noted below, encounters with more than one RHC or FQHC practitioner on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day, constitute a single RHC or FQHC visit and is payable as one visit.

This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit.

This would include situations where a RHC or FQHC patient has a medically-necessary face-to-face visit with a RHC or FQHC practitioner, and is then seen by another RHC or FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another RHC or FQHC practitioner (including a specialist) for evaluation of a different condition on the same day.

New - Exceptions for FQHCs that are authorized to bill under the PPS

The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC or FQHC) (two visits can be billed), or

- The patient has a medical visit and a mental health visit on the same day (two visits can be billed).

50.1 - RHC services

New – RHC services includes Hepatitis C screenings.

Clarification - Except for influenza and pneumococcal vaccines and their administration, which are paid through the cost report, RHCs are paid for the professional component of these services based on their AIR.

50.2 – FQHC services

New – FQHC services includes Hepatitis C screenings.

See **POLICY**, next page

POLICY

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Clarification/new - Except for influenza and pneumococcal vaccines and their administration which are paid through the cost report, FQHCs are paid for the professional component of these services based on their AIR, or, for FQHCs that are authorized to bill under the PPS, based on the lesser of the FQHC's charge or the PPS rate for the specific payment code.

Section 70.1.2 – FQHC per-visit payment limit

New – FQHCs that bill under the AIR and are located within a metropolitan statistical area are considered urban FQHCs. MSAs are core-based statistical areas that are associated with at least one urbanized area that has a population of at least 50,000 people.

Section 70.2 – FQHCs billing under the PPS payment rate and adjustments

New – For FQHCs that are authorized to bill under the PPS, Medicare pays 80 percent of the lesser of the FQHC's charge or the PPS payment rate for the specific payment code, unless otherwise noted.

The PPS payment rate reflects a base rate that is the same for all FQHCs, a geographic adjustment, and other applicable adjustments as described below. The PPS base rate will be updated annually by the Medicare economic index (MEI) or by a FQHC market basket.

Geographic adjustment: The PPS base rate will be adjusted for each FQHC based on its location by the FQHC geographic adjustment factor (FQHC GAF). The PPS payment rate is the PPS base rate multiplied by the FQHC GAF for the location where the service is furnished.

Since the FQHC GAF is based on where the services are furnished, the FQHC payment rate may differ among FQHC sites within the same organization. FQHC GAFs are available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html*.

New patient adjustment: The PPS payment rate will be adjusted by a factor of 1.3416 when a FQHC furnishes care to a patient who is new to the FQHC. A new patient is someone who has not received any professional health services (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past three years from the date of service.

IPPE and AWV adjustment: The PPS payment rate will be adjusted by a factor of 1.3416 when a FQHC furnishes an IPPE or an Annual Wellness Visit (AWV) to a Medicare beneficiary.

Section 70.2.1 – Payment codes for FQHCs billing under the PPS

New – FQHCs that are authorized to bill under the PPS must include a FQHC payment code on their claim for payment. FQHCs set their own charges for services they provide and determine which services are included in the bundle of services associated with each FQHC G-code. The five specific payment codes to be used by FQHCs submitting claims under the PPS are:

G0466 – FQHC visit, new patient

G0467 – FQHC visit, established patient

G0468 – FQHC visit, Initial Preventative Physical Exam (IPPE) or AWV

G0469 – FQHC visit, mental health, new patient

G0470 – FQHC visit, mental health, established patient

Section 70.3 – Cost reports

New – FQHCs that are authorized to bill under the FQHC PPS are required to file a cost report annually and are paid for the costs of GME, bad debt, and influenza and pneumococcal vaccines and their administration through the cost report.

Section 70.4 – Productivity standards

New – FQHCs that are authorized to bill under the FQHC PPS are not subject to the productivity standards.

Section 80 – RHC and FQHC patient charges, coinsurance, deductible, and waivers

New – For FQHCs billing under the PPS, the coinsurance is 20 percent of the lesser of the FQHC's charge for the specific payment code or the PPS rate.

Section 100.4 – Transitional care management (TCM) services

Clarification – TCM services can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC or FQHC practitioner and it meets the TCM billing requirements. If it is furnished on the same day as another visit, only one visit can be billed.

Section 110.3 – Payment for incident to services and supplies

Clarification – If a Medicare-covered Part B drug is furnished by a RHC or FQHC practitioner to a Medicare patient as part of a billable visit, the cost of the drug and its administration is included in the RHC or FQHC's AIR or the FQHC's PPS payment. RHCs and FQHCs cannot bill separately for Part B drugs or other incident to services or supplies.

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Section 170 – Physical and occupational therapy

New – PT and OT therapists who provide services incident to a physician, NP, or PA visit may be an employee of the RHC or FQHC or contracted to the RHC or FQHC.

Section 190 – Telehealth services

Clarification – RHCs and FQHCs are not authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner at the time the telehealth service is furnished, and may not bill or include the cost of a visit on the cost report. This includes telehealth services that are furnished by a RHC or FQHC practitioner who is employed by or under contract with the RHC or FQHC, or a non-RHC or FQHC practitioner furnishing services through a direct or indirect contract.

Section 210 – Preventive health services

Clarification – RHCs and FQHCs are paid for the professional component of allowable preventive services when all of the program requirements are met. The beneficiary copayment and deductible (where applicable) is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. Healthcare Common Procedure Coding System (HCPCS) coding is required on all claims to allow for the coinsurance and deductible to be waived.

Section 210.1 – Preventive health services in RHCs

Clarification – HCPCS codes, payment and billing, and coinsurance and deductible information is provided for Influenza (G0008) and Pneumococcal Vaccines (G0009), Hepatitis B Vaccine (G0010), Initial Preventive Physical Exam (G0402), Annual Wellness Visit (G0438 and G0439), Screening Pelvic and Clinical Breast Examination (G0101), Screening Papanicolaou Smear (Q0091); Prostate Cancer Screening (G0102), and Glaucoma Screening (G0117 and G0118).

New – Hepatitis C screening (GO472)

Hepatitis C screening is included in a RHC visit and is not separately billable. The cost of the professional component of the screening can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if this is the only service the RHC provides. Effective for claims with dates of service on or after June 2, 2014, the beneficiary coinsurance and deductible are waived.

210.3 – Preventive health services in FQHCs

Clarification – HCPCS codes, payment and billing, and coinsurance information is provided for Influenza and Pneumococcal Vaccines G0009), Hepatitis B Vaccine (G0010), Initial Preventive Physical Exam (G0402), Annual Wellness Visit (G0438 and G0439), Diabetes Counseling and Medical Nutrition Services, Screening Pelvic and Clinical Breast Examination (G0101), Screening Papanicolaou Smear (Q0091),Prostate Cancer Screening (G0102),Glaucoma Screening (G0117 and G0118).

New – Hepatitis C screening (GO472)

Hepatitis C screening is included in a FQHC visit and is not separately billable. The cost of the professional component of the screening can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if this is the only service the FQHC provides. Effective for claims with dates of service on or after June 2, 2014, the beneficiary coinsurance is waived.

Section 210.4 – Copayment for FQHC preventive health services

Clarification – When one or more qualified preventive service is provided as part of a FQHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary copayment.

For example, if the total charge for the visit is $150, and $50 of that is for a qualified preventive service, the beneficiary copayment is based on $100 of the total charge, and Medicare would pay 80 percent of the $100, and 100 percent of the $50. If no other FQHC service took place along with the preventive service, there would be no copayment applied, and Medicare would pay 100 percent of the payment amount.

New – FQHCs that are authorized to bill under the FQHC PPS would follow the same process, but would deduct the total charges for the preventive services from the lesser of the FQHC's charge or the PPS rate.

Additional information

The official instruction, CR 8981, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R201BP.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: MM8981
Related Change Request (CR) #: CR 8981
Related CR Release Date: December 12, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R201BP
Implementation Date: January 5, 2015

2015 Medicare deductible, coinsurance, and premium rates

Provider types affected

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

Provider action needed

Change request (CR) 8982 informs the MACs about the changes needed to update the claims processing system with the new 2015 Medicare deductible, coinsurance, and premium rates. Make sure that your billing staff is aware of these changes.

Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness.

When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10 percent penalty is assessed for two years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the supplementary medical insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll. The 2015 rates are as follows:

2015 Part A - Hospital insurance (HI)

- Deductible: $1,260.00
- Coinsurance
  - $315.00 a day for 61st-90th day
  - $630.00 a day for 91st-150th day (lifetime reserve days)
  - $157.50 a day for 21st-100th day (skilled nursing facility coinsurance)
- Base premium (BP): $407.00 a month
- BP with 10 percent surcharge: $447.70 a month
- BP with 45 percent reduction: $224.00 a month (for those who have 30-39 quarters of coverage)
- BP with 45 percent reduction and 10% surcharge: $246.40 a month

2015 Part B - Supplementary medical insurance

- Standard Premium: $104.90 a month
- Deductible: $147.00 a year
- Pro Rata Data Amount
  - $114.99 1st month :
  - $32.01 2nd month
- Coinsurance: 20 percent

Additional information

The official instruction, CR 8982, issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R89GI.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: MM8982
Related Change Request (CR) #: CR 8982
Related CR Release Date: November 21, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R89GI
Implementation Date: January 5, 2015

Provider enrollment requirements for writing prescriptions for Medicare Part D drugs

Provider types affected

This *MLN Matters*® special edition is intended for physicians 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.

This rule requires physicians and, when applicable, other eligible professionals 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 covered under Part D. The final regulation stated that the effective date for this requirement would be June 1, 2015.

However, CMS is announcing that it will delay enforcement of the requirements in *42 CFR 423.120(c)(6)* until December 1, 2015.

Nevertheless, prescribers of Part D drugs must submit their Medicare enrollment applications or opt-out affidavits to their Part B Medicare administrative contractors (MACs) by June 1, 2015, or earlier, to ensure that MACs have sufficient time to process the applications or opt out affidavits and avoid their patients' prescription drug claims from being denied by their Part D plans, beginning December 1, 2015. Note that enrollment functions for physicians and other prescribers are handled by Part B MACs.

Background

If you write prescriptions for covered Part D drugs and you are not enrolled in Medicare in an approved status or have a valid record of opting out, you need to submit an enrollment application or an opt out affidavit to your Medicare administrative contractor (MAC) by June 1, 2015, or earlier.

You may submit your 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/CMSForms/CMS-Forms/CMS-Forms-List.html*. Note that an application fee is not required as part of your application submission.

If you wish to enroll to be reimbursed for the covered services furnished to Medicare beneficiaries, you must complete the CMS-855I application. The CMS-855O, which is a shorter, abbreviated form, should only be completed if you are seeking to enroll solely to order and refer and/or prescribe Part D drugs. (While the CMS-855O form states it is for physicians and non-physician practitioners who want to order and refer, it is appropriate for use by prescribers, who also want to enroll to prescribe Part D drugs.) If you do not see your specialty listed on either of the applications, select the undefined physician/non-physician type option and identify your specialty in the space provided.

If you are a physician or eligible professional who wants to opt out of Medicare, you must submit an opt-out affidavit to the MAC within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every two years, and a national provider identifier (NPI) is required to be submitted on the affidavit).

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 Refer Services," which is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf*.

In an effort to prepare the prescribers and Part D sponsors for the December 1, 2015 enforcement date, CMS is making available an enrollment file that identifies physician and eligible professional who are enrolled in Medicare in an approved or opt out status. The first iteration of the enrollment file is now 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 and continue through the December 1, 2015 enforcement date.

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PRESCRIPTIONS

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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 periods after November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will be on the file with its respective end dates 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	Effective date	End date	Opt out flag
123456789	John	Smith	11/01/2014	12/15/2014	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 refer, 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	12/01/2014	12/01/2016	Y
987654321	Mary	Jones	01/01/2017		N

After the enforcement date of December 1, 2015, the applicable effective dates on the file will be adjusted to December 1, 2015, and it will no longer be considered a test file. All inactive periods prior to December 1, 2015, will be removed from the file and it will only contain active

and inactive enrollment or opt out periods as of December 1, 2015, and after. The file will continue to be generated every two weeks, with a purposeful goal toward more frequent updates on a set schedule.

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 *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Part-D-Enrollment-Information.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 *http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf*.

To identify your Medicare contractor, locate the state in which you provide services and refer to the contractor listed on the "Part B Contractor" line.

MLN Matters® Number: SE1434 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

General Coverage

Screening for hepatitis C virus (HCV) in adults

Note: This article was revised November 26, 2014, in order to (1) make editorial changes, (2) add TOBs 71X & 77X and clarify payment methodology, (3) add POS 50, 72 & 81, (4) clarify MAC claims processing prior to January 1, 2015, (5) clarify remittance codes, and (6) revise implementation information. All other information remains the same. It was previously published in the September 2014 edition of Medicare A Connection, Pages 12-14.

Provider types affected

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

What you need to know

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

Background

Hepatitis C virus (HCV) is an infection that attacks the liver and is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring, called cirrhosis.

A cirrhotic liver fails to perform the normal functions of the liver which leads to liver failure. Cirrhotic livers are more prone to become cancerous and liver failure leads to serious complications, even death. HCV is reported to be the leading cause of chronic hepatitis, cirrhosis, and liver cancer, and a primary indication for liver transplant in the western world.

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

Effective June 2, 2014, CMS will cover screening for HCV with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests (used consistently with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations) and point-of-care tests (such as rapid anti-body tests that are performed in outpatient clinics and physician offices) when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting,

and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

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

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

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

1. New HCPCS G0472, short descriptor – Hep C screen high risk/other and long descriptor-Hepatitis C antibody screening for individual at high risk and other covered indication(s), will be used. HCPCS G0472 will appear in the January 2015 recurring updates of the *Medicare Physician Fee Schedule Data Base* (MPFSDB) and the integrated outpatient code editor (I/OCE) with a June 2, 2014, effective date. Contractors shall apply contractor pricing to claims with dates of service June 2, 2014, through December 31, 2014, that contain HCPCS G0472.
2. Beneficiary coinsurance and deductibles do not apply to HCPCS G0472.

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3. For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk, HCV screening is limited to once per lifetime, claims shall be submitted with:
    - HCPCS G0472

4. For those determined to be high-risk initially, claims must be submitted with:
    - HCPCS G0472; and
    - ICD-9 diagnosis code V69.8, other problems related to life style/ICD-10 diagnosis code Z72.89, other problems related to lifestyle (once ICD-10 is implemented)

5. Screening may occur on an annual basis if appropriate, as defined in the policy. Claims for adults at high risk who have had continued illicit injection drug use since the prior negative screening shall be submitted with:

- HCPCS G0472;
- ICD diagnosis code V69.8/Z72.89; and
- ICD diagnosis code 304.91, unspecified drug dependence, continuous/F19.20, other psychoactive substance abuse, uncomplicated (once ICD-10 is implemented).

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

Institutional billing requirements

Effective for claims with dates of service on and after June 2, 2014, institutional providers may use types of bill (TOB) 13x, 71x, 77x, and 85x when submitting claims for HCV screening, HCPCS G0472. Medicare will deny G0472 service line-items on other TOBs using the following messages:

- Claim adjustment reason code (CARC) 170 – Payment denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance advice remarks code (RARC) N95 – This provider type/provider specialty may not bill this service.
- Group code CO (contractual obligation) – If claim received without a GZ modifier.
- The service is paid on the following basis:
- Outpatient hospitals – TOB 13x – based on Medicare physician fee schedule (MPFS).
- Rural health clinics (RHCs) – TOB 71x – and federally qualified health centers (FQHCs) – 77x – technical component paid based on the MPFS. For RHCs and FQHCs that are authorized to bill under the reasonable cost system, payment for the professional component is included in the RHC/FQHC all-inclusive rate (AIR). HCV screening is not a stand-alone payable visit for RHCs and FQHCs.
- Critical access hospitals (CAHs) – TOB 85x – based on reasonable cost; and
- CAH method II – TOB 85x – based on 115 percent of the lesser of the MPFS amount or actual charge as applicable with revenue codes 096x, 097x, or 098x.

Note: Separate guidance shall be issued for FQHCs that are authorized to bill under the prospective payment system.

