# Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

*A Newsletter for MAC Jurisdiction N Providers*

January 2015


## In this issue



# New timeframe for response to additional documentation requests

*Note: This article was revised January 8, 2015, to reflect the revised change request (CR) 8583 issued January 7. The article was revised to include a statement that reviewers should not grant providers additional time to respond to additional documentation requests.*

*Also, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This article was previously published in the November 2014 edition of Medicare A Connection, Page 4.*

### Provider types affected

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

### What you need to know

This article is based on CR 8583, which instructs MACs and zone program integrity contractors (ZPICs) to produce pre-payment review additional documentation requests (ADRs) that state that providers and suppliers have 45 days to respond to an ADR issued by a MAC or a ZPIC. Failure to respond within 45 days of a pre-payment review ADR will result in denial of the claim(s) related to the ADR. Make sure your billing staffs are aware of these changes.

### Background

In certain circumstances, the Centers for Medicare & Medicaid Services (CMS) review contractors (MACs, ZPICs, recovery auditors, the comprehensive error rate testing contractor and the supplemental medical review contractor) may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments or the billing history found in claims processing system (if applicable) or Medicare's common working file (CWF).

In those instances, the CMS review contractor will solicit documentation from the provider or supplier by issuing an

See **DOCUMENT**, Page 3

# Contents






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

## DOCUMENT

From front page

ADR. The requirements for additional documentation are as follows:

The Social Security Act, Section 1833(e) - Medicare contractors are authorized to collect medical documentation.

The Act states that no payment shall be made to any provider or other person for services unless they have furnished such information as may be necessary in order to determine the amounts due to such provider or other person for the period with respect to which the amounts are being paid or for any prior period.

According to the *Medicare Program Integrity Manual*, Chapter 3, Section 3.2.3.2, (Verifying Potential Errors and Tracking Corrective Actions), when requesting documentation for pre-payment review, the MAC and ZPIC shall notify providers that the requested documentation is to be submitted within 45 calendar days of the request.

The reviewer should not grant extensions to the providers who need more time to comply with the request. Reviewers shall deny claims for which the requested documentation was not received by day 46.

### Additional information

The official instruction, CR 8583, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R566PI.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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# Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt.

The applicable number of days is also known as the payment ceiling. For example, a clean claim received March 1, 2014, must be paid before the end of business March 31, 2014.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1.

Providers may access the Treasury Department Web page *http://fms.treas.gov/prompt/rates.html* for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.

**The new rate of 2.125 percent is in effect through June 30, 2015.** Interest is not paid on:

- Claims requiring external investigation or development by the Medicare contractor
- Claims on which no payment is due
- Claims denied in full
- Claims for which the provider is receiving periodic interim payment
- Claims requesting anticipated payments under the home health prospective payment system.

**Note**: The Medicare contractor reports the amount of interest on each claim on the remittance advice to the provider when interest payments are applicable.

# CMS clarifies long-term care hospital moratorium

The Centers for Medicare and Medicaid Services (CMS) recently issued change request (CR) 9025, which clarifies three exceptions to a moratorium on new long-term care hospitals (LTCH) or LTCH satellites.

CMS states in the CR that there are no exceptions for increases in the number of beds for existing LTCHs and LTCH satellites.
For details, click *here to review CR 9025.*

## General Information

# CMS updates provider enrollment policies

### Provider types affected

This *MLN Matters*® article is intended for physicians and eligible professionals who prescribe Medicare Part D drugs, and for providers and suppliers that submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

### What you need to know

Change request (CR) 8901 incorporates into Chapter 15 of the *Program Integrity Manual* (PIM) several provider enrollment policies in the final rule titled, "Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs."

### Key points of CR 8901

The key points of the updated Chapter 15 of the *Medicare Program Integrity Manual* are as follows:

- If a MAC approves a provider's or supplier's Form CMS-855 reactivation application or reactivation certification package (RCP) for a Part B non-certified supplier, the reactivation effective date will be the date the MAC received the application or RCP that was processed to completion. Also, upon reactivating billing privileges for a Part B non-certified supplier, the MAC will issue a new provider transaction access number (PTAN).
- CMS may deny a physician's or eligible professional's Form CMS-855 enrollment application under § 424.530(a)(11) if:
  - The physician's or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked; or
  - The applicable licensing or administrative body for any state in which the physician or eligible professional practices has suspended or revoked the physician's or eligible professional's ability to prescribe drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits his or her enrollment application to the Medicare contractor.
- CMS may revoke a physician's or eligible professional's Medicare enrollment under § 424.535(a)(13) if:
  - The physician's or eligible professional's DEA certificate of registration is suspended or revoked; or
  - The applicable licensing or administrative body for any state in which the physician or eligible professional practices has suspended or revoked the physician's or eligible professional's ability to prescribe drugs.
- CMS may revoke a physician's or eligible professional's Medicare enrollment under § 424.535(a)(14) if CMS determines that the physician or eligible professional has a pattern or practice of prescribing Part D drugs that falls into one of the following categories:
  - The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both.
  - The pattern or practice of prescribing fails to meet Medicare requirements.

### Additional information

The official instruction, CR 8901, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R561PI.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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Effective Date: March 18, 2015
Related CR Transmittal #: R561PI
Implementation Date: March 18, 2015

General Coverage

# Fluorodeoxyglucose PET scan for solid tumors

***Note**: This article was revised January 12, 2015, to reflect the revised change request (CR) 8739 issued January 8. In the article, reference to an attachment at the bottom of page 2 has been replaced with a Web link to the list of appropriate diagnosis codes. Note that 793.11 has been added to that list. Also, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This article was previously published in the May 2014 edition of Medicare A Connection.*

## Provider types affected

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

## Provider action needed

This article is based on CR 8739, which advises MACs, effective for dates of service on or after June 11, 2013, to cover three FDG PET scans when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same cancer diagnosis.

Coverage of any additional FDG PET scans (that is, beyond three) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same diagnosis will be determined by your MAC. Make sure your billing staffs are aware of these changes.

## Background

The Centers for Medicare & Medicaid Services (CMS) has reconsidered Section 220.6, of the *National Coverage Determinations (NCD) Manual* to end the prospective data collection requirements across all oncologic indications of FDG PET in the context of CR 8739. The term FDG PET includes PET/computed tomography (CT) and PET/magnetic resonance (MRI).

CMS is revising the *NCD Manual*, Section 220.6, to reflect that CMS has ended the coverage with evidence development (CED) requirement for (2-[F18] fluoro-2-deoxy-D-glucose) FDG PET, PET/CT, and PET/MRI for all oncologic indications contained in Section 220.6.17 of the *NCD Manual*. This removes the current requirement for prospective data collection by the National Oncologic PET Registry (NOPR) for oncologic indications for FDG (Healthcare Common Procedure Coding System (HCPCS) code A9552) only.

**Note**: For clarification purposes, as an example, each different cancer diagnosis is allowed one (1) initial treatment strategy (-PI modifier) FDG PET scan and three (3) subsequent treatment strategy (-PS modifier) FDG PET scans without the -KX modifier.

The fourth FDG PET scan and beyond for subsequent treatment strategy for the same cancer diagnosis will always require the -KX modifier.

If a different cancer diagnosis is reported, whether reported with a -PI modifier or a -PS modifier, that cancer diagnosis will begin a new count for subsequent treatment strategy for that beneficiary.

A beneficiary's file may or may not contain a claim for initial treatment strategy with a -PI modifier. The existence or non-existence of an initial treatment strategy claim has no bearing on the frequency count of the subsequent treatment strategy (-PS) claims.

Providers may refer to *http://cms.gov/medicare/coverage/determinationprocess/downloads/petforsolidtumorsoncologicdxcodesattachment_NCD220_6_17.pdf* for a list of diagnosis codes.

Effective for claims with dates of service on or after June 11, 2013, Medicare will accept and pay for FDG PET oncologic claims billed to inform initial treatment strategy or subsequent treatment strategy for suspected or biopsy proven solid tumors for all oncologic conditions without requiring the following:

- Q0 modifier: Investigational clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);:
- Q1 modifier: routine clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);
- V70.7: Examination of participant in clinical research; or
- Condition code 30 (institutional claims only).

Effective for dates of service on or after June 11, 2013, MACs will use the following messages when denying claims in excess of **three** for PET FDG scans for subsequent treatment strategy when the –KX modifier is not included, identified by *CPT*® codes *78608*, *78811*, *78812*, *78813*, *78814*, *78815*, or *78816*, modifier –PS, HCPCS A9552, and the same cancer diagnosis code:

- Claim adjustment reason code (CARC) 96: "Non-Covered Charge(s). **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- Remittance advice remarks code (RARC) N435: "Exceeds number/frequency approved/allowed within

See **PET**, next page

# PET

From previous page

time period without support documentation."