Professional billing requirements

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

01 – General practice

08 – Family practice

11 – Internal medicine

16 – Obstetrics/gynecology

37 – Pediatric medicine

38 – Geriatric medicine

42 – Certified nurse midwife

50 – Nurse practitioner

89 – Certified clinical nurse specialist

97 – Physician assistant

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

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

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

11 – Physician's office

22 – Outpatient hospital

49 – Independent clinic

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50 – FQHC

71 – State or local public health clinic

72 – RHC

81 – Independent laboratory

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

- CARC 171 – Payment denied when performed by this type of provider in this type of facility.
  Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 service payment information REF), if present.
- RARC N428 – Not covered when performed in this place of service.
- Group code – CO if claim received without GZ modifier.

Other billing information for both professional and institutional claims

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

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

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

When applying the annual frequency limitation, MACs will allow both a claim for a professional service and a claim for a facility fee. In addition, remember that the initial HCV screening for beneficiaries at high risk must also contain ICD-9 diagnosis code V69.8 (ICD-10 code Z72.89 once ICD-10 is implemented).

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

- CARC 119 – Benefit maximum for this time period or occurrence has been reached. (for initial high risk screening), or,
- CARC 167 – This (these) diagnosis(es) is (are) not covered.
  Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (for subsequent annual high risk screening)
- RARC N386 – This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered.
  A copy of this policy is available at *www.cms.gov/mcd/search.asp* on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group code CO if claim received without GZ modifier.

Additional information

The official instruction, CR 8871, was issued to your MAC regarding this change via two transmittals. The first transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R3127CP.pdf*.

The second transmittal updates the *NCD Manual* and it is available at *http://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R177NCD.pdf*.

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

MLN Matters® Number: MM8871
Revised Related Change Request (CR) #: CR 8871
Related CR Release Date: November 19, 2014
Effective Date: June 2, 2014
Related CR Transmittal #: R3127CP and R177NCD
Implementation Date: January 5, 2015, non-shared MAC edits and CWF analysis; April 6, 2015, for remaining shared system edits

Medicare update on preventive and screening services

Provider types affected

This *MLN Matters*® article is intended for Medicare practitioners providing preventive and screening services to Medicare beneficiaries and billing Medicare administrative contractors (MACs) for those services.

Provider action needed

Change request (CR) 8874 is an update from the Centers for Medicare & Medicaid Services (CMS) to ensure accurate program payment for three screening services. The coinsurance and deductible for these services are currently waived, but due to coding changes and additions, the payments for 2015 would not be accurate without updated CR 8874 for intensive behavioral group therapy for obesity, digital breast tomosynthesis, and anesthesia associated with screening colonoscopy. Make sure billing staffs are aware of these updates.

Background

The following outlines the CMS updates:

Intensive behavioral therapy for obesity became a covered preventive service under Medicare, effective November 29, 2011. It is reported with HCPCS code G0447 (Face-to-face behavioral counseling for obesity, 15 minutes). Coverage requirements are in the *Medicare National Coverage Determinations* (NCDs) *Manual,*" Chapter 1, Section 210.

Intensive behavioral therapy for obesity

To improve payment accuracy, in 2015 *Physician Fee Schedule (PFS) Proposed Rule*, CMS created a new HCPCS code for the reporting and payment of behavioral group counseling for obesity -- HCPCS codes G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes).For coverage requirements of intensive behavioral therapy for obesity, see the NCD for intensive behavioral therapy for obesity.

The same claims editing that applies to G0447 applies to G0473. Therefore, effective for claims with dates of service on or after January 1, 2015, MACs will recognize HCPCS code G0473, but only when billed with one of the ICD-9 codes for body mass index (BMI) 30.0 and over (V85.30,-V85.39, V85.41-V85.45). (Once ICD-10 is effective, the related ICD-10 codes are Z68.30-Z68.39 and Z68.41-Z68.45.) When claims for G0473 are submitted without a required diagnosis code, they will be denied using the following remittance codes:

- Claim adjustment reason code (CARC) 167: This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 service payment information REF), if present.

Remittance advice remarks code (RARC) N386: This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.mcd.search.asp*.

If you do not have Web access, you may contact the contractor to request a copy of the NCD.

Effective for claims with dates of service on or after January 1, 2015, beneficiary coinsurance and deductible do not apply to claim lines with HCPCS code G0473.

Note that Medicare pays claims with code G0473 only when submitted by the following provider specialty types as found on the provider's Medicare enrollment record:

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

Claim lines submitted with G0473, but without an appropriate provider specialty will be denied with the following remittance codes:

- CARC 8: The procedure code is inconsistent with the provider type/specialty (taxonomy). **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 service payment information REF), if present.
- RARC N95: This provider type/provider specialty may not bill this service.
- Group code CO (if GZ modifier present) or PR (if modifier GA is present).

Further, effective for dates of service on or after January 1, 2015, claim lines with G0473 are only payable for the following places of service (POS) codes:

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- 11 – Physician's office
- 22 – Outpatient hospital
- 49 – Independent clinic
- 71 – State or local public health clinic

Claim lines for G0473 will be denied without an appropriate POS code using the following remittance codes:

- CARC 5: The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC M77: Missing/incomplete/invalid place of service.
- Group code CO (if GZ modifier present) or PR (if modifier GA is present).

Remember that Medicare will deny claim lines billed for HCPCS codes G0447 and G0473 if billed more than 22 times in a 12-month period using the following codes:

- CARC 119: Benefit maximum for this time period or occurrence has been reached.
- RARC N362: The number of days or units of service exceeds our acceptable maximum.
- Group code CO (if GZ modifier present) or PR (if modifier GA is present).

Note: MACs will display the next eligible date for obesity counseling on all MAC provider inquiry screens.

MACs will allow both a claim for the professional service and a claim for a facility fee for G0473 when that code is billed on type of bill (TOB) 13x or on TOB 85x when revenue code 096x, 097x, or 098x is on the TOB 85x. Payment on such claims is based on the following:

- TOB 13x paid based on the OPPS:
- TOB 85x in critical access hospitals based on reasonable cost; except
- TOB 85x Method II hospitals based on 115 percent of the lesser of the fee schedule amount or the submitted charge.

Institutional claims submitted on other than TOB 13x or 85x will be denied using:

- CARC 171: Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N428: Not covered when performed in this place of service.
- Group code CO (if GZ modifier present) or PR (if modifier GA is present).

Digital breast tomosynthesis

In the *2015 PFS Final Rule* with comment period, CMS established a payment rate for the newly created *Current Procedural Terminology* (*CPT*®) code *77063* for screening digital breast tomosynthesis mammography. The same policies that are applicable to other screening mammography codes are applicable to *CPT*® code *77063*. In addition, since this is an add-on code it should only be paid when furnished in conjunction with a 2D digital mammography.

Effective January 1, 2015, HCPCS code *77063* (Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)), must be billed in conjunction with the screening mammography HCPCS code G0202 (Screening mammography, producing direct digital image, bilateral, all views, 2D imaging only.

Effective January 1, 2015, beneficiary coinsurance and deductible does not apply to claim lines with *77063* (Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure).

Payment for *77063* is made only when billed with an ICD-9 code of V76.11 or V76.12 (and when ICD-10 is effective with ICD-10 code Z12.31). When denying claim lines for *77063* that are submitted without the appropriate diagnosis code, the claim lines are denied using the following messages:

- CARC 167: This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386: This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *www.cms.mcd.search.asp*. If you do not have Web access, you may contact the contractor to request a copy of the NCD.
- Group code CO (if GZ modifier present) or PR (if modifier GA is present).

On institutional claims:

- MACs will pay for tomosynthesis, HCPCS code *77063*, on TOBs 12x, 13x, 22x, 23x based on MPFS, and TOB 85x with revenue code other than 096x, 097x, or 098x based on reasonable cost. TOB 85x claims with revenue code 096x, 097x, or 098x are paid based on MPFS (115 percent of the lesser of the fee schedule amount and submitted charge).
- MACs will pay for tomosynthesis, HCPCS code *77063* with revenue codes 096x, 097x, or 098x when billed on TOB 85x Method II based on 115 percent of the lesser of the fee schedule amount or submitted charge.

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- MACs will return to the provider any claim submitted with tomosynthesis, HCPCS code *77063* when the TOB is not 12x, 13x, 22x, 23x, or 85x.
- MACs will pay for tomosynthesis, HCPCS code *77063*, on institutional claims TOBs 12x, 13x, 22x, 23x, and 85x when submitted with revenue code 0403 and on professional claims TOB 85x when submitted with revenue code 096x, 097x, or 098x.
- Effective for claims with dates of service on or after January 1, 2015, MACs will RTP claims for HCPCS code *77063* that are not submitted with revenue code 0403, 096x, 097x, or 098x.

Section 4104 of the Affordable Care Act defined the term "preventive services" to include "colorectal cancer screening tests" and as a result it waives any coinsurance that would otherwise apply under Section 1833(a)(1) of the Act for screening colonoscopies. In addition, the Affordable Care Act amended Section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies. These provisions are effective for services furnished on or after January 1, 2011.

Anesthesia furnished in conjunction with colonoscopy

In the 2015 PFS proposed rule, CMS proposed to revise the definition of "colorectal cancer screening tests" to include anesthesia separately furnished in conjunction with screening colonoscopies; and in the *2015 PFS Final Rule* with comment period, CMS finalized this proposal. The definition of "colorectal cancer screening tests" includes anesthesia separately furnished in conjunction with screening colonoscopies in the Medicare regulations at Section 410.37(a)(1)(iii). As a result, beneficiary coinsurance and deductible does not apply to anesthesia services associated with screening colonoscopies.

As a result, effective for claims with dates of service on or after January 1, 2015, anesthesia professionals who furnish a separately payable anesthesia service in conjunction with a screening colonoscopy (HCPCS code *00810* performed in conjunction with G0105 and G0121) shall include the following on the claim for the services that qualify for the waiver of coinsurance and deductible:

Modifier 33 – Preventive services: when the primary purpose of the service is the delivery of an evidence based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

Additional information

The official instruction, CR 8874 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3146CP.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: MM8874
Related Change Request (CR) #: CR 8874
Related CR Release Date: December 11, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3146CP
Implementation Date: January 5, 2015

Try our E/M interactive worksheet

First Coast Service Options (First Coast) Inc. offers its exclusive E/M interactive worksheet, available at *http://medicare.fcso.com/EM/165590.asp* to assist providers with identifying the appropriate code to bill for evaluation and management (E/M) services performed during a specific patient visit.

This interactive resource is ideal for use as a checklist by physicians or as a quality assurance tool by auditors, billing specialists, and coders.

Click here to read how one innovative provider is using the E/M worksheet to improve communication in her office.

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.

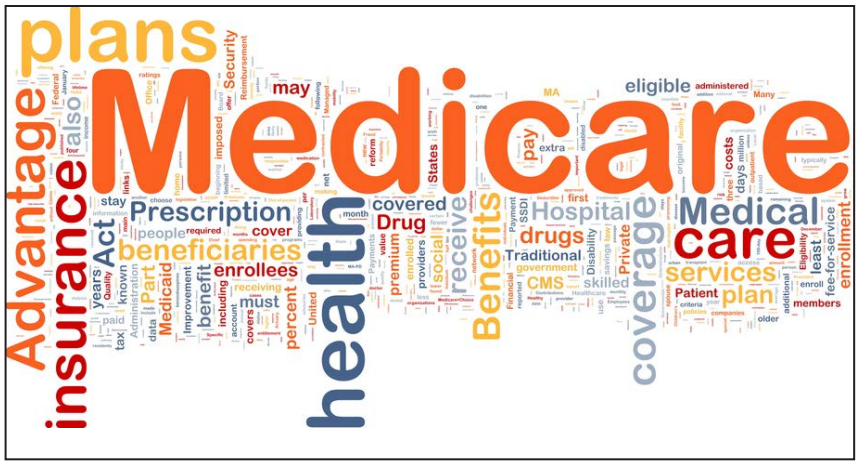
Effective and notice dates

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

Spinal cord stimulation for chronic pain – new LCD

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

Data analysis identified an increase in utilization of spinal cord stimulation services, *CPT*® codes *63650* and *63655*. The Medicare Part B extraction summary system (BESS) statistical medical data obtained for dates of service July 1, 2013, through December 31, 2013, indicated a carrier to nation ratio for Florida at *1.52 for proced6ure code *63650* (between 50-100 percent above the national average), and *2.02 (100-150 percent above the national average) for CPT® code *63655*. (Note: data for Puerto Rico and the U.S. Virgin Islands was below the national average for the applicable codes).

Due to the risk for a high dollar claim payment error, the LCD for spinal cord stimulation for chronic pain has been created to address the limited indications for these services and to further clarify national coverage determination (NCD) 160.7, Electrical Nerve Stimulators, as well as align with other Medicare administrative contractors.

This LCD supplements but does not replace, modify or supersede existing Medicare applicable NCDs or payment policy rules and regulations for spinal cord stimulation (dorsal column stimulation).

This LCD has been created to outline indications and limitations of coverage and/or medical necessity, *CPT*® codes, ICD-9-CM diagnosis codes, documentation guidelines, and utilization guidelines for spinal cord stimulation for chronic pain. In addition, coding guidelines were created and attached to the LCD to provide instructions on coding and billing for all the codes in the policy.

Effective date

The LCD revision is effective for services rendered **on or after February 7, 2015**. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the Jump to Section…" drop-down menu at the top of the LCD page.

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

Revised LCDs

Psychiatric diagnostic evaluation and psychotherapy services – revision to Part A LCD

LCD ID number: L33130
(Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for psychiatric diagnostic evaluation and psychotherapy services was revised based on data analysis and medical review for psychiatric and psychotherapy services. Issues were identified related to the frequent use of psychotherapy services on an on-going basis, specifically in a nursing facility. Revisions were made to the "Utilization Guidelines" section of the LCD to outline the reasonable and necessary parameters that would address the issues identified in medical review.

Effective date

The LCD revision is effective for services rendered **on or after February 7, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the Jump to Section…" drop-down menu at the top of the LCD page.

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

Hepatitis C antibody in the ESRD and non-ESRD setting – retired Part A LCD

LCD ID number: L28886 (Florida)
LCD ID number: L28908
(Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for Hepatitis C antibody in the ESRD and non-ESRD setting is being retired based on data analysis.

Effective date

The LCD retirement is effective for services rendered **on or after December 16, 2014**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the Jump to Section…" drop-down menu at the top of the LCD page.

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

Noncovered services – revision to the Part A LCD

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

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

Therefore, the following procedure codes have been added to the Noncovered Services local coverage determination (LCD). After a draft LCD becomes effective/active, any stakeholder may request a revision to the LCD, by following the reconsideration process as outlined on our website.

- C2624 – Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components
- C9741 – Right heart catheterization with implantation of wireless pressure sensor in the pulmonary artery, including any type of measurement, angiography, imaging supervision, interpretation, and report
- *0008M – Oncology (breast), mRNA analysis of 58 genes using hybrid capture, on formalin-fixed paraffin-embedded (FFPE) tissue, prognostic algorithm reported as a risk score*
- *0347T – Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)*
- *0348T – 0350T* – Radiologic examination, radiostereometric analysis (RSA)
- *0351T – 0352T*– Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen
- *0353T – 0354T* – Optical coherence tomography of breast, surgical cavity
- *0355T – Gastrointestinal tract imaging, intraluminal (eg,capsule endoscopy), colon, with interpretation and report*
- *0356T – Insertion of drug-eluting implant (including punctual dilation and implant removal when performed) into lacrimal canaliculus, each*
- *0358T – Bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report*
- *0359T* – Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report
- *0360T – Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient*
- *0361T – Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)*
- *0362T – Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient*
- *0363T – Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)*
- *0364T – 0365T* – Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient
- *0366T – 0367T* – Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients
- *0368T – 0369T* – Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient
- *0370T – Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)*
- *0371T – Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)*
- *0372T – Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients*
- *0373T – 0374T* – Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s)

In determining if a service or procedure reaches the threshold for coverage, this contractor addresses the

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

Any denied claim would have Medicare's appeal rights. The second level of appeal (qualified independent contractor) requires review by a clinician to uphold any denial. Providers should submit for review all the relevant medical documentation and case specific information of merit and/or new information in the public domain.

An interested stakeholder can request a reconsideration of an LCD after the notice period has ended and the draft becomes active. In the case of the noncovered services LCD, the stakeholder may request the list of the articles and related information in the public domain that were considered by the Medical Policy department in making the noncoverage decision. If the stakeholder has new information based on the evaluation of the list of articles and related information, an LCD reconsideration can be initiated.