- Group code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

MACs will not search their files to adjust claims processed prior to implementation of CR 8739. However, if you have such claims and bring them to the attention of your MAC, the MAC will adjust such claims if appropriate.

**Synopsis of coverage of FDG PET for oncologic conditions**

Effective for claims with dates of service on and after June 11, 2013, the chart below summarizes national FDG PET coverage for oncologic conditions:

| FDG PET for cancers tumor type | Initial treatment strategy (formerly "diagnosis" & "staging") | Subsequent treatment strategy (formerly "restaging" & "monitoring response to treatment" |
|---|---|---|
| Colorectal | Cover | Cover |
| Esophagus | Cover | Cover |
| Head and neck (not thyroid, CNS) | Cover | Cover |
| Lymphoma | Cover | Cover |
| Non-small cell lung | Cover | Cover |
| Ovary | Cover | Cover |
| Brain | Cover | Cover |
| Cervix | Cover with exceptions * | Cover |
| Small cell lung | Cover | Cover |
| Soft tissue sarcoma | Cover | Cover |
| Pancreas | Cover | Cover |
| Testes | Cover | Cover |
| Prostate | Non-cover | Cover |
| Thyroid | Cover | Cover |
| Breast (male/ female) | Cover with exceptions * | Cover |
| Melanoma | Cover with exceptions * | Cover |
| All other solid tumors | Cover | Cover |
| Myeloma | Cover | Cover |

*Cervix: Nationally non-covered for the initial diagnosis of cervical cancer related to initial anti-tumor treatment strategy. All other indications for initial anti-tumor treatment strategy for cervical cancer are nationally covered.

*Breast: Nationally non-covered for initial diagnosis and/ or staging of axillary lymph nodes. Nationally covered for initial staging of metastatic disease. All other indications for initial anti-tumor treatment strategy for breast cancer are nationally covered.

*Melanoma: Nationally non-covered for initial staging of regional lymph nodes. All other indications for initial anti-tumor treatment strategy for melanoma are nationally covered.

## Additional information

The official instruction, CR 8739, issued to your MAC regarding this change, is available at in two transmittals at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3162CP.pdf* and *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R168NCD.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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Implementation Dates: May 19, 2014 - MAC Non-Shared System Edits; July 7, 2014 - CWF development/testing, FISS requirement development; October 6, 2014 - CWF, FISS, MCS Shared System Edits

# Transcatheter mitral valve repair national coverage determination

## Provider types affected

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

## Provider action needed

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

TMVR is non-covered for the treatment of MR when not furnished under CED according to the above-noted criteria. TMVR used for the treatment of any non-MR indications are non-covered by Medicare.

## Background

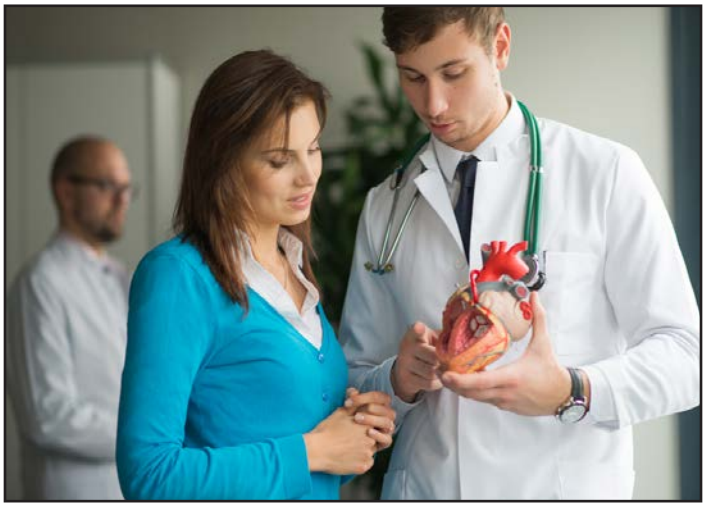
TMVR is a new technology for use in treating MR. MR occurs when the leaflets of the mitral valve do not close properly and blood flows from the left ventricle back into the left atrium, causing the heart to work harder to pump. This, in turn, causes enlargement of the left ventricle and can lead to potential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

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

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

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

- Treatment of significant, symptomatic, degenerative MR when furnished according to an FDA-approved indication, and all CMS coverage criteria are met; and



- TMVR for MR uses not expressly listed as FDA-approved indications but only within the context of an FDA-approved, randomized clinical trial that meets all CMS coverage criteria.

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

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

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

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

- On-site active valvular heart disease surgical program with > two hospital-based cardiothoracic surgeons experienced in valvular surgery;
- Cardiac catheterization lab or hybrid operating room/catheterization lab equipped with a fixed radiographic imaging system with flat-panel fluoroscopy, offering catheterization laboratory-quality imaging;

See **VALVE**, next page

# VALVE

From previous page

- Non-invasive imaging expertise including transthoracic/transesophageal/3D echocardiography, vascular studies, and cardiac CT studies;
- Sufficient space, in a sterile environment, to accommodate necessary equipment for cases with and without complications;
- Post-procedure intensive care facility with personnel experienced in managing patients who have undergone open-heart valve procedures;
- Adequate outpatient clinical care facilities; and
- Appropriate volume requirements per the applicable qualifications below.

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

- A surgical program that performs =25 total mitral valve surgical procedures for severe MR per year of which at least 10 must be mitral valve repairs;
- An interventional cardiology program that performs =1000 catheterizations per year, including = 400 percutaneous coronary interventions (PCIs) per year, with acceptable outcomes for conventional procedures compared to National Cardiovascular Data Registry (NCDR) benchmarks;
- The heart team must include:

1. An interventional cardiologist(s) who:
    - performs = 50 structural procedures per year including atrial septal defects (ASD), patent foramen ovale (PFO) and trans-septal punctures; and,
    - must receive prior suitable training on the devices to be used; and,
    - must be board-certified in interventional cardiology or board-certified/eligible in pediatric cardiology or similar boards from outside the United States;
2. Additional members of the heart team, including cardiac echocardiographers, other cardiac imaging specialists, heart valve and heart failure specialists, electrophysiologists, cardiac anesthesiologists, intensivists, nurses, nurse practitioners, physician assistants, data/research coordinators, and a dedicated administrator.
    - All cases must be submitted to a single national database;
    - Ongoing continuing medical education (or the nursing/technologist equivalent) of 10 hours per year of relevant material; and
    - The cardiothoracic surgeon(s) must be board-certified in thoracic surgery or similar foreign equivalent.
    - The heart team's interventional cardiologist or a cardiothoracic surgeon must perform the TMVR. Interventional cardiologist(s) and cardiothoracic surgeon(s) may jointly participate in the intra-operative technical aspects of TMVR as appropriate.

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

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

**Coding requirements/claims processing requirements**

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

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

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

See **VALVE**, next page

# VALVE

From previous page

- *33419* - Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session. (List separately in addition to code for primary procedure.) (**Note**: *CPT*® code *33419* is effective January 1, 2015.)

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

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

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

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

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

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

**Professional claims modifiers for TMVR for MR claims**

Effective for claims with dates of service on or after August 7, 2014, MACs will pay TMVR for MR claim lines billed with *CPT*® codes *0343T*, *0344T*, and *00345T* when billed for two surgeons/co-surgeons only when the claim includes modifier *-62*. (Effective January 1, 2015, *CPT*® codes *33418* and *33419* replace *CPT*® codes *0343T* and *0344T*, respectively.) Claim lines for two surgeons/co-surgeons billed without modifier *-62* shall be returned as unprocessable.

MACs will supply the following messages when returning TMVR for MR claim lines for two surgeons/co-surgeons billed without modifier *-62* as unprocessable:

- CARC 4: "The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- Remittance advice remarks code (RARC) N517: "Resubmit a new claim with the requested information."
- Group code: CO

Effective for claims with dates of service on or after August 7, 2014, MACs will pay claim lines for TMVR for MR billed with *CPT*® codes *0343T*, *0344T*, and *0345T* in a clinical trial when billed with modifier *-Q0*. (Effective January 1, 2015, *CPT*® codes *33418* and *33419* replace *CPT*® codes *0343T* and *0344T*, respectively.)

TMVR for MR claim lines in a clinical trial billed without modifier *-Q0* will be returned as unprocessable. MACs will supply the following messages when returning TMVR for MR claim lines in a clinical trial billed without modifier *-Q0* as unprocessable:

- CARC 4: "The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- RARC N517: "Resubmit a new claim with the requested information."
- Group code: CO

**Professional clinical trial diagnostic coding for TMVR for MR claims**

Effective for claims with dates of service on or after August 7, 2014, MACs will pay claim lines for TMVR for MR billed with *CPT*® codes *0343T*, *0344T*, and *0345T* in a clinical trial when billed with ICD-9 diagnosis code 424.0 (ICD-10 I34.0 or I34.8) and secondary ICD-9 diagnosis code V70.7 (ICD-10=Z00.6). (Effective January 1, 2015, *CPT*® codes *33418* and *33419* replace *CPT*® codes *0343T* and *0344T*, respectively.)