It is the responsibility of the interested stakeholder to request the evidentiary list from the contractor and to submit the additional articles, data, and related information in support of their request for coverage. The request must meet the LCD reconsideration requirements outlined on the web site.

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

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

Effective date

The LCD revision is effective for services rendered **on or after February 7, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the Jump to Section…" drop-down menu at the top of the LCD page.

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

Mohs micrographic surgery – Part A LCD revision

LCD ID number: L28932 (Florida)
LCD ID number: L28953
(Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for Mohs micrographic surgery (MMS) was revised to update the following sections: "Coverage Indications, Limitations, and/or Medical Necessity," "Indications," "Limitations," and "Documentation Requirements."

Language in these sections was revised to make the intent of the LCD clearer: coverage is based on characteristics of the lesion, qualifications of the performing physician, and documentation of medical need in the medical record.

Medical need entails that the beneficiaries were informed of their treatment options and explained the risk/benefits of the MMS technique and associated repair.

The qualifications of the performing physician must be verifiable if requested by the contractor, and examples of verification were expanded based on the varying input by the different physician specialties and their societies that have an interest in the MMS technique.

Effective date

The LCD revision is effective for services rendered **on or after January 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*. Coding guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the Jump to Section…" drop-down menu at the top of the LCD page.

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

2015 HCPCS local coverage determination changes

First Coast Service Options Inc. revised local coverage determinations (LCDs) impacted by the 2015 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted accordingly:

LCD Title	Changes
Alemtuzumab (Campath®)	▪ LCD is being retired based on the OPPS payment status indicator being changed to an "E" (Not paid by Medicare when submitted on outpatient claims [any outpatient bill type]) for HCPCS code J9010
Allergy Testing	▪ Deleted HCPCS code G0461 ▪ Added *CPT® codes 88341, 88342, and 88344* ▪ Descriptor change for *CPT®* code *84600*
Biventricular Pacing/Cardiac Resynchronization Therapy	▪ Descriptor changes for *CPT®* codes *33217, 33224, 33225, 33230, 33231, 33240,* and *33249*
Bone Mineral Density Studies	▪ Deleted *CPT®*code *77082* ▪ Added *CPT®* codes *77085 and 77086*
Colorectal Cancer Screening	▪ Added *HCPCS* code *G0464* ▪ Added language pertaining to *CPT®* code *00810* and Modifier 33 **(Related to change request (CR) 8874)** ▪ Revised LCD to re-state utilization parameters and ordering requirements **(Related to CR 8881)**
Diagnostic and Therapeutic Esophagogastroduodenoscopy	▪ Descriptor change for *CPT®* codes *43247* and *43250*
Diagnostic Colonoscopy	▪ *Descriptor change for CPT®* codes *44388, 44390, 44391, 44392, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45391,* and *45392* ▪ Deleted *CPT®* codes *44393, 44397, 45355, 45383,* and *45387* ▪ Added HCPCS codes G6019, G6020, G6021, G6024, and G6025 ▪ Added *CPT®* codes *44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45388, 45389, 45390, 45393, 45398,* and *45399*
Erythropoiesis Stimulating Agents	▪ Removed HCPCS code J0890 based on the OPPS payment status indicator being changed to an E" (Not paid by Medicare when submitted on outpatient claims [any outpatient bill type]) and the nationwide recall and revisions in language were made throughout the LCD for clarification ▪ Added HCPCS codes *J0887* and *J0888*
Parenteral Iron Supplementation for Patients Receiving ESA Therapy for Anemia of Chronic Kidney Disease or Iron Deficiency Anemia	▪ Added HCPCS code *J1439*
Gene Expression Profiling Panel for use in Management of Breast Cancer Treatment	▪ Removed unlisted *CPT®* code *84999* and replaced with *CPT®* code *81519*
Genetic Testing for Lynch Syndrome	▪ Deleted HCPCS code G0461 and G0462 ▪ Added *CPT®* codes *81288, 88341, 88342, and 88344*
Hemophilia Clotting Factors	▪ Descriptor change for HCPCS code J7195 ▪ Deleted HCPCS codes C9133 and C9135 ▪ Removed unlisted HCPCS code C9399 and replaced with HCPCS code C9136 ▪ Added HCPCS codes J7200 and J7201

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LCD Title	Changes
Hyperbaric Oxygen Therapy (HBO Therapy)	▪ Deleted HCPCS code C1300 ▪ Added HCPCS code G0277
Implantable Infusion Pump for the Treatment of Chronic Intractable Pain **(Coding Guidelines only)**	▪ Deleted HCPCS code J2275 ▪ Added HCPCS code J2274
Intensity Modulated Radiation Therapy (IMRT)	▪ Deleted *CPT®* codes *0073T, 76950, 77305, 77310 ,77315, 77326, 77327, 77328, 77385, 77386, 77387, 77403, 77404, 77406, 77408, 77409, 77411, 77413, 77414, 77416, 77418 , and 77421* ▪ Added *HCPCS* codes G6001, G6002, G6003, G6004, G6005, G6006, G6007, G6008, G6009, G6010, G6011, G6012, G6013, G6014, G6015, G6016 and *CPT®* codes *77306, 77307, 77316, 77317,* and *77318*
Mohs Micrographic Surgery (MMS)	▪ Deleted HCPCS codes G0461 and G0462 ▪ Added *CPT®* codes *88341, 88342, and 88344*
Molecular Pathology Procedures	▪ Descriptor change for *CPT®* code *81245* ▪ Added *CPT®* codes *81246, 81288, and 81313*
Noncovered Services	▪ Deleted *CPT®* code *0181T* (replaced with *CPT®* code *92145*), *CPT®* code *0199T* (replaced with unlisted *CPT®* code *95999* – Tremor measurement with accelerometer(s) and/or gyroscope(s), *CPT®* code *0226T* (replaced with HCPCS code G6027), *CPT®* code *0227T* (replaced with HCPCS code G6028), *CPT®* code *0239T* (replaced with *CPT®* code *93702*), *CPT®* code *0334T* (replaced with *CPT®* code *27279),* and *CPT®* codes *87620/87622* (replaced with *CPT®* codes *87623, 87624, and 87625*) ▪ Deleted *CPT®* code *88349*
Paclitaxel (Taxol®)	▪ Deleted HCPCS code J9265 ▪ Added HCPCS code J9267
Psychiatric Diagnostic Evaluation and Psychotherapy Services	▪ Deleted HCPCS code M0064
Qutenza® (capsaicin) 8% patch	▪ Deleted HCPCS code J7335 ▪ Added HCPCS code J7336
Radiation Therapy for T1 Basal Cell and Squamous Cell Carcinomas of the Skin	▪ Descriptor change for *CPT®* code *77401* ▪ Deleted *CPT®* codes *77403, 77404, 77406, 77408, 77409, 77411, 77413, 77414, 77416, and 77418* ▪ Added HCPCS codes G6003, G6004, G6005, G6006, G6007, G6008, G6009, G6010, G6011, G6012, G6013, G6014, G6015
Screening and Diagnostic Mammography	▪ Descriptor change for HCPCS *codes* G0204 and G0206 ▪ Added *CPT®* code *77063* and HCPCS code G0279
Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)	▪ Deleted HCPCS codes G0173 and G0251 ▪ Added *CPT®* codes *77372 and 77373*
Transesophageal Echocardiogram	▪ Added *CPT®* code *93355*
Vertebroplasty, Vertebral Augmentation; Percutaneous	▪ Deleted *CPT®* code *22520, 22521, 22522, 22523, 22524, 22525, 72291,* and *72292* ▪ Added *CPT®* codes *22510, 22511, 22512, 22513, 22514, and 22515*
Viscosupplementation Therapy for Knee	▪ Descriptor change for *CPT®* codes *20610* and *27370* ▪ Removed unlisted HCPCS codes C9399/J3490 (Monovisc) and replaced with HCPCS code J7327

Electronic Data Interchange

Claim status category and claim status codes update

Provider types affected

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

Provider action needed

Change request (CR) 8994 informs MACs about the changes to claim status category codes and claim status codes. Make sure that your billing staff is aware of these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care payers to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the Accredited Standards Committee (ASC) x12 276/277 health care claim status request and response format adopted as the standard for national use under HIPAA.

These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC x12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each ASC x12 trimester meeting (January, June, and October) and makes decisions about additions of new codes, as well as modifications and retirement of existing codes.

The codes sets are available at *http://www.wpc-edi.com/reference/codelists/healthcare/claimstatus-category-codes/* and *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/*. These pages have previously been referenced at *http://www.wpc-edi.com/codes*. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the January 2015 committee meeting shall be posted on the previously mentioned websites on or about February 1, 2015. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 8994.

These code changes are to be used in the editing of all

ASC x12 276 transactions processed on or after the date of implementation and are to be reflected in ASC x12 277 transactions issued on and after the date of implementation of CR 8994.

Additional information

The official instruction, CR 8994 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3143CP.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: MM8994
Related Change Request (CR) #: CR 8994
Related CR Release Date: December 5, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R3143CP
Implementation Date: April 6, 2015

Uniform use of CARCs and RARCs update from CAQH CORE

Provider types affected

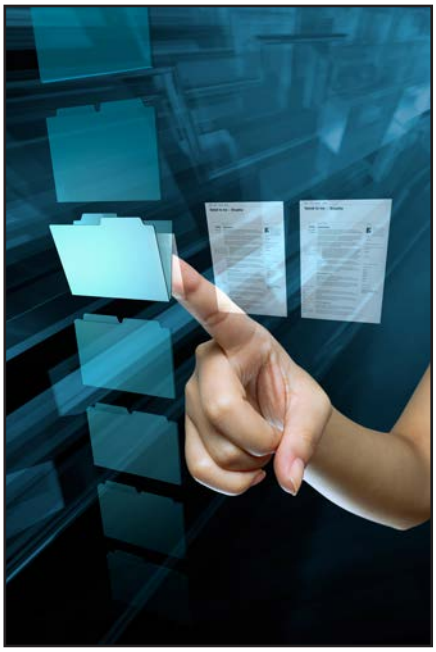
This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including home health & hospice (HH&H) MACs and durable medical equipment MACs (DME MACs) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 8983 deals with the regular update in Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of CARCs and RARCs (835) Rule.

CAQH CORE will publish the next version of the code combination list on or about February 1, 2015, and CR 8983 instructs the MACs to use that list as of April 1, 2015. This update is based on November 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website.

Visit *http://www.wpc-edi.com/reference* for CARC and RARC updates and *http://www.caqh.org/CORECodeCombinations.php* for CAQH CORE defined code combination updates.



Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI of the Act, requiring the Secretary of the Department of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

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

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

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

Additional information

The official instruction for CR 8983 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3135CP.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: MM 8983
Related Change Request (CR) #: CR 8983
Related CR Release Date: November 26, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R3135CP
Implementation Date: April 6, 2015

Reprocessing IPPS claims assigned to DRG 410, 573 or 907

The Centers for Medicare & Medicaid Services (CMS) was recently made aware of a discrepancy in the relative weight assigned to diagnosis related groups (DRGs) 410, 573, and 907 in the inpatient prospective payment system (IPPS) pricer.

The relative weight for these DRGs is scheduled to be corrected in January 2015. Once corrected, your Medicare administrative contractor will reprocess affected claims to correct reimbursement.The relative weight for these DRGs is scheduled to be corrected in January 2015.

Medicare ICD-10 testing approach takes shape

***Note**: This article was revised December 8, 2014, to include the dates and some additional details for the three end-to-end testing periods. It was previously published in the August 2014 Medicare A Connection, Pages 51-52.*

Provider types affected

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

Provider action needed

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

The HIPAA standard health care claim transactions are among those for which International Classification of Diseases, 10th Edition (ICD-10) codes must be used for dates of service on and after October 1, 2015. Be sure you are ready. This *MLN Matters*® special edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

Background

The implementation of ICD-10 represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2015, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing for ICD-10 to ensure that CMS as well as the FFS provider community is ready. When "you" is used in this publication, we are referring to the FFS provider community. The four-pronged approach includes:

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

Each approach is discussed in more detail below.

Internal testing of claims processing systems

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

- Alpha testing is performed by each FFS claims processing system maintainer for four weeks;
- Beta testing is performed by a separate integration contractor for eight weeks; and

- Acceptance testing is performed by each MAC for 4 weeks to ensure that local coverage requirements are met and the systems are functioning as expected.

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

Provider-initiated beta testing tools

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

- NCDs and LCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at *http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html*;
- The ICD-10 Medicare Severity-Diagnosis Related Groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the General Equivalence Mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at *http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html*.

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

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- A pilot version of the October 2013 integrated outpatient code editor (IOCE) that utilizes ICD-10-CM located at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/ICD-10-IOCE-Code-Lists.pdf*. The final version of the IOCE that utilizes ICD-10-CM is scheduled for release in the near future.

Acknowledgement testing

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

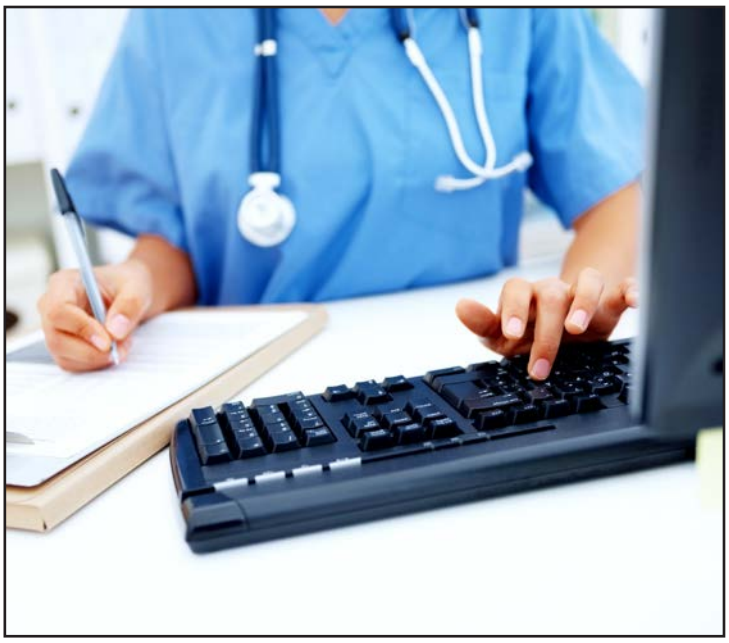
All MACs and the DME MAC common electronic data interchange (CEDI) contractor will promote this ICD-10 acknowledgement testing with trading partners. This testing allows all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with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

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

End-to-end testing

During 2015, CMS plans to offer three separate end-to-end testing opportunities. Each opportunity will be open to a limited number of providers that volunteer for this testing. As planned, approximately 2,550 volunteer submitters will have the opportunity to participate over the course of the three testing periods. End-to-end testing includes the submission of test claims to Medicare with ICD-10 codes and the provider's receipt of a remittance advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

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



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

- Conduct limited end-to-end testing with submitters in three testing periods; January 2015, April 2015 and July 2015. Test claims will be submitted January 26 – 30, 2015, April 27 – May 1, 2015, and July 20 – 24, 2015.
- Each MAC (and CEDI with assistance from DME MACs) will select 50 submitters for each MAC Jurisdiction supported to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will also select 50 submitters. Testers will be selected randomly from a list of volunteers to represent a broad cross-section of provider types, claims types, and submitter types. At least five, but not more than fifteen, of the testers will be a clearinghouse.
- MACs and CEDI will post a volunteer form to their website during the enrollment periods to collect volunteer information with which to select volunteers. Those interested in testing should review the minimum testing requirements on the form to ensure they qualify before volunteering.

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

Claims submission alternatives

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

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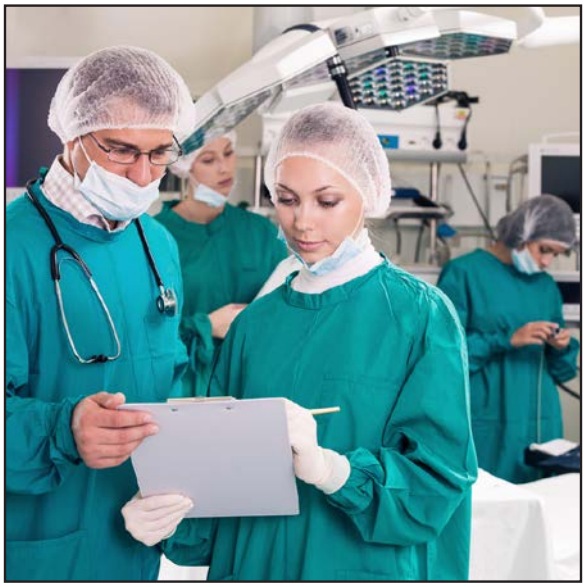
ICD-10 frequently-asked questions on end-to-end testing

Provider types affected

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

Provider action needed

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



What to know prior to testing

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

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

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

2. What constitutes a testing slot for this testing?

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

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

For each testing slot, you must provide the MAC: up to two submitter identifiers (IDs), up to five national provider identifiers (NPIs)/provider transaction access numbers (PTANs), and up to 10 health insurance claim numbers (HICNs). You may use these in any combination on the 50 claims. You will need to use the same HICN on multiple claims. Therefore, you will need to consider this when designing a test plan, since claims will be subject to standard utilization edits.

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

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

Additional information

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

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

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If you were selected to test with only one submitter ID but would like to choose a second one, you must contact the MAC to add the second submitter ID. If the MAC is not aware of your preference to use a second submitter ID, claims submitted with that ID may not be processed.

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

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

5. If I was selected for the January 2015 end-to-end testing, do I need to reapply for later testing rounds?

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

6. Does this mean that no new submitters will be accepted for the April and July 2015 end-to-end testing periods or will a new group of 850 testers be selected for both April and July?

A new group will be selected for each of the April and July 2015 testing periods, and these groups will be able to test in addition to the already chosen testers. Therefore, the total number of potential testers will be 1,700 for April 2015 and 2,550 for July 2015.

7. Do you have information on who has been selected for the January 2015 end-to-end testing?

We will release this information as part of the public release of our January test results.

8. When do you expect to publically release results of the first round of end-to-end testing?

We expect to publicly release results of the first round of end-to-end testing around the end of February 2015.

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

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

What to know during testing

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

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

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

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

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

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

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

ICD-9 and ICD-10 codes cannot be submitted on the same claim. For additional information on how to submit claims that span the ICD-10 implementation date (when ICD-9 codes are effective for that portion of the services rendered on September 30, 2015, and earlier, and when ICD-10 codes are effective for that portion of the services rendered October 1, 2015, and later), please refer to *MLN Matters*® article SE1325, "Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims that span the ICD-10 Implementation Date" located at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf*.

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

Institutional claims that fail return to provider (RTP) editing

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count toward the 50 claim submission limit. Claims that are RTP'd will not appear on the electronic remittance advice, and will not be available through DDE. If claims accepted by the front end edits do not appear on the remittance advice, please contact the Medicare administrative contractor (MAC) for further information.

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

5. If a certificate of medical necessity (CMN) or DME information form (DIF) is required for a supplier claim, do I need to submit a CMN during testing?

If the beneficiary has a valid CMN or DIF on file for that equipment/supply covered by the dates of service on your test claim (after 10/1/2015), you do not need to submit a new CMN/DIF. If the beneficiary's CMN/DIF has expired for the dates of service on your test claim (after 10/1/2015), you must submit a revised CMN/DIF to extend the end date for that CMN/DIF. If the beneficiary does not have a CMN or DIF for that equipment/supply, you must submit a new CMN/DIF.

6. For home health claims, how should I submit the request for anticipated payment (RAP) and final claim for testing?

Submit the RAP and final claim in the same file and the system will allow them to process. The final claim will be held and recycle (as in normal processing) until the RAP finalizes. It will then be released to the common working file (CWF).

The RAP processing time will be short since the test beneficiaries are set up in advance. To get your results more quickly, you may also want to consider billing low utilization payment adjustment claims with four visits or less that do not require a RAP.

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

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

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

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

Additional information

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Discover the benefits of electronic remittance advice

Do you receive standard paper remittance (SPR) advices?

The majority of the providers in the First Coast Service Options Inc. (First Coast) jurisdiction submit their claims electronically.

However, First Coast's records also show that for October 2014, 11 percent of all the Part A remittance advices and 12 percent of all the Part B remittance advices were sent to providers as paper instead of an easy-to-use electronic format.

Why not go electronic?

Here are a few benefits to receiving electronic remittance advice (ERA):

- Receive your remittances the day the claim finalizes
- Reduce costs associated with:
- Storage and maintenance of SPRs
- Staff time to review and file SPRs

The Centers for Medicare & Medicaid Services (CMS) provides free software for you so that you can download, view, and print duplicate copies of Part A or B electronic remittances whenever you wish.

If you currently submit your claims electronically and are not set up for electronic remittance, please complete the *Electronic Data Interchange (EDI) Enrollment form* prior to downloading the free software.

How do you get this free software?

- For Part A providers, download *PC-Print Software*.
- For Part B providers, download *MREP software*.

Your time and money are valuable. Save both by downloading the software for electronic remittance advices today.

Reimbursement

2015 home health prospective payment system rate update

Provider types affected

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

Provider action needed

CR 8969 informs MACs about the changes and updates to the 60-day national episode rates, the national per-visit amounts, low-utilization payment adjustment (LUPA) add-on amounts, and the non-routine medical supply payment amounts under the HH PPS for 2015. Make sure that your billing staffs are aware of these changes.

Background

The Affordable Care Act of 2010 mandated several changes to Section 1895(b) of the Social Security Act (or the Act) and hence the HH PPS Update for 2014. Section 3131(a) of the Affordable Care Act mandates that, starting in 2014, the Secretary must apply an adjustment to the national, standardized 60-day episode payment rate and other amounts applicable under Section 1895(b)(3)(A)(i)(III) of the Act to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. In addition, Section 3131(a) of the Affordable Care Act mandates that this rebasing must be phased in over a 4-year period in equal increments, not to exceed 3.5 percent of the amount (or amounts), as of the date of enactment, applicable under Section 1895(b)(3)(A)(i)(III) of the Act, and be fully implemented by 2017.

Also, Section 3131(c) of the Affordable Care Act amended Section 421(a) of the Medicare Modernization Act (MMA), which was amended by Section 5201(b) of the Deficit Reduction Act (DRA). The amended Section 421(a) of the MMA provides an increase of 3 percent of the payment amount otherwise made under Section 1895 of the Act for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2016. The statute waives budget neutrality related to this provision, as the statute specifically states that the Secretary shall not reduce

the standard prospective payment amount (or amounts) under Section 1895 of the Act applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

Market basket update

The multi-factor productivity (MFP) adjusted home health (HH) market basket update for 2015 is 2.1 percent. HHAs that do not report the required quality data will receive a 2-percentage point reduction to the MFP adjusted HH market basket update of 2.1 percent for 2015.

National, standardized 60-day episode payment

As described in the 2015 final rule, to determine the 2015 national, standardized 60-day episode payment rate, the Centers for Medicare & Medicaid Services (CMS) starts with the 2014 national, standardized 60-day episode rate ($2,869.27). CMS applies a wage index budget neutrality factor of 1.0024 and a case-mix weight budget neutrality factor of 1.0366. CMS then applies an $80.95 reduction (which is 3.5 percent of the 2010 national, standardized 60-day episode rate of $2,312.94).

Lastly, the national, standardized 60-day episode payment rate is updated by the 2015 MFP adjusted HH market basket update of 2.1 percent for HHAs that do submit the required quality data and by 0.1 percent for HHAs that do not submit quality data. The updated 2015 national standardized 60-day episode payment rate for HHAs that

Table 1: For HHAs that submit quality data – national 60-day episode amounts updated by the MFP adjusted home health market basket update for 2015 before case-mix adjustment, wage index adjustment based on the site of service for the beneficiary

2014 national, standardized 60-day episode payment	Wage index budget neutrality factor	Case-mix weights budget neutrality factor	2015 rebasing adjustment	2015 HH payment update percentage	2015 national, standardized 60-day episode payment
$2,869.27	x 1.0024	x 1.0366	-$80.95	x 1.021	=$2,961.38

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do submit the required quality data is shown in Table 1 on the previous page and for HHAs that do not submit the required quality data are shown in Table 2 below. These payments are further adjusted by the individual episode's case-mix weight and wage index.

Table 2: For HHAs that DO NOT submit quality data – national 60-day episode amounts updated by the MFP adjusted home health market basket update for 2015 before case-mix adjustment, wage index adjustment based on the site of service for the beneficiary

2014 national, standardized 60-day episode payment	Wage index budget neutrality factor	Case-mix weights budget neutrality factor	2015 rebasing adjustment	2015 HH payment update percentage minus 2 percentage points	2015 national, standardized 60-day episode payment
$2,869.27	X 1.0024	X 1.0366	-$80.95	X 1.001	=$2,903.37

National per-visit rates

To calculate the 2015 national per-visit payment rates, CMS starts with the 2014 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0012 to ensure budget neutrality for LUPA per-visit payments after applying the 2014 wage index, and then applies the maximum rebasing adjustments to the 2014 per-visit rates. The per-visit rates for each discipline are then updated by the MFP adjusted 2015 HH market basket update of 2.1 percent for HHAs that do submit the required quality data and by 0.1 percent for HHAs that do not submit quality data. The 2015 national per-visit rates per discipline for HHAs that do submit the required quality data are shown in Table 3 below and for HHAs that do not submit the required quality data are shown in Table 4 below.

Table 3: For HHAs that submit quality data – 2015 national per-visit amounts for LUPAs and outlier calculations updated by the MFP adjusted HH market basket update, before wage index adjustment

HH discipline type	2014 per-visit payment	Wage index budget neutrality factor	2015 rebasing adjustment	2015 HH payment update percentage	2015 per-visit payment
Home health aide	$54.84	x 1.0012	+$1.79	x 1.021	$57.89
Medical social services	$194.12	x 1.0012	+$6.34	x 1.021	$204.91
Occupational therapy	$133.30	x 1.0012	+$4.35	x 1.021	$140.70
Physical therapy	$132.40	x 1.0012	+$4.32	x 1.021	$139.75
Skilled nursing	$121.10	x 1.0012	+$3.96	x 1.021	$127.83
Speech-language pathology	$143.88	x 1.0012	+$4.70	x 1.021	$151.88

Table 4: For HHAs that DO NOT submit quality data – 2015 national per-visit amounts for LUPAs and outlier calculations updated by the MFP adjusted HH market basket update, before wage index adjustment

HH discipline type	2014 per-visit payment	Wage index budget neutrality factor	2015 rebasing adjustment	2015 HH payment update percentage minus 2 percentage points	2015 per-visit payment
Home health aide	$54.84	x 1.0012	+$1.79	x 1.001	$56.75
Medical social services	$194.12	x 1.0012	+$6.34	x 1.001	$200.89
Occupational therapy	$133.30	x 1.0012	+$4.35	x 1.001	$137.95
Physical therapy	$132.40	x 1.0012	+$4.32	x 1.001	$137.02
Skilled nursing	$121.10	x 1.0012	+$3.96	x 1.001	$125.33
Speech-language Pathology	$143.88	x 1.0012	+$4.70	x 1.001	$148.90

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Low-utilization payment adjustment add-on payments

Low-utilization payment adjustment (LUPA) episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment.

Beginning in 2014, CMS calculates the payment for the first visit in a LUPA episode by multiplying the per-visit rate by a LUPA add-on factor specific to the type of visit (skilled nursing, physical therapy, or speech-language pathology).

The specific requirements for the new LUPA add-on calculation are described in Transmittal 2796 dated September 27, 2013. The 2015 LUPA add-on adjustment factors are displayed in Table 5.

Table 5: 2015 LUPA add-on factors

HH discipline type	
Skilled nursing	1.8451
Physical therapy	1.6700
Speech-language pathology	1.6266

Non-routine supply payments

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by the NRS conversion factor. To determine the 2015 NRS conversion factor, CMS starts with the 2014 NRS conversion factor ($53.65) and applies a 2.82 percent rebasing adjustment calculated in the 2015 final rule (1 - 0.0282 = 0.9718). CMS then updates the conversion factor by the MFP adjusted HH market basket update of 2.1 percent for HHAs that do submit the required quality data and by 0.1 percent for HHAs that do not submit quality data.

CMS does not apply a standardization factor as the NRS payment amount calculated from the conversion factor is not wage or case-mix adjusted when the final claim payment amount is computed. The NRS conversion factor for 2015 payments for HHAs that do submit the required quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b. The NRS conversion factor for 2015 payments for HHAs that do not submit quality data is shown in Table 7a and the payment amounts for the various NRS severity levels are shown in Table 7b.

Table 6a: NRS conversion factor for HHAs that DO submit the required quality data

2014 NRS conversion factor	2015 rebasing adjustment
2015 HH payment update percentage	2015 NRS conversion factor
$53.65	x 0.9718
x 1.021	$53.23

Table 6b: Relative weights and payment amounts for the six-severity NRS system for HHAs that submit quality data

Severity level	Points (scoring)	Relative weight	2015 NRS payment amount
1	0	0.2698	$14.36
2	1 to 14	0.9742	$51.86
3	15 to 27	2.6712	$142.19
4	28 to 48	3.9686	$211.25
5	49 to 98	6.1198	$325.76
6	99+	10.5254	$560.27

Table 7a: NRS conversion factor for HHAs that DO NOT submit the required quality data

2014 NRS conversion factor	2015 rebasing adjustment	2015 HH payment update percentage minus 2 percentage points	2015 NRS conversion factor
$53.65	X 0.9718	X 1.001	$52.19

Table 7b: 2015 relative weights and payment amounts for the six-severity NRS system for HHAs that DO NOT submit quality data

Severity level	Points (scoring)	Relative weight	2015 NRS payment amount
1	0	0.2698	$14.08
2	1 to 14	0.9742	$50.84

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Severity level	Points (scoring)	Relative weight	2015 NRS payment amount
3	15 to 27	2.6712	$139.41
4	28 to 48	3.9686	$207.12
5	49 to 98	6.1198	$319.39
6	99+	10.5254	$549.32

Rural add-on

Section 3131(c) of the Affordable Care Act applies a 3 percent rural add-on to the national standardized 60-day episode rate, national per-visit payment rates, LUPA add-on payments, and the NRS conversion factor when home health services are provided in rural (non-CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2016. The following tables show the 2015 rural payment rates.

Table 8a: 2015 payment amounts for 60-day episodes for services provided in a rural area before case-mix and wage index adjustment for HHAs that submit quality data

2015 national, standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	2015 rural national, standardized 60-day episode payment rate
$2,961.38	X 1.03	$3,050.22

Table 8b: 2015 payment amounts for 60-day episodes for services provided in a rural area before case-mix and wage index adjustment for HHAs that DO NOT submit quality data

2015 national standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	2015 rural national, standardized 60-day episode payment rate
$2,903.37	X 1.03	$2,990.47

Table 9a: 2015 per-visit amounts for services provided in a rural area, before wage index adjustment for HHAs that submit quality data

Home health discipline type	2015 per-visit rate	Multiply by the 3 percent rural add-on	2015 rural per-visit rate
HH Aide	$57.89	X 1.03	$59.63
MSS	$204.91	X 1.03	$211.06
OT	$140.70	X 1.03	$144.92
PT	$139.75	X 1.03	$143.94
SN	$127.83	X 1.03	$131.66
SLP	$151.88	X 1.03	$156.44

Table 9b: 2015 per-visit amounts for services provided in a rural area, before wage index adjustment for HHAs that DO NOT submit quality data

Home health discipline type	2015 per-visit rate	Multiply by the 3 percent rural add-on	2015 rural per-visit rate
HH Aide	$56.75	X 1.03	$58.45
MSS	$200.89	X 1.03	$206.92
OT	$137.95	X 1.03	$142.09
PT	$137.02	X 1.03	$141.13
SN	$125.33	X 1.03	$129.09
SLP	$148.90	X 1.03	$153.37

Table 10a: 2015 Conversion factor for services provided in rural areas for HHAs that submit quality data

2015 conversion factor	Multiply by the 3 percent rural add-on	2015 rural conversion factor
$53.23	x 1.03	$54.83

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Table 10b: 2015 conversion factor for services provided in rural areas for HHAs that DO NOT submit quality data

2015 conversion factor	Multiply by the 3 percent rural add-on	2015 rural conversion factor
$52.19	x 1.03	$53.76

Table 10c: 2015 relative weights and payment amounts for the six-severity NRS system for services provided in rural areas for HHAs that submit quality data

Severity level	Points (Scoring)	Relative weight	Total 2015 NRS payment amount for rural areas
1	0	0.2698	$14.79
2	1 to 14	0.9742	$53.42
3	15 to 27	2.6712	$146.46
4	28 to 48	3.9686	$217.60
5	49 to 98	6.1198	$335.55
6	99+	10.5254	$577.11

Table 10d: 2015 relative weights and payment amounts for the six-severity NRS system for services provided in rural areas for HHAs that DO NOT submit quality data

Severity level	Points (scoring)	Relative weight	Total 2015 NRS payment amount for rural areas
1	0	0.2698	$14.50
2	1 to 14	0.9742	$52.37
3	15 to 27	2.6712	$143.60
4	28 to 48	3.9686	$213.35
5	49 to 98	6.1198	$329.00
6	99+	10.5254	$565.85

These changes are to be implemented through the home health pricer software found in Medicare contractor standard systems. HHAs should remember to:

- Submit the core based statistical area (CBSA) code or special wage index code corresponding to the state and county of the beneficiary's place of residence in value code 61 on home health requests for anticipated payments (RAPs) and claims;
- Use the wage index table attached to CR 8969, which associates states and counties to CBSA codes (codes in the range *10020 – 49780* and 999xx rural state codes) to determine the code to report in value code 61;
- Use the codes in the range 50xxx in the wage index table attached to CR 8969 to determine the code to report in value code 61 if the provider serves beneficiaries in areas where there is more than one unique CBSA due to the wage index transition.