TMVR for MR claim lines in a clinical trial billed without

See **VALVE**, next page

## VALVE

From previous page

ICD-9 diagnosis code 424.0 (ICD-10 I34.0 or I34.8) and secondary ICD-9 diagnosis code V70.7 (ICD-10=Z00.6) will be denied.

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

- CARC 50: "These are non-covered services because this is not deemed a "medical necessity" by the payer."
- RARC N386: "This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- Group code: CO

**Claims processing requirements for TMVR for MR on inpatient hospital claims**

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

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

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

- CARC: 50 - "These are non-covered services because this is not deemed a "medical necessity" by the payer."
- RARC N386 - "This decision was based on a national coverage determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at *http://www.cms.hhs.gov/mcd/search.asp*. If you do not have web access, you may contact the contractor to request a copy of the NCD."
- Group code - contractual obligation (CO)

### Additional information

The official instruction, CR 9002, issued to your MAC regarding this change consists of two transmittals. The first updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3142CP.pdf*.

The second updates the *NCD Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R178NCD.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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Implementation Date: April 6, 2015

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# Hold on certain CAH method II claims for anesthesiologist and CRNA services

Critical access hospital (CAH) method II claims for anesthesiologist and certified registered nurse anesthetist (CRNA) services outside of the normal anesthesia code range (*00100 – 01999*) and billed with revenue code 0964 are being held due to inaccurate payments. Claims will be held until a system correction is implemented January 5, 2015. No action is required by providers.

# Preventive and screening services update

*Note: This article was revised January 8, 2015, to reflect the revised change request (CR) 8874 issued January 7. In the article, the CR release date, transmittal number, and the Web address for accessing CR 8874 are revised. All other information remains the same. This article was previously published in the December 2014 edition of Medicare A Connection, Page 14.*

## 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

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. The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8865 to alert providers and suppliers that CMS issued instructions updating the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule payment amounts, effective October 1, 2014. Make sure your billing staffs are aware of these changes.

## Background

The following outlines the CMS updates:

**Intensive behavioral therapy for obesity**

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.

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.

See **PREVENTIVE**, next page

# PREVENTIVE

From previous page

- 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:

- 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).

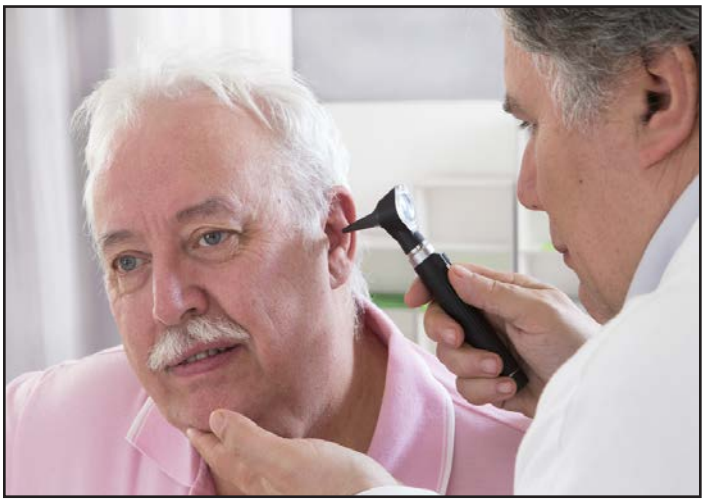
Remember that Medicare will deny claim lines billed for HCPCS codes G0447 and G0473 if billed more than 22 times in a 12-month period using the following codes:

- 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:

See **PREVENTIVE**, next page

# PREVENTIVE

From previous page

- 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.
- 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.

**Anesthesia furnished in conjunction with colonoscopy**

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.

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/R3160CP.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 *Revised*
Related Change Request (CR) #: CR 8874
Related CR Release Date: January 7, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R3160CP
Implementation Date: January 5, 2015

# Modifications to coverage of pneumococcal vaccinations

## Provider types affected

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

## Provider action needed

Change request (CR) 9051 provides an update to the Medicare pneumococcal vaccine coverage requirements, to align with new Advisory Committee on Immunization Practices (ACIP) recommendations. Make sure your billing staffs are aware of these updates.