Additional information

The official instruction, CR 8969, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3145CP.pdf*. If you have any questions, please contact your MAC at their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - *How Does It Work*.

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Related Change Request (CR) #: CR 8969
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Implementation Date: January 5, 2015

Implementation of changes in the end-stage renal disease prospective payment system for 2015

Note: This article was revised December 8, 2014, to reflect the revised change request (CR) 8978 issued December 2. In the article, the CR release date, transmittal numbers, and the Web addresses for accessing CR 8978 are revised. All other information remains the same. This article was previously published in the November 2014 edition of the Medicare A Connection, Pages 31-32.

Provider types affected

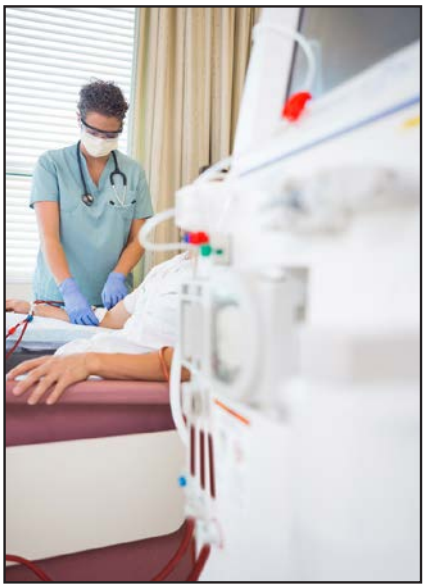
This *MLN Matters*® article is intended for end stage renal disease (ESRD) facilities submitting claims to Medicare administration contractors (MACs) for renal dialysis services provided to Medicare beneficiaries.

Provider action needed

This article is based on CR 8978 which implements the 2015 rate updates for the ESRD prospective payment system (PPS). Make sure that your billing staffs are aware of these changes for 2015.

Background

In accordance with the Medicare Improvements for Patients and Providers Act (MIPPA; section 153(b)), the Centers for Medicare & Medicaid Services (CMS) implemented the end-stage renal disease (ESRD) prospective payment system (PPS) effective January 1, 2011. You may review MIPPA (section 153(b)) at *http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf*.



The Affordable Care Act (Section 3401(h) amended MIPPA (section 153(b)); see *http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf*), and states that for 2012 and each subsequent year, CMS will reduce the ESRD bundled (ESRDB) market basket increase factor by a productivity adjustment described in the Social Security Act (Section 1886(b)(3)(B)(xi)(II); see *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm*). The ESRDB market basket increase factor minus the productivity adjustment will update the ESRD PPS base rate.

For 2015, CMS rebased and revised the ESRDB market basket so that the cost weights and price proxies reflect the mix of goods and services that underlie ESRD bundled operating and capital costs for 2012. A payment provision for 2015 that is affected by the rebase and revision is an increase in the labor-related share, which is used when adjusting payments for geographic locality. CMS is implementing a two-year transition under which a 50/50 blended labor-related share will apply to all ESRD facilities. In addition, the Protecting Access to Medicare Act of 2014 (PAMA; Section 217; see *http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf*) includes several provisions that apply to the ESRD PPS. The most significant provisions for 2015 are the elimination of the drug utilization adjustment transition, a 0.0 percent update to the ESRD PPS base rate, and a delay in the inclusion of oral-only drugs used for the treatment of ESRD into the bundled payment until January 1, 2024.

The 2015 ESRD PPS final rule adopts the most recent core-based statistical area (CBSA) delineations as described in the February 28, 2013, Office of Management and Budget (OMB) Bulletin No. 13-01. In addition, CMS is implementing a two-year transition under which a 50/50 blended wage index will apply to all ESRD facilities. As a result, several counties now have new CBSA numbers. In addition, for 2015 only, there are several special wage index values that need to be sent to the ESRD PPS pricer in order to apply correct payments to certain ESRD facilities.

ESRD facilities can confirm their 2015 CBSA delineation status and wage index value at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment*.

The consolidated billing requirements for drugs and biologicals included in the ESRD PPS will be updated to include Health Care Procedure Coding System (HCPCS) code J3480 (Injection, potassium chloride, per 2 meq). It is a composite rate drug and therefore, is not eligible for outlier consideration.

Regarding the calculation for outlier payments, there is a correction to the mean unit cost associated with the oral equivalent drug, Hectorol (doxercalciferol) 0.5 mcg capsule and 1 mcg capsule, applicable to claims with dates of service in 2014. Facilities that believe the mean unit cost corrections may impact their outlier payments for claims in 2014, should submit adjustments to their claims within six months from the effective date of CR 8978. MACs will be instructed to override timely filing if necessary.

Finally, in an effort to enhance the ESRD claims data for possible future refinements to the ESRD PPS, CMS is requiring ESRD facilities to begin reporting composite rate drugs and biologicals on the claim. Specifically, ESRD facilities should only report the composite rate drugs identified on the consolidated billing drug list provided in Attachment B of CR 8978. The ESRD PPS payment policy remains the same for composite rate drugs, therefore, no separate payment is made and these drugs will not be included in the outlier policy.

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ESRD

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2015 ESRD PPS updates:

ESRD PPS base rate:

A zero percent update to the payment rate results in a 2015 ESRD PPS base rate of $239.02 in accordance with section 217(b)(2) of PAMA. With a wage index budget neutrality adjustment factor of 1.001729, the 2015 ESRD PPS base rate is $239.43 ($239.02 x 1.001729 = $239.43).

Wage index:

The wage index adjustment will be updated to reflect the latest available wage data. New CBSA delineations are being implemented with a 50/50 blend of wage indices and the wage index floor will be reduced from 0.45 to 0.40.

Labor-related share:

The revised labor-related share is 50.673 percent, an increase from 41.737 percent. CMS will implement the revised labor-related share with a 50/50 blend under a two-year transition which results in a labor-related share value of 46.205 percent for 2015.

Outlier policy:

CMS will make the following updates to the adjusted average outlier service Medicare allowable payment (MAP) amount per treatment:

1. For adult patients, the adjusted average outlier service MAP amount per treatment is $51.29.

2. For pediatric patients, the adjusted average outlier service MAP amount per treatment is $43.57.

CMS will make the following updates to the fixed dollar loss amount that is added to the predicted MAP to determine the outlier threshold:

1. The fixed dollar loss amount is $86.19 for adult patients.
2. The fixed dollar loss amount is $54.35 for pediatric patients.

CMS will make the following changes to the list of outlier services:

1. Renal dialysis drugs, that are oral equivalents to injectable drugs are based on the most recent prices retrieved from the *Medicare Prescription Drug Plan Finder*, will be updated to reflect the most recent mean unit cost. In addition, CMS will add or remove any renal dialysis items and services that are eligible for outlier payment. See Attachment A of CR 8978 which provides a list of 2015 Oral and Other Equivalent Forms of Injectable Drugs.
2. The mean dispensing fee of the national drug codes (NDC) qualifying for outlier consideration is revised to $1.15 per NDC per month for claims with dates of service on or after January 1, 2015. See Attachment A of CR 8978.

Claims reporting:

ESRD facilities shall begin reporting the composite rate drugs itemized on the consolidated billing list (see Attachment B of CR 8978) when provided, on ESRD claims with dates of service on or after January 1, 2015.

CR 8978 also revises the *Medicare Benefit Policy Manual* (Chapter 11 (End Stage Renal Disease (ESRD), sections 10, 20, 30, 40, 50, and 60) and the *Medicare Claims Processing Manual* (Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), section 50.3 (Required Information for In-Facility Claims Paid Under the Composite Rate and the ESRD PPS). These manual revisions are included as attachments to CR 8978.

As part of the manual changes, ESRD facilities are required, effective January 1, 2015, to report on the claim the composite rate drugs identified on the consolidated billing list provided at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDPayment/Consolidated_Billing.html*. No other composite rate drugs, items, or services are to be reported on the claim.

Additional information

The official instruction, CR 8978, issued to your MAC regarding this change, consists of two transmittals. The first updates the *Medicare Benefit Policy Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R200BP.pdf*.

The second transmittal updates the *Medicare Claims Processing Manual,* which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3139CP.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: MM8978 Revised
Related Change Request (CR) #: CR 8978
Related CR Release Date: December 2, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R200BP and R3139CP
Implementation Date: January 5, 2015

Rate increases and policy update for rural health clinic and federally qualified health centers

Provider types affected

This *MLN Matters*® article is intended for rural health clinics (RHCs) and federally qualified health centers (FQHCs) submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

This article is based on change request (CR) 8980 which informs MACs about instructions for the 2015 payment rate increases for RHCs and FQHCs billing under the all-inclusive rate (AIR) system, and updates to the urban and rural designations for FQHCs billing under the AIR. Make sure that your billing staffs are aware of these changes.

Background

CR 8980 provides instructions to MACs for the 2015 payment rate increases for RHCs and FQHCs billing under the AIR. As authorized by §1833(f) of the Social Security Act (the Act), the payment limits for a subsequent year are increased in accordance with the rate of increase in the Medicare Economic Index (MEI).

The RHC payment limit per visit for 2015 is $80.44 effective January 1, 2015, through December 31, 2015. The 2015 RHC rate reflects a 0.8 percent increase above the 2014 payment limit of $79.80. The FQHC payment limit per visit for urban FQHCs for 2015 is $130.05 and the payment limit per visit for rural FQHCs is $112.56 effective January 1, 2015, through December 31, 2015. The 2015 FQHC rates reflect a 0.8 percent increase above the 2014 rates of $129.02 and $111.67 in accordance with the rate of increase in the MEI.

CR 8980 also provides instructions to the MACs regarding the urban and rural designations for FQHCs that are authorized to bill under the AIR system. Each FQHC site is designated as an urban or rural entity based on the urban and rural definitions in §1886(d)(2)(D) of the Act, which defines urban and rural for hospital payment purposes.

If the FQHC is located within a metropolitan statistical area (MSA), then the urban upper payment limit applies. If the FQHC is not in an MSA and cannot be classified as a large or other urban area, the rural payment limit applies. Rural FQHCs cannot be reclassified into an urban area for FQHC payment limit purposes. The definition of urban and rural is based upon the most recent available data from the Bureau of Census and is issued by the Office of Management and Budget (OMB). OMB reviews its statistical area standards and delineations preceding each decennial census.

On February 28, 2013, OMB issued "OMB Bulletin No. 13-01," which established revised delineations for its statistical areas and provided guidance on the use of these delineations. OMB defines an MSA as a core-based statistical area (CBSA) associated with at least one urbanized area that has a population of at least 50,000, and defines a micropolitan statistical area as a CBSA

associated with at least one urban cluster that has a population of at least 10,000 but less than 50,000 (75 FR 37252).

On August 22, 2014, CMS published the *FY 2015 Hospital Inpatient Prospective Payment System (IPPS) Final Rule* (79 FR 49952). This final rule states the Centers for Medicare & Medicaid Services (CMS) policy for using OMB's revised CBSA delineations based on the 2010 Census data for updating the definitions of labor market or geographic areas for purposes of payment under the IPPS, effective October 1, 2014. For the IPPS, MSAs are defined as urban, and micropolitan statistical areas and other non-urban areas are defined as rural. In addition, the IPPS definition of rural and urban is used to determine the rural or urban status of FQHC sites.

Additional information

The official instruction, CR 8980 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3147CP.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: MM8980
Related Change Request (CR) #: CR 8980
Related CR Release Date: December 12, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3147CP
Implementation Date: January 5, 2015

2015 update for durable medical equipment, prosthetics, orthotics and supplies fee schedule

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8999 to advise providers of the 2015 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your staffs are aware of these updates.

Background

CMS updates the DMEPOS fee schedules on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf*.

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

Key points

Fee schedule files

The DMEPOS fee schedule file will be available for providers and suppliers, as well as State Medicaid Agencies, managed care organizations, and other interested parties at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/*.

Healthcare Common Procedure Coding System (HCPCS) codes added/ deleted

The following new codes are effective January 1, 2015:

- A4602 in the inexpensive/routinely purchased (IN) payment category.
- The following new codes are in the prosthetics and orthotics (PO) payment category: A7048, L3981, L6026, L7259, and L8696. (Fee schedule amounts for these codes will be added to the DMEPOS fee schedule, effective January 1, 2015.)
- Also, code A4459 is added.

The base fee for code A4602 will be submitted to CMS by CMS contractors by April 3, 2015, for inclusion in the July 2015 DMEPOS fee schedule update.

The following codes are deleted from the DMEPOS fee schedule files effective January 1, 2015: A7042, A7043, L6025, L7260, and L7261. For gap-filling purposes, the 2014 deflation factors by payment category are as follows:

Factor	
0.459	Oxygen
0.462	Capped rental
0.464	Prosthetics and orthotics
0.588	Surgical dressings
0.640	Parenteral and enteral nutrition
0.963	Intraocular lenses
0.980	Splints and casts

Specific coding and pricing issues

CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004.

For 2015, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during 2013.

The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2015.

Diabetic testing supplies (DTS)

The fee schedule amounts for non-mail order diabetic testing supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for 2014. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in 2013 so that they are equal to the single payment amounts for mail order DTS established in implementing the national mail order competitive bidding program (CBP) under Section 1847 of the Act.

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The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years as CBP contracts are re-competed. The national competitive bidding program for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016.

The program instructions reviewing the changes are in Transmittal 2661, CR 8204, dated February 22, 2013. The *MLN Matters*® article related to CR 8204 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM8204.pdf*.

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing bid limits for future rounds of competitive bidding programs.

The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for multi-factor productivity (MFP), which results in update of 1.5 percent for 2015. The single payment amount public use file for the national mail order competitive bidding program is available at *http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts*.

2015 fee schedule update factor of 1.5 percent

For 2015, the update factor of 1.5 percent is applied to the applicable 2014 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2015 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2014, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP). The MFP adjustment is 0.6 percent and the CPI-U percentage increase is 2.1 percent. Thus, the 2.1 percentage increase in the CPI-U is reduced by the 0.6 percentage increase in the MFP resulting in a net increase of 1.5 percent for the update factor.

2015 update to the labor payment rates

The table below contains the 2015 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI-U for the 12-month period ending with June 30, 2014, is 2.1 percent this change is applied to the 2014 labor payment amounts to update the rates for 2015.

The 2015 labor payment amounts in the following table are effective for claims submitted using HCPCS codes K0739, L4205 and L7520 with dates of service from January 1, 2015, through December 31, 2015.

STATE	K0739	L4205	L7520
AK	$27.98	$31.88	$37.50
AL	14.86	22.14	30.05
AR	14.86	22.14	30.05
AZ	18.37	22.11	36.97
CA	22.79	36.34	42.35
CO	14.86	22.14	30.05
CT	24.81	22.63	30.05
DC	14.86	22.11	30.05
NC	$14.86	$22.14	$30.05
ND	18.51	31.81	37.50
NE	14.86	22.11	41.90
NH	15.95	22.11	30.05
NJ	20.04	22.11	30.05
NM	14.86	22.14	30.05
NV	23.67	22.11	40.96
NY	27.35	22.14	30.05
DE	27.35	22.11	30.05
FL	**14.86**	**22.14**	**30.05**
GA	14.86	22.14	30.05
HI	18.37	31.88	37.50
IA	14.86	22.11	35.97
ID	14.86	22.11	30.05
IL	14.86	22.11	30.05
IN	14.86	22.11	30.05
KS	14.86	22.11	37.50
KY	14.86	28.34	38.43
LA	14.86	22.14	30.05
MA	24.81	22.11	30.05
MD	14.86	22.11	30.05
ME	24.81	22.11	30.05
MI	14.86	22.11	30.05
MN	14.86	22.11	30.05
MO	14.86	22.11	30.05
MS	14.86	22.14	30.05
MT	14.86	22.11	37.50
OH	14.86	22.11	30.05
OK	14.86	22.14	30.05
OR	14.86	22.11	43.21
PA	15.95	22.77	30.05
PR	14.86	22.14	30.05
RI	17.70	22.79	30.05
SC	14.86	22.14	30.05
SD	16.60	22.11	40.18
TN	14.86	22.14	30.05
TX	14.86	22.14	30.05
UT	14.90	22.11	46.79
VA	14.86	22.11	30.05
VI	14.86	22.14	30.05
VT	15.95	22.11	30.05
WA	23.67	32.44	38.53
WI	14.86	22.11	30.05
WV	14.86	22.11	30.05
WY	20.71	29.50	41.90

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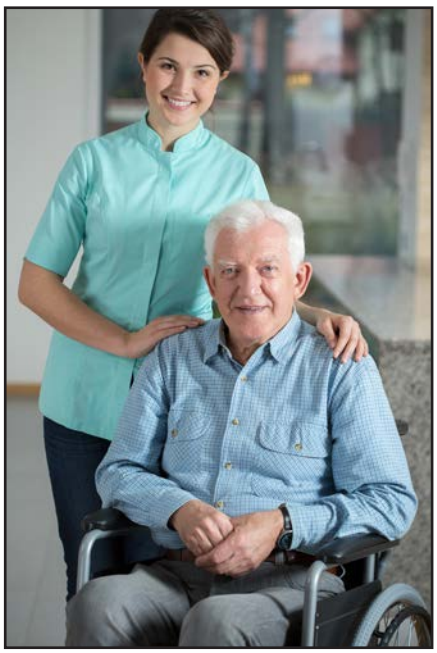
2015 national monthly payment amounts for stationary oxygen equipment

As part of CR 8999, CMS is implementing the 2015 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2015. Included is the updated national 2015 monthly payment amount of $180.92 for stationary oxygen equipment codes in the DMEPOS fee schedule.

As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for oxygen generating portable equipment (OGPE). Also, the updated 2015 monthly payment amount of $180.92 includes the 1.5 percent update factor for the 2015 DMEPOS fee schedule. Thus, the 2014 rate changed from $178.24 to the 2015 rate of $180.92.



When updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2015 maintenance and servicing payment amount for certain oxygen equipment

Also updated for 2015 is the payment amount for maintenance and servicing for certain oxygen equipment.

Payment instructions for claims for maintenance and servicing of oxygen equipment are in Transmittal 635, CR 6792, dated February 5, 2010, (see the article at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM6792.pdf*) and Transmittal 717, CR 6990, dated June 8, 2010, (see the related article at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM6990.pdf*).

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every six months beginning six months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any six-month period.

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2014 maintenance and servicing fee is adjusted by the 1.5 percent MFP-adjusted covered item update factor to yield a 2015 maintenance and servicing fee of $69.76 for oxygen concentrators and transfilling equipment.

Update to change request (CR) 8566

Effective April 1, 2014, payment on a purchase basis was established for capped rental wheelchair accessory codes furnished for use with complex rehabilitative power wheelchairs. Such accessories are considered as part of the complex rehabilitative power wheelchair and associated lump sum purchase option set forth at *42 CFR Section 414.229(a)(5)*. These changes were implemented in Transmittal 1332, CR 8566, dated January 2, 2014. Code E2378 is added to the list of codes eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair.

Additional information

The official instruction for CR 8999 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3129CP.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: MM8999
Related Change Request (CR) #: CR 8999
Related CR Release Date: November 21, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3129CP
Implementation Date: January 5, 2015

January 2015 update of the outpatient PPS

Provider types affected

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

Provider action needed

Change request (CR) 9014 describes changes to and billing instructions for various payment policies implemented in the January 2015 OPPS update. Make sure your billing staffs are aware of these changes.

Background

CR 9014 describes changes to and billing instructions for various payment policies implemented in the January 2015 outpatient prospective payment system (OPPS) update. The January 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, status indicators (SIs) and revenue code additions, changes, and deletions identified in CR 9014.

The January 2015 revisions to I/OCE data files, instructions, and specifications are provided in CR 9005. The *MLN Matters*® article related to CR 9005 is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9005.pdf* on the Centers for Medicare & Medicaid Services (CMS) website. Key changes to and billing instructions for various payment policies implemented in the January 2015, OPPS update is as follows:

New service: The new service listed in Table 1 is assigned for payment under the OPPS, effective January 1, 2015.

Table 1 – New service assigned for payment under OPPS, effective January 1, 2015

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	Payment	Minimum unadjusted copayment
C9742	01/01/2015	T	0073	Laryngoscopy with injection	Laryngoscopy, flexible fiberoptic, with injection into vocal cord(s), therapeutic, including diagnostic laryngoscopy, if performed	$1259.06	$251.82

New device pass-through categories

The Social Security Act (Section 1833(t)(6)(B); see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Social Security Act (the Act) requires that CMS create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices. CMS is establishing one new device pass-through category as of January 1, 2015. Table 2 provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

Table 2 – New device pass-through code

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	Device offset from payment
C2624	01/01/15	H	2624	Wireless pressure sensor	Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components	$310.33

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

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CMS has determined that a portion of the APC payment amount associated with the cost of C2624 is reflected in APC 0080, diagnostic cardiac catheterization. The C2624 device should always be billed with procedure code C9741 (Right heart catheterization with implantation of wireless pressure sensor in the pulmonary artery, including any type of measurement, angiography, imaging supervision, interpretation, and report), which is assigned to APC 0080 for 2015. The device offset from payment represents a deduction from pass-through payments for the device in category C2624. Therefore, CMS is establishing the offset amount for C2624 to be that of APC 0080, $310.33, which will be deducted from pass-through payment.

Comprehensive APCs

For 2015, CMS is creating a new category of codes, called "Comprehensive APCs," for which CMS provides a single claim payment. Through OCE logic, the PRICER will automatically assign payment for a "Comprehensive APC" service reported on a claim. Both the OCE and the pricer will implement these new policies without any coding change required on the part of hospitals.

Effective January 1, 2015, comprehensive APCs (Identified by a new status indicator, J1) provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service.

CMS is updating the *Medicare Claims Processing Manual*, (Chapter 4), by adding Section 10.2.3 and revising Section 10.4 to reflect comprehensive APC payment policies. The added Section 10.2.3 (Comprehensive APCs) and revised Section 10.4 (Packaging) are included in CR 9014. The added Section 10.2.3 states the following:

HCPCS codes assigned to comprehensive APCs are designated with status indicator J1, See Addendum B at *www.cms.hhs.gov/HospitalOutpatientPPS/* for the list of HCPCS codes designated with status indicator J1.

Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:

- Major OPPS procedure codes (status indicators P, S, T, V);
- Lower ranked comprehensive procedure codes (status indicator J1);
- Non-pass-through drugs and biologicals (status indicator K);
- Blood products (status indicator R);
- DME (status indicator Y); and
- Therapy services (HCPCS codes with status indicator A reported on therapy revenue centers).

The following services are excluded from comprehensive APC packaging:

- Brachytherapy sources (status indicator U);
- Pass-through drugs, biologicals and devices (status indicators G or H);
- Corneal tissue, CRNA services, and Hepatitis B vaccinations (status indicator F);
- Influenza and pneumococcal pneumonia vaccine services (status indicator L);
- Ambulance services;
- Mammography; and
- Certain preventive services

The single payment for a comprehensive claim is based on the rate associated with the J1 service. When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service. When certain pairs of J1 services (or in certain cases a J1 service and an add-on code) are reported on the same claim, the claim is eligible for a complexity adjustment, which provides a single payment for the claim based on the rate

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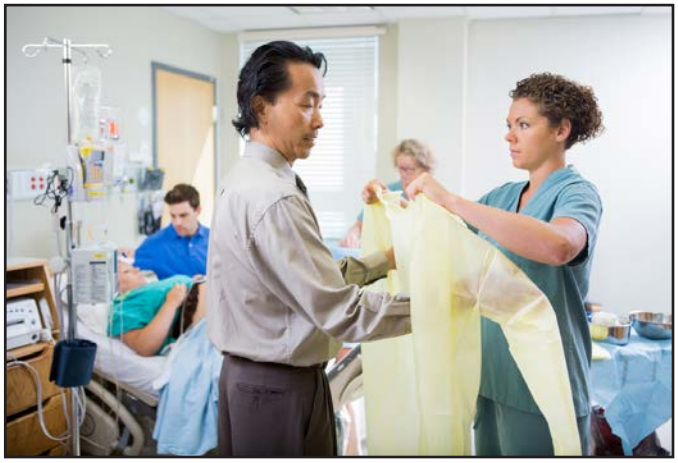
of the next higher comprehensive APC within the same clinical family. Note that complexity adjustments will not be applied to discontinued services (reported with modifier -73 or -74).



Billing for corneal tissue

CMS reminds hospitals that according to the *Medicare Claims Processing Manual* (Chapter 4, Section 200.1 at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*), the corneal tissue is paid on a cost basis and not under the OPPS. To receive cost based reimbursement for corneal tissue, hospitals must bill charges for corneal tissue using HCPCS code V2785.

Billing for mobile cardiac telemetry monitoring services

Current Procedural Terminology (CPT®) code *93229* describes wearable mobile cardiovascular telemetry services. As instructed in the 2015 OPPS/ASC final rule, *CPT®* code *93229* should be used to report continuous outpatient cardiovascular monitoring that includes up to 30 consecutive days of real-time cardiac monitoring. In particular, the 2015 *CPT®* code book defines *CPT®* code *93229* as:

> "Mobile cardiovascular telemetry (MCT): continuously records the electrocardiographic rhythm from external electrodes placed on the patient's body. Segments of the ECG data are automatically (without patient intervention) transmitted to a remote surveillance location by cellular or landline telephone signal. The segments of the rhythm, selected for transmission, are triggered automatically (MCT device algorithm) by rapid and slow heart rates or by the patient during a symptomatic episode. There is continuous real time data analysis by preprogrammed algorithms in the device and attended surveillance of the transmitted rhythm segments by a surveillance center technician to evaluate any arrhythmias and to determine signal quality. The surveillance center technician reviews the data and notifies the physician or other qualified health care professional depending on the prescribed criteria." (2015 *CPT® Professional Edition*; page 578).

CMS expects that hospitals will report *CPT®* code *93229* on hospital claims only when they have provided the mobile telemetry service as described above.

For information on the APC assignment, OPPS status indicator, and payment rate for *CPT®* code *93229* effective January 1, 2015, refer to Addendum B of the January 2015 OPPS Update that is posted at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

Billing for "sometimes therapy" services that may be paid as non-therapy services for hospital outpatients

The Social Security Act (Section 1834(k); see *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm*, as added by Section 4541 of the Balanced Budget Act (BBA), allows payment at 80 percent of the lesser of the actual charge for the services or the applicable fee schedule amount for all outpatient therapy services; that is, physical therapy services, speech-language pathology services, and occupational therapy services. As provided under Section 1834(k)(5) of the Act, a therapy code list was created based on a uniform coding system (that is, the HCPCS) to identify and track these outpatient therapy services paid under the *Medicare Physician Fee Schedule (MPFS)*.

The list of therapy codes, along with their respective designation, can be found at *http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage*. Two of the designations that are used for therapy services are: "always therapy" and "sometimes therapy." An "always therapy" service must be performed by a qualified therapist under a certified therapy plan of care, and a "sometimes therapy" service may be performed by physician or a non-physician practitioner outside of a certified therapy plan of care.

Under the OPPS, separate payment is provided for certain services designated as "sometimes therapy" services if these services are furnished to hospital outpatients as a non-therapy service, that is, without a certified therapy plan of care. Specifically, to be paid under the OPPS for a non-therapy service, hospitals SHOULD NOT append the therapy modifier GP (physical therapy), GO (occupational therapy), or GN (speech language pathology), or report a therapy revenue code 042x, 043x, or 044x in association with the "sometimes therapy" codes listed in Table 3 on the next page.

To receive payment under the MPFS, when "sometimes therapy" services are performed by a qualified therapist under a certified therapy plan of care, providers should append the appropriate therapy modifier GP, GO, or GN, and report the charges under an appropriate therapy revenue code, specifically 042x, 043x, or 044x. This instruction does not apply to

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claims for "sometimes therapy" codes furnished as non-therapy services in the hospital outpatient department and paid under the OPPS.

Effective January 1, 2015, two HCPCS codes designated as "sometimes therapy" services, G0456 (Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters) and G0457 (Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters) would be terminated and replaced with two new *CPT*® codes *97607* (Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters) and *97608* (Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters).

The list of HCPCS codes designated as "sometimes therapy" services that may be paid as non-therapy services when furnished to hospital outpatients is displayed in Table 3.

Table 3 – Services designated as "sometimes therapy" that may be paid as non-therapy services for hospital outpatients

HCPCS code	Long descriptor
92520	*Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)*
97597	*Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (for example, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters*
97598	*Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (for example,, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters*
97602	*Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (for example,, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session*
97605	*Negative pressure wound therapy (for example,, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters*
97606	*Negative pressure wound therapy (for example,, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters*
97607	*Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters*
97608	*Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters*
97610	*Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day*

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New laboratory HCPCS G-codes effective January 1, 2015

For the 2015 update, the *CPT*® editorial panel deleted several laboratory services on December 31, 2014, and replaced them with new *CPT*® codes effective January 1, 2015. Because the laboratory services described by the 2014 *CPT*® codes (which are being deleted) will continue to be paid under the clinical lab fee schedule (CLFS) in 2015, Medicare has established the following HCPCS G-codes to replace the deleted *CPT*® codes for these laboratory services.

Under the hospital OPPS, the HCPCS G-codes are assigned to status indicator "N" (packaged) effective January 1, 2015. In addition, the new laboratory 2015 *CPT*® codes that replaced the deleted laboratory 2014 *CPT*® codes have been assigned to status indicator "B" to indicate that another code should be reported under the hospital OPPS. The list of the new HCPCS G-codes and their predecessor *CPT*® codes are in Table 4.

Table 4 – New HCPCS G-codes and their predecessor *CPT*® codes

2014 *CPT*® code	2014 *CPT*® long descriptor	2015 HCPCS code	2015 HCPCS G-code long descriptor	2015 OPPS SI
80102	*Drug confirmation, each procedure*	G6058	Drug confirmation, each procedure	N
80152	*Amitriptyline*	G6030	Amitriptyline	N
80154	*Benzodiazepines*	G6031	Benzodiazepines	N
80160	*Desipramine*	G6032	Desipramine	N
80166	*Doxepin*	G6034	Doxepin	N
80172	*Gold*	G6035	Gold	N
80174	*Imipramine*	G6036	Imipramine	N
80182	*Nortriptyline*	G6037	Nortriptyline	N
80196	*Salicylate*	G6038	Salicylate	N
82003	*Acetaminophen*	G6039	Acetaminophen	N
82055	*Alcohol (ethanol); any specimen except breath*	G6040	Alcohol (ethanol); any specimen except breath	N
82101	*Alkaloids, urine, quantitative*	G6041	Alkaloids, urine, quantitative	N
82145	*Amphetamine or methamphetamine*	G6042	Amphetamine or methamphetamine	N
82205	*Barbiturates, not elsewhere specified*	G6043	Barbiturates, not elsewhere specified	N
82520	*Cocaine or metabolite*	G6044	Cocaine or metabolite	N
82646	*Dihydrocodeinone*	G6045	Dihydrocodeinone	N
82649	*Dihydromorphinone*	G6046	Dihydromorphinone	N
82651	*Dihydrotestosterone (DHT)*	G6047	Dihydrotestosterone (DHT)	N
82654	*Dimethadione*	G6048	Dimethadione	N
82666	*Epiandrosterone*	G6049	Epiandrosterone	N
82690	*Ethchlorvynol*	G6050	Ethchlorvynol	N
82742	*Flurazepam*	G6051	Flurazepam	N
83805	*Meprobamate*	G6052	Meprobamate	N
83840	*Methadone*	G6053	Methadone	N
83858	*Methsuximide*	G6054	Methsuximide	N
83887	*Nicotine*	G6055	Nicotine	N
83925	*Opiate(s), drug and metabolites, each procedure*	G6056	Opiate(s), drug and metabolites, each procedure	N
84022	*Phenothiazine*	G6057	Phenothiazine	N

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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 Chapter VIII, Section D, Item 20 of the 2015 *National Correct Coding Initiative (NCCI) Policy Manual*, injection of a drug during a cataract extraction procedure or other ophthalmic procedure is not separately reportable. Specifically, no separate procedure code may be reported for any type of injection during surgery or in the perioperative period. Injections are a part of the ocular surgery and are included as a part of the ocular surgery and the HCPCS code used to report the surgical procedure.