## Background

Medicare Part B covers certain vaccinations including pneumococcal vaccines. Specifically, Section 1861(s)(10)(A) of the Social Security Act, which is available at *http://www.ssa.gov/OP_Home/ssact/title18/1861.htm*, and regulations at *42 CFR 410.57* (*http://www.ecfr.gov/cgi-bin/text-idx?SID=85dbd4cb66820b751ffe58a6c58988df&node=se42.2.410_157&rgn=div8)* authorize Medicare coverage under Part B for pneumococcal vaccine and its administration.

For services furnished on or after May 1, 1981, through September 18, 2014, the Medicare Part B program covered pneumococcal pneumonia vaccine and its administration when furnished in compliance with any applicable state law by any provider of services or any entity or individual with a supplier number.

Coverage included an initial vaccine administered only to persons at high risk of serious pneumococcal disease (including all people 65 and older; immunocompetent adults at increased risk of pneumococcal disease or its complications because of chronic illness; and individuals with compromised immune systems), with revaccination administered only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least five years had passed since the previous dose of pneumococcal vaccine.

However, ACIP updated its guidelines regarding pneumococcal vaccines; now recommending the administration of two different pneumococcal vaccinations.

The Centers for Medicare & Medicaid Services (CMS) is updating the Medicare coverage requirements to align with the updated ACIP recommendations. Effective for dates of service on or after September 19, 2014, (and upon implementation of CR 9051), Medicare will cover:

- An initial pneumococcal vaccine to all Medicare beneficiaries who have never received the vaccine under Medicare Part B; and

different, second pneumococcal vaccine one year after the first vaccine was administered (that is, 11 full months have passed following the month in which the last pneumococcal vaccine was administered).

Since the updated ACIP recommendations are specific to vaccine type and sequence of vaccination, prior pneumococcal vaccination history should be taken into consideration. For example, if a beneficiary who is 65 years or older received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) a year or more ago, then the 13-valent pneumococcal conjugate vaccine (PCV13) should be administered next as the second in the series of the two recommended pneumococcal vaccinations.

Receiving multiple vaccinations of the same vaccine type is not generally recommended. Ideally, providers should readily have access to vaccination history, such as with electronic health records, to ensure reasonable and necessary pneumococcal vaccinations.

Medicare does not require that a doctor of medicine or osteopathy order the vaccine; therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Note that MACs will not search for and adjust any claims for pneumococcal vaccines and their administration, with dates of service on and after September 19, 2014. However, they may adjust such claims that you bring to their attention.

## Additional information

The official instruction, CR 9051, issued to your MAC includes two transmittals. The first updates the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 50.4.4.2 (Immunizations) and *Medicare Claims Processing Manual*, Chapter 18 (Preventive and Screening Services), Section

See **VACCINATION**, next page

## VACCINATION

From previous page

10.1.1 (Pneumococcal Vaccine) as attachments to that transmittal. It is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R202BP.pdf*.

The second transmittal updates the *Medicare Claims Processing Manual* and that transmittal is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3159CP.pdf.*

The Centers for Disease Control and Prevention (CDC) recommends that providers use two pneumococcal vaccines for adults aged ≥ 65.

These vaccinations are 13-Valent Pneumococcal Conjugate Vaccine (PCV13) and 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23). For more information on these recommendations, visit *http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6337a4.htm.*

If you have questions, please contact your DME MAC at their toll-free number. The 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 9051
Related CR Release Date: December 31, 2014
Effective Date: September 19, 2014
Related CR Transmittal #: R202BP and R3159CP
Implementation Date: February 2, 2015

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# Certifying patients for the Medicare home health benefit

### Provider types affected

This *MLN Matters*® special edition (SE) 1436 is intended for Medicare-enrolled physicians who certify patient eligibility for home health care services and submit claims to Medicare administrative contractors (MACs) for those services provided to Medicare beneficiaries.

### What you need to know

This *MLN Matters*® SE1436 article gives Medicare-enrolled providers an overview of the Medicare home health services benefit, including patient eligibility requirements and certification/recertification requirements of covered Medicare home health services.

### Key points

To be eligible for Medicare home health services a patient must have Medicare Part A and/or Part B per Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Social Security Act (the Act):

- Be confined to the home;
- Need skilled services;
- Be under the care of a physician;
- Receive services under a plan of care established and reviewed by a physician; and
- Have had a face-to-face encounter with a physician or allowed non-physician practitioner (NPP).

Care must be furnished by or under arrangements made by a Medicare-participating home health agency (HHA).

**Patient eligibility – confined to home**

Section 1814(a) and Section 1835(a) of the Act specify that an individual is considered "confined to the home" (homebound) if the following two criteria are met:

| **First criteria**<br>**<u>One</u> of the following must be met:** | **Second criteria**<br>**<u>Both</u> of the following must be met:** |
|---|---|
| 1. Because of illness or injury, the individual needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence. | 1. There must exist a normal inability to leave home. |
| 2. Have a condition such that leaving his or her home is medically contraindicated. | 2. Leaving home must require a considerable and taxing effort. |

The patient may be considered homebound (that is, confined to the home) if absences from the home are:

- Infrequent;
- For periods of relatively short duration;
- For the need to receive health care treatment;

See **HOME**, next page

# HOME

From previous page

- For religious services;
- To attend adult daycare programs; or
- For other unique or infrequent events (for example, funeral, graduation, trip to the barber).

Some examples of persons confined to the home are:

- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence;
- A patient who has just returned from a hospital stay involving surgery, who may be suffering from resultant weakness and pain and therefore their actions may be restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time or walking stairs only once a day; and
- A patient with a psychiatric illness that is manifested, in part, by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

**Patient eligibility – need skilled services**

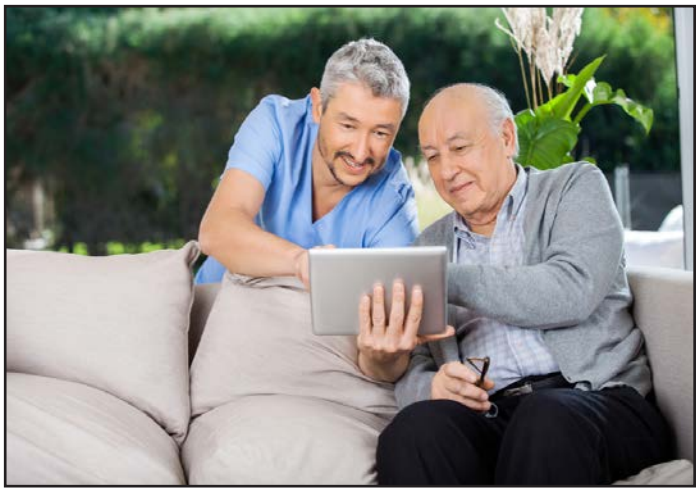
According to Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act, the patient must be in need of one of the following services:

- Skilled nursing care on an intermittent basis (furnished or needed on fewer than seven days each week or less than eight hours each day for periods of 21 days or less, with extensions in exceptional circumstances when the need for additional care is finite and predictable per Section 1861(m) of the Act);
- Physical therapy (PT);
- Speech-language pathology (SLP) services; or
- Continuing occupational therapy (OT)

Patient eligibility – under the care of a physician and receiving services under a plan of care

Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act require that the patient must be under the care of a Medicare-enrolled physician, defined at 42 CFR 424.22(a)(1)(iii) as follows:

- Doctor of medicine;
- Doctor of osteopathy; or
- Doctor of podiatric medicine (may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under state law).



According to Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act, the patient must receive home health services under a plan of care established and periodically reviewed by a physician. Based on *4*2 CFR 424.22(d)(1) a plan of care may not be established and reviewed by any physician who has a financial relationship with the HHA.

**Physician certification of patient eligibility**

As a condition for payment, according to the regulations at 42 CFR 424.22(a)(1):

- A physician must certify that a patient is eligible for Medicare home health services according to 42 CFR 424.22(a)(1)(i)(v); and
- The physician who establishes the plan of care must sign and date the certification.

The Centers for Medicare & Medicaid Services (CMS) does not require a specific form or format for the certification as long as a physician certifies that the following five requirements, outlined in 42 CFR Section 424.22(a)(1), are met:

1. The patient needs intermittent SN care, PT, and/or SLP services;
2. The patient is confined to the home (that is, homebound);
3. A plan of care has been established and will be periodically reviewed by a physician;
4. Services will be furnished while the individual was or is under the care of a physician; and
5. A face-to-face encounter:
   a. Occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care;
   b. Was related to the primary reason the patient

See **HOME**, next page

# HOME

From previous page

requires home health services; and

c. Was performed by a physician or allowed non-physician practitioner.