According to the *Medicare Claims Processing Manual* (Chapter 17, Section 90.2; see *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf*), the compounded drug combinations described above and similar drug combinations should be reported with HCPCS code J3490 (Unclassified drugs), regardless of the site of service of the surgery, and are packaged as surgical supplies in both the HOPD and the 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 ; *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. New 2015 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

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

Table 5 – New 2015 HCPCS codes effective for certain drugs, biologicals, and radiopharmaceuticals

2015 HCPCS code	2015 long descriptor	2015 SI	2015 APC
A9606	Radium ra-223 dichloride, therapeutic, per microcurie	K	1745
C9027	Injection, pembrolizumab, 1 mg	G	1490
C9136	Injection, factor viii, fc fusion protein, (recombinant), per i.u.	G	1656
C9349	FortaDerm, and FortaDerm Antimicrobial, any type, per square centimeter	G	1657
C9442	Injection, belinostat, 10 mg	G	1658
C9443	Injection, dalbavancin, 10 mg	G	1659
C9444	Injection, oritavancin, 10 mg	G	1660
C9446	Injection, tedizolid phosphate, 1 mg	G	1662
C9447	Injection, phenylephrine and ketorolac, 4 ml vial	G	1663
J0571	Buprenorphine, oral, 1 mg	E	

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2015 HCPCS code	2015 long descriptor	2015 SI	2015 APC
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg	E	
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg	E	
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg	E	
J0575	Buprenorphine/naloxone, oral, greater than 10 mg	E	
J1826	Injection, interferon beta-1a, 30 mcg	E	
J2704	Injection, Propofol, 10mg	N	
J7182	Factor viii, (antihemophilic factor, recombinant), (novoeight), per iu	E	
J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5mg	E	
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg	E	
J7327	Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose	K	1747
J8565	Gefitinib, oral, 250 mg	E	
Q4150	Allowrap dds or dry, per square centimeter	N	
Q4151	Amnioband or guardian, per square centimeter	N	
Q4152	Dermapure, per square centimeter	N	
Q4153	Dermavest, per square centimeter	N	
Q4154	Biovance, per square centimeter	N	
Q4155	Neoxflo or Clarixflo, 1 mg	N	
Q4156	Neox 100, per square centimeter	N	
Q4157	Revitalon, per square centimeter	N	
Q4158	Marigen, per square centimeter	N	
Q4159	Affinity, per square centimeter	N	
Q4160	Nushield, per square centimeter	N	

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

Many HCPCS and *CPT*® codes for drugs, biologicals, and radiopharmaceuticals have changes in their HCPCS and *CPT*® code descriptors that will be effective in 2015. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2014, and replaced with permanent HCPCS codes in 2015. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active 2015 HCPCS and *CPT*® codes.

Table 6 on the next page notes those drugs, biologicals, and radiopharmaceuticals that have changes in their HCPCS code, their long descriptor, or both. Each product's 2014 HCPCS code and long descriptor are noted in the two left hand columns and the 2015 HCPCS code and long descriptor are noted in the adjacent right hand columns.

Table 6 – Other 2015 HCPCS code changes for certain drugs, biologicals, and radiopharmaceuticals

2014 HCPCS code	2014 long descriptor	2015 HCPCS code	2015 long descriptor
J7195	Factor ix (antihemophilic factor, recombinant) per i.u.	J7195	Injection, Factor ix (antihemophilic factor, recombinant) per iu, not otherwise specified
J7301	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5mg	J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5mg
Q4119	Matristem wound matrix, psmx, rs, or psm, per square centimeter	Q4119	Matristem wound matrix, per square centimeter
Q4147	Architect, extracellular matrix, per square centimeter	Q4147	Architect, architect px, or architect fx, extracellular matrix, per square centimeter

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2014 HCPCS code	2014 long descriptor	2015 HCPCS code	2015 long descriptor
C9021	Injection, obinutuzumab, 10 mg	J9301	Injection, obinutuzumab, 10 mg
C9022	Injection, elosulfase alfa, 1mg	J1322	Injection, elosulfase alfa, 1mg
C9023	Injection, testosterone undecanoate, 1 mg	J3145	Injection, testosterone undecanoate, 1 mg
C9133	Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.	J7200	Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.
C9134	Factor XIII (antihemophilic factor, recombinant), Tretten, per i.u.	J7181	Factor XIII (antihemophilic factor, recombinant), Tretten, per i.u.
C9135	Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.	J7201	Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.
J0150	Injection, adenosine for therapeutic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use a9270)	J0153	Injection, adenosine for therapeutic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use a9270)
J0151	Injection, adenosine for diagnostic use, 1 mg (not to be used to report any adenosine phosphate compounds, instead use a9270)	J0153	Injection, adenosine for diagnostic use, 1 mg (not to be used to report any adenosine phosphate compounds, instead use a9270)
J1070	Injection, testosterone cypionate, up to 100 mg	J1071	Injection, testosterone cypionate, 1mg
J1080	Injection, testosterone cypionate, 1 cc, 200 mg	J1071	Injection, testosterone cypionate, 1mg
J2271	Injection, morphine sulfate, 100mg	J2274	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg
J2275	Injection, morphine sulfate (preservative-free sterile solution), per 10 mg	J2274	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg
J3120	Injection, testosterone enanthate, up to 100 mg	J3121	Injection, testosterone enanthate, 1mg
J3130	Injection, testosterone enanthate, up to 200 mg	J3121	Injection, testosterone enanthate, 1mg
J7335	Capsaicin 8% patch, per 10 square centimeters	J7336	Capsaicin 8% patch, per square centimeter
J9265	Injection, paclitaxel, 30 mg	J9267	Injection, paclitaxel, 1 mg
Q9970	Injection, ferric carboxymaltose, 1mg	J1439	Injection, ferric carboxymaltose, 1 mg
Q9972	Injection, epoetin beta, 1 microgram, (For ESRD On Dialysis)	J0887	Injection, epoetin beta, 1 microgram, (for esrd on dialysis)
Q9973	Injection, Epoetin Beta, 1 microgram, (Non-ESRD use)	J0888	Injection, epoetin beta, 1 microgram, (for non esrd use)
Q9974	Injection, morphine sulfate (preservative-free sterile solution), per 10 mg	J2274	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg
S0144	Injection, Propofol, 10mg	J2704	Injection, Propofol, 10mg

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

For 2015, payment for nonpass-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.

Effective January 1, 2015, payment rates for many drugs and biologicals have changed from the values published in the 2015 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of 2014. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2015 release of the OPPS pricer. CMS is not publishing the updated payment rates in this CR implementing the January 2015 update of the OPPS. However, the updated payment rates effective January 1, 2015, can be found in the January 2015 update of the OPPS Addendum A and Addendum B at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html*.

d. Skin substitute procedure edits

The payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. The skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products for packaging purposes. Table 7 lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. CMS will implement an OPPS edit that requires hospitals to report all high-cost skin substitute products in combination with one of the skin application procedures described by *CPT*® codes *15271-15278* and to report all low-cost skin substitute products in combination with one of the skin application procedures described by HCPCS codes C5271-C5278. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by *CPT*® codes *15271-15278*.

Table 7 – Skin substitute product assignment to high cost/low cost status for 2015

2015 HCPCS code	2015 short descriptor	2015 SI	Low/high cost skin substitute
C9349	Fortaderm, fortaderm antimic	G	High
C9358	SurgiMend, fetal	N	Low
C9360	SurgiMend, neonatal	N	Low
C9363	Integra Meshed Bil Wound Mat	N	High
Q4100	Skin substitute, NOS	N	Low
Q4101	Apligraf	N	High
Q4102	Oasis wound matrix	N	Low
Q4103	Oasis burn matrix	N	Low
Q4104	Integra BMWD	N	High
Q4105	Integra DRT	N	High
Q4106	Dermagraft	N	High
Q4107	Graftjacket	N	High
Q4108	Integra Matrix	N	High
Q4110	Primatrix	N	High
Q4111	Gammagraft	N	Low
Q4112	Cymetra injectable	N	N/A
Q4113	GraftJacket Xpress	N	N/A
Q4114	Integra Flowable Wound Matrix	N	N/A
Q4115	Alloskin	N	Low
Q4116	Alloderm	N	High
Q4117	Hyalomatrix	N	Low
Q4118	Matristem Micromatrix	N	N/A
Q4119	Matristem Wound Matrix	N	Low

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2015 HCPCS code	2015 short descriptor	2015 SI	Low/high cost skin substitute
Q4120	Matristem Burn Matrix	N	Low
Q4121	Theraskin	G	High
Q4122	Dermacell	G	High
Q4123	Alloskin	N	High
Q4124	Oasis Tri-layer Wound Matrix	N	Low
Q4125	Arthroflex	N	High
Q4126	Memoderm/derma/tranz/integup	N	High
Q4127	Talymed	G	High
Q4128	Flexhd/Allopatchhd/matrixhd	N	High
Q4129	Unite Biomatrix	N	High
Q4131	Epifix	N	High
Q4132	Grafix core	N	High
Q4133	Grafix prime	N	High
Q4134	HMatrix	N	High
Q4135	Mediskin	N	Low
Q4136	EZderm	N	Low
Q4137	Amnioexcel or Biodexcel, 1cm	N	High
Q4138	BioDfence DryFlex, 1cm	N	High
Q4139	Amniomatrix or Biodmatrix, 1cc	N	N/A
Q4140	Biodfence 1cm	N	High
Q4141	Alloskin ac, 1 cm	N	Low
Q4142	Xcm biologic tiss matrix 1cm	N	Low
Q4143	Repriza, 1cm	N	Low
Q4145	Epifix, 1mg	N	N/A
Q4146	Tensix, 1cm	N	Low
Q4147	Architect ecm px fx 1 sq cm	N	High
Q4148	Neox 1k, 1cm	N	High
Q4149	Excellagen, 0.1 cc	N	N/A
Q4150	Allowrap DS or Dry 1 sq cm	N	Low
Q4151	AmnioBand, Guardian 1 sq cm	N	Low
Q4152*	Dermapure 1 square cm	N	High
Q4153	Dermavest 1 square cm	N	Low
Q4154	Biovance 1 square cm	N	High
Q4155	NeoxFlo or ClarixFlo 1 mg	N	N/A
Q4156	Neox 100 1 square cm	N	High
Q4157	Revitalon 1 square cm	N	Low
Q4158	MariGen 1 square cm	N	Low
Q4159	Affinity 1 square cm	N	High
Q4160	NuShield 1 square cm	N	High

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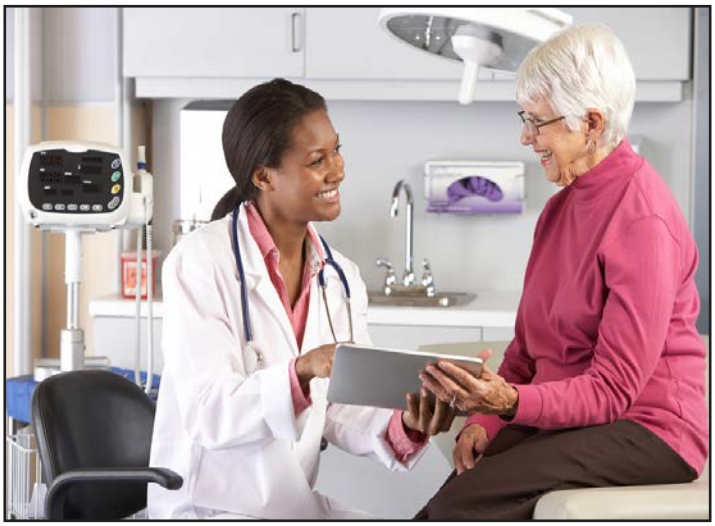
HCPCS code Q4152 was assigned to the low cost group in the 2015 OPPS/ASC final rule with comment period. Upon submission of updated pricing information, Q4152 is assigned to the high cost group for 2015.



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?redirect=/HospitalOutpatientPPS/01_overview.asp*. Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files.

Changes to OPPS pricer logic

a. Rural sole community hospitals and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in 2015. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with Section 1833(t)(13)(B) of the Social Security Act, as added by Section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA)

b. New OPPS payment rates and copayment amounts will be effective January 1, 2015. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the 2014 inpatient deductible.

c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2015. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost-(APC payment x 1.75))/2.

d. The fixed-dollar threshold decreases in 2015 relative to 2014. The estimated cost of a service must be greater than the APC payment amount plus $2,775 in order to qualify for outlier payments.

e. For outliers for community mental health centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2015. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost-(APC 0173 payment x 3.4))/2.

f. Effective October 1, 2013, and continuing for 2015, one device is eligible for pass-through payment in the OPPS Pricer logic. Category C1841 (Retinal prosthesis, includes all internal and external components), has an offset amount of $0, because CMS is not able to identify portions of the APC payment amounts associated with the cost of the device in APC 0672, Level III, Posterior segment eye procedures. For outlier purposes, when C1841 is billed with *CPT®* code *0100T*, assigned to APC 0672, it will be eligible for outlier calculation and payment.

g. C2624 (Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components), is effective January 1, 2015, device offset is $310.33, assigned to APC 2624. The procedure this should be billed with is C9741 (Right heart catheterization with implantation of wireless pressure sensor in the pulmonary artery, including any type of measurement, angiography, imaging supervision, interpretation, and report), and the procedure maps to APC 0080 (which has the offset of $310.33).

h. Effective January 1, 2015, the OPPS pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

i. Effective January 1, 2015, there will be two diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset

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OUTPATIENT

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amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the "policy-packaged" portions of the 2014 APC payments for nuclear medicine procedures and may be found on the CMS website.

j. Effective January 1, 2015, there will be four skin substitute products receiving pass-through payment in the OPPS pricer logic. For skin substitute application procedure codes that are assigned to APC 0328 (Level III Skin Repair) or APC 0329 (Level IV Skin Repair), Pricer will reduce the payment amount for the pass-through skin substitute product by the wage-adjusted offset for the APC when the pass-through skin substitute product appears on a claim with a skin substitute application procedure that maps to APC 0328 or APC 0329. The offset amounts for skin substitute products are the "policy-packaged" portions of the 2014 payments for APC 0328 and APC 0329.

k. Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals with pass-through status when those payment rates are based on ASP on a quarterly basis.

l. Effective January 1, 2015, CMS is adopting the FY 2015 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-inpatient prospective payment system (IPPS) hospitals discussed below.

m. Effective January 1, 2015, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40 percent), a device offset cap will be applied based on the credit amount listed in the "FD" (Credit Received from the Manufacturer for a replaced medical device) value code. The credit amount in value code "FD" which reduces the APC payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs are available on the CMS website.

n. Effective January 1, 2015, CMS is adopting the FY 2014 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals discussed below.

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. 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 9014 issued to your MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3156CP.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: MM9014
Related Change Request (CR) #: CR 9014
Related CR Release Date: December 22, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3156CP
Implementation Date: January 5, 2015

CMS updates IRIS software – intern and resident information system

The Intern and Resident Information System (IRIS) software programs (IRISV3 and IRISEDV3) each have three updated files (medical school codes, residency type codes, and IRISV3 Operating Instructions) for collecting and reporting information on resident training in hospital and non-hospital settings.

They are categorized as follows:

August 2014 IRISV3 Operating Instructions and Excerpts from IRISV3 Operating Instructions to Use with IRISEDV3 (mandatory for cost reporting periods beginning before July 1, 2014):

- CMS added nine new IRIS residency type codes to the IRIS Residency Type Code Table.
- CMS also added seven new IRIS medical school codes to the IRIS Medical School Code Table.
- Providers may begin using the new medical school and residency type codes in the IRIS programs for cost reporting periods ending on or after June 30, 2014.

September 2014 IRISV3 Operating Instructions and Excerpts from IRISV3 Operating Instructions to Use with IRISEDV3 (mandatory for cost reporting periods beginning on or after July 1, 2014):

- CMS renumbered IRIS residency type codes in the IRIS Residency Type Code Table; CMS removed obsolete IRIS residency type codes from this table.
- CMS removed obsolete IRIS medical school codes from the IRIS Medical School Code Table.
- Providers must use the renumbered IRIS residency type codes in the IRIS programs for cost reporting periods beginning on or after July 1, 2014.

The IRIS programs are available for downloading via the IRIS website (*http://go.usa.gov/Grw3*).

Clarification of specialty care ambulance transport

Specialty care transport (SCT) under the fee schedule for ambulance services is defined in 42 *Code of Federal Regulations* (CFR) §414.605 as an interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the emergency medical technician (EMT) – paramedic.

SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

In the December 1, 2006, final rule (71 FR 69716), the Centers for Medicare & Medicaid Services (CMS) expanded the definition of "interfacility" to include both hospitals and skilled nursing facilities (SNFs).

CMS considers a "facility" to include only a SNF or a hospital that participates in the Medicare program, or a hospital-based facility that meets our requirements for provider-based status as specified at 42 CFR §413.65.

Medicare hospitals include, but are not limited to, rehabilitation hospitals, cancer hospitals, children's hospitals, psychiatric hospitals, critical access hospitals (CAHs), inpatient acute care hospitals, and sole community hospitals (SCHs).

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 educational events – March 2015

Medicare A – Changes and regulations

When: Tuesday, March 17
Time: 10:00 a.m. - 11:30 p.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/276916.asp

Medicare B – Changes and regulations

When: Wednesday, March 18
Time: 11:30 a.m. - 1:00 p.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/274919.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.

To improve consistency and to streamline operations in messaging to the FFS provider community across all Medicare information channels, CMS conducted a pilot that ended September 30, 2012; however, CMS has extended it until further notice. The following articles link to recent *MLN Connects*™ e-News:

MLN Connects™ Provider eNews for November 20, 2014

MLN Connects™ Provider eNews for November 20, 2014

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs – Register Now
- National Partnership to Improve Dementia Care in Nursing Homes – Register Now
- Certifying Patients for the Medicare Home Health Benefit – Register Now
- • New MLN Connects™ National Provider Call Audio Recording and Transcript

CMS Events

- "Home Health Change of Care Notice and Advance Beneficiary Notice of Noncoverage" Webinar – Registration Open

Announcements

- National Home Care and Hospice Month
- Seasonal Influenza and Diabetes Awareness
- Affordable Care Act and Health Care Coverage: CME Articles on Medscape
- Prior Authorization Process for Repetitive, Scheduled, Non-Emergent Ambulance Transport
- 2013 QRURs Available
- PEPPER Still Available for SNFs, Hospices, CAHs, LTCHs, IPFs, IRFs and PHPs
- Distribution of 2012 PQRS Supplemental Incentive Payments
- EHR Incentive Program: How to Report Once in 2014 for Medicare Quality Reporting Programs
- EHR Incentive Programs: Summary of Care Meaningful Use Requirements in Stage 2

MLN® Educational Products

- The Medicare Learning Network® Autumn 2014 Catalog – Released
- • "Revised Centers for Medicare & Medicaid Services (CMS) 855R Application – Reassignment of Medicare Benefits" MLN Matters® Article – Released
- "Medicare Billing: 837I and Form CMS-1450" Fact Sheet -- Revised
- "Medicare Billing: 837P and Form CMS-1500" Fact Sheet – Revised
- "Evaluation and Management Services Guide" Educational Tool – Revised
- New Medicare Learning Network® Provider Compliance Fast Fact
- Medicare Learning Network® Product Available in Electronic Publication Format

Online Medicare refreshers

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

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

Click here to explore the wide away of training opportunities.

MLN Connects™ Provider eNews for November 26, 2014

MLN Connects™ Provider eNews for November 26, 2014

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- 2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs – Last Chance to Register
- National Partnership to Improve Dementia Care in Nursing Homes – Register Now
- Certifying Patients for the Medicare Home Health Benefit – Register Now

CMS Events

- "Home Health Change of Care Notice and Advance Beneficiary Notice of Noncoverage" Webinar – Reminder

Announcements

- In Observance of World AIDS Day – Remember HIV Screenings
- CMS Creates New Chief Data Officer Post
- Get Ready for DMEPOS Competitive Bidding
- EHR Incentive Programs: Hardship Exception Applications due November 30
- New EHR Attestation Deadline for Eligible Hospitals: December 31

Claims, Pricers, and Codes

- Hospice Notices Returned to Provider
- MA Claims Issue for FQHCs that Bill Under the AIR System
- Medicare Learning Network® Educational Products

MLN® Educational Products

- "Hospice Related Services – Part B" Podcast – Revised
- New Medicare Learning Network® Educational Web Guides Fast Fact
- Submit Your Feedback on the Medicare Learning Network® Learning Management System and Product Ordering System
- Medicare Learning Network® Product Available in Electronic Format

MLN Connects™ Provider eNews for December 4, 2014

MLN Connects™ Provider eNews for December 4, 2014

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes – Last Chance to Register
- Certifying Patients for the Medicare Home Health Benefit – Register Now

MLN Connects™ Videos

- Monthly Spotlight: Physician Feedback Program/ Value-based Payment Modifier

CMS Events

- Webinar for Comparative Billing Report on Modifier 25: Family Practice

Announcements

- National Influenza Vaccination Week – December 7-13
- CMS Releases New Proposal to Improve Accountable Care Organizations
- Efforts to Improve Patient Safety Result in 1.3 Million Fewer Patient Harms, 50,000 Lives Saved and $12 Billion in Health Spending Avoided
- Provider Enrollment Application Fee Amount for 2015
- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- ICD-10 MS-DRGs v32 Software Now Available
- Inpatient PPS FY 2014.8 PC Pricer Updated
- Clarification of Specialty Care Transport Payment Policy for Ambulance Transportation Services

MLN® Educational Products

- "Affordable Care Act Provider Compliance Programs: Getting Started" Web-Based Training Course
- "Complying With Medical Record Documentation Requirements" Fact Sheet – Released
- "Hospital Reclassifications" Fact Sheet – Revised
- Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects™ Provider eNews for December 11, 2014

MLN Connects™ Provider eNews for December 11, 2014

View this edition as a PDF

In this edition:

MLN Connects™ National Provider Calls

- Certifying Patients for the Medicare Home Health Benefit – Last Chance to Register
- ESRD QIP Payment Years 2017 and 2018 Final Rule – Registration Opening Soon

MLN Connects™ Videos

- Coding for ICD-10-CM: More of the Basics

CMS Events

- Volunteer for ICD-10 End-to-End Testing in April – Registration Opening Soon
- QRDA I and III Submissions for Eligible Professionals eHealth Provider Webinar
- Physician Compare Virtual Office Hour Session

Announcements

- New CMS Rules Enhance Medicare Provider Oversight; Strengthens Beneficiary Protections
- New Requirements for Prescribers of Medicare Part D Drugs
- ESRD PPS Low-Volume Payment Adjustment: Act by December 31
- Eligible Hospitals Must Attest By December 31 to Receive 2014 EHR Incentive
- Financial Incentives and Ability to Exchange Clinical Information Found to be Top Reasons for EHR Adoption
- HHS Awards $36.3 Million in Affordable Care Act Funding to Reward and Expand Quality Improvement in Health Centers
- See the Big Picture with Open Payments Search Tool Enhancements
- Contractor Assists Hospitals in Reporting Inpatient Quality Data
- Updates to IRIS Software
- Access Your 2013 QRUR
- 2012 Supplemental QRURs Available to Group Practices
- EHR Incentive Programs: Protect Electronic Health Information Core Objective
- Get Ready Now for ICD-10

Claims, Pricers, and Codes

- January 2015 Average Sales Price Files Now Available

MLN® Educational Products

- "Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach" MLN Matters® Article – Revised
- "Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs" MLN Matters® Article – Revised
- "Skilled Nursing Facility Billing Reference" Fact Sheet – Revised
- The Basics of Internet-based PECOS for DMEPOS Suppliers" Fact Sheet – Reminder
- New Medicare Learning Network® Provider Compliance Fast Fact
- Medicare Learning Network® Products Available In Electronic Publication Format
- Submit Your Feedback on the Medicare Learning Network® Learning Management System and Product Ordering System

Got a success story using First Coast Web tools?

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

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

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

MLN Connects™ Provider eNews for December 18, 2014

MLN Connects™ Provider eNews for December 18, 2014

View this edition as a PDF

CMS Provider Education Message:

Happy holidays from the eNews staff! The next regular edition of the eNews will be released on Thursday, January 8, 2015.

In this edition:

MLN Connects™ National Provider Calls

- Medicare Quality Reporting Programs: Data Submission Process – Registration Opening Soon
- IRF PPS: New IRF-PAI Items Effective October 1, 2015 – Registration Now Open
- ESRD QIP Payment Year 2017 and 2018 Final Rule – Registration Now Open
- New MLN Connects™ National Provider Call Video Slideshow, Audio Recording, and Transcript

CMS Events

- Volunteer for ICD-10 End-to-End Testing in April – Forms Due January 9

Announcements

- CDC Continues to Recommend a Flu Vaccine as the Best Way to Protect Against the Flu
- Revisions to Certain Patient's Rights Conditions of Participation and Conditions for Coverage Overview
- HIS Data Collection for FY 2016 Annual Payment Update Ends December 31
- IRF-PAI Training Manual Updated with Information on New Items Effective October 1, 2015
- Frequently Asked Questions on DMEPOS 2015 Medicare Payment Final Rule
- Open Payments: Final Rule Changes Related to Continuing Education Events
- Comparative Billing Report on Modifier 59: Dermatology

Claims, Pricers, and Codes

- Reprocessing of IPPS Claims Assigned to DRG 410, 573 or 907

MLN® Educational Products

- "FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing" MLN Matters® Article – Released
- "Medical Privacy of Protected Health Information" Fact Sheet – Revised
- Medicare Learning Network Products® Available In Electronic Publication Format

CMS MLN Connects™ Provider eNews – Special Edition

Monday, December 22, 2014

Results from November ICD-10 acknowledgement testing week

CMS conducted another successful acknowledgement testing week last month. Acknowledgement testing gives providers and others the opportunity to submit claims with ICD-10 codes to the Medicare fee-for-service (FFS) claim systems and receive electronic acknowledgements confirming that their claims were accepted. While providers are welcome to submit acknowledgement test claims anytime, during the November testing week, testers submitted almost 13,700 claims.

More than 500 providers, suppliers, billing companies, and clearinghouses participated in the testing week last month. Testers included small and large physician practices, small and large hospitals, labs, ambulatory surgical centers, dialysis facilities, home health providers, ambulance providers, and several other physician specialties. Acceptance rates improved throughout the week with Friday's acceptance rate for test claims at 87 percent.

Nationally, CMS accepted 76 percent of total test claims. Testing did not identify any issues with the Medicare FFS claims systems. This testing week allowed an opportunity for testers and CMS alike to learn valuable lessons about ICD-10 claims processing.

To ensure a smooth transition to ICD-10, CMS verified all test claims had a valid diagnosis code that matched the date of service, a national provider identifier (NPI) that was valid for the submitter ID used for testing, and an ICD-10 companion qualifier code to allow for processing of claims. In many cases, testers intentionally included errors in their claims to make sure that the claim would be rejected, a process often referred to as "negative testing."

The majority of rejections on professional claims were common rejects related to an invalid NPI. Some claims were rejected because they were submitted with future dates. Acknowledgement testing cannot accept claims for future dates. Additionally, claims using ICD-10 must have an ICD-10 companion qualifier code. Claims that did not meet these requirements were rejected.

Mark your calendar for upcoming acknowledgement testing weeks on March 2-6, 2015, and June 1-5, 2015. In addition to the special testing weeks, providers are welcome to submit acknowledgement test claims anytime up to the October 1, 2015, implementation date. Contact your *Medicare administrative contractor* for more information.

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SPECIAL

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For more information:

- *MLN Matters® article MM8858*, "ICD-10 Testing – Acknowledgement Testing with Providers"
- *MLN Matters® special edition article SE1409*, "Medicare FFS ICD-10 Testing Approach," which also includes information on opportunities for end-to-end testing with FFS Medicare

Registration reminder for DMEPOS competitive bidding: round two recompete & national mail-order recompete

CMS would like to remind all suppliers that registration is now open for those interested in participating in the Round 2 Recompete and/or the national mail-order recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. In order to submit a bid(s) for the Round 2 Recompete and/or the national mail-order recompete, you must first register in the Individuals Authorized Access to CMS Computer Services (IACS) online application. Once you have registered in IACS, you will receive a user ID and password to access the online DMEPOS Bidding System (DBidS). You must register even if you registered during a previous round of competition (Round 1 Recompete, Round 2, or the national mail-order competition). Only suppliers who have a user ID and password will be able to access DBidS; suppliers that do not register will not be able to submit a bid.

If you are a supplier interested in bidding, you must designate one individual listed as an authorized official (AO) on your organization's CMS-855S enrollment application in the Provider Enrollment, Chain, and Ownership System (PECOS) to act as your AO for registration purposes. After an AO successfully registers, other individuals listed as an AO on the CMS-855S in PECOS may register as backup authorized officials (BAOs).The AO must approve a BAO's request to register. The AO and BAOs can designate other individuals not listed as an AO on the CMS-855S in PECOS to serve as end users (EUs).BAOs and EUs must also register for a user ID and password in IACS in order to access DBidS. The name and Social Security number of the AO and BAO entered in IACS must match exactly with what is recorded on the CMS-855S and on file in PECOS to register successfully. Bidders are prohibited from sharing user IDs and passwords.

CMS strongly urges all AOs to register no later than January 6, 2015, to ensure that BAOs and EUs have time to register. We recommend that BAOs register no later than January 20, 2015, so that they will be able to assist AOs with approving EU registration before bidding begins on January 22, 2015.

Registration extends into the bidding period and will close on Tuesday, February 17, 2015, at 9pm prevailing ET– no AOs, BAOs, or EUs can register after registration closes. Bidding will close on Wednesday, March 25, 2015.

To register, go to the Competitive Bidding Implementation Contractor (CBIC) website, *www.dmecompetitivebid.com*, click on Round 2 & National Mail-Order Recompete, and then click on "Registration is Open" above the Registration clock. CMS strongly recommends that you:

- Review the *IACS Reference Guide*,
- Watch the short and very helpful *instructional video*, "How to Register to Submit a Bid," on your computer, tablet, or phone, and
- Use the *IACS: Getting Started Registration Checklist*.

CMS would also like to remind you to:

- **Review and update your enrollment records**. Suppliers must maintain accurate information on their CMS-855S enrollment application with the national supplier clearinghouse (NSC) and in PECOS. It is important to note that if your record is not current at the time of registration, you may experience delays and/or be unable to register and bid. We will also validate your bid data against your enrollment record in PECOS during bid evaluation. If it is not current or accurate, your bid(s) may be disqualified.
- **Get licensed**. Supplier locations must be licensed as applicable by the state in which it furnishes, or will furnish, products and services under the DMEPOS Competitive Bidding Program.
- **Get accredited**. Supplier locations must be accredited by a CMS-approved accrediting organization for the products and services it furnishes, or will furnish, under the DMEPOS Competitive Bidding Program.

The CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for E-mail Updates on the home page of the *CBIC website*. For information about the Round 2 Recompete and the national mail-order recompete, please refer to the bidder education materials located under Round 2 & National Mail-Order Recompete > Bidding Suppliers on this website. The CBIC participates in numerous educational events to assist stakeholders in understanding the rules that govern the DMEPOS Competitive Bidding Program. Visit the CBIC website for a listing and schedule of educational events under the Educational Information section of the Round 2 & national mail-order recompete page.

In addition to viewing the information on the CBIC website, suppliers are encouraged to call the CBIC customer service center toll-free, at 877-577-5331, with their questions. During registration and bidding periods, the customer service center will be open from 9am to 9pm ET.

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