**Note**: The certifying physician must also document the date of the face-to-face encounter.

According to the regulations at 42 CFR 424.22(a)(2) physicians should complete the certification when the plan of care is established or as soon as possible thereafter. The certification must be complete prior to when an HHA bills Medicare for reimbursement.

**Certification requirements: who can perform a face-to-face encounter**

According to 42 CFR 424.22(a)(1)(v)(A), the face-to-face encounter can be performed by:

- The certifying physician;
- The physician who cared for the patient in an acute or post-acute care facility (from which the patient was directly admitted to home health);
- A nurse practitioner or a clinical nurse specialist who is working in collaboration with the certifying physician or the acute/post-acute care physician; or
- A certified nurse midwife or physician assistant under the supervision of the certifying physician or the acute/post-acute care physician.

According to 42 CFR 424.22(d)(2), the face-to-face encounter cannot be performed by any physician or allowed NPP (listed above) who has a financial relationship with the HHA.

**Certification requirements: management and evaluation narrative**

According to 42 CFR 424.22(a)(1)(i) if a patient's underlying condition or complication requires a registered nurse (RN) to ensure that essential **non-skilled** care is achieving its purpose and a RN needs to be involved in the development, management and evaluation of a patient's care plan, the physician will include a brief narrative describing the clinical justification of this need.

If the narrative is part of the certification form then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the certification form in addition to the physician's signature on the certification form, the physician must sign immediately following the narrative in the addendum.

For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of a registered nurse to promote the patient's recovery and medical safety in view of the patient's overall condition.

For more information about SN for management and evaluation refer to Section 40.1.2.2, Chapter 7 of the *Medicare Benefit Policy Manual* at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf*.

**Certification requirements: supporting documentation**

- Documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) shall be used as the basis for certification of home health eligibility. If the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment will not be rendered for home health services provided.
- According to the regulations at 42 CFR 424.22(c), Certifying physicians and acute/post-acute care facilities must provide, upon request, the medical record documentation that supports the certification of patient eligibility for the Medicare home health benefit to the home health agency, review entities, and/or CMS. Certifying physicians who show patterns of non-compliance with this requirement, including those physicians whose records are inadequate or incomplete for this purpose, may be subject to increased reviews, such as provider-specific probe reviews.
- Information from the HHA, such as the patient's comprehensive assessment, can be incorporated into the certifying physician's and/or the acute/post-acute care facility's medical record for the patient.
  - Information from the HHA must be corroborated by other medical record entries and align with the time period in which services were rendered.
  - The certifying physician must review and sign off on anything incorporated into the patient's medical record that is used to support the certification of patient eligibility (that is, agree with the material by signing and dating the entry).
- The certifying physician's and/or the acute/post-acute care facility's medical record for the patient must contain information that **justifies the referral** for Medicare home health services. This includes

See **HOME**, next page

# HOME

From previous page

documentation that substantiates the patient's:

1. Need for the skilled services; and
2. Homebound status.

- The certifying physician's and/or the acute/post-acute care facility's medical record for the patient must contain the **actual clinical note for the face-to-face encounter visit** that demonstrates that the encounter:

1. Occurred within the required timeframe;
2. Was related to the primary reason the patient requires home health services; and
3. Was performed by an allowed provider type.

This information can be found most often in, but is not limited to, clinical and progress notes and discharge summaries.

Please review the following examples included at the end of this article:

1. Discharge summary;
2. Progress note;
3. Progress note and problem list; or
4. Discharge summary and comprehensive assessment.

**Recertification**

At the end of the initial 60-day episode, a decision must be made as to whether or not to recertify the patient for a subsequent 60-day episode.

According to the regulations at 424.22(b)(1) recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode and unless there is a:

- Patient-elected transfer; or
- Discharge with goals met and/or no expectation of a return to home health care.

(These situations trigger a new certification, rather than a recertification)

Medicare does not limit the number of continuous episodes of recertification for patients who continue to be eligible for the home health benefit.

**Recertification requirements:**

1. Must be signed and dated by the physician who reviews the plan of care;
2. Indicate the continuing need for skilled services (the need for OT may be the basis for continuing services that were initiated because the individual needed SN, PT or SLP services); and
3. Estimate how much longer the skilled services will be required.

**Physician billing for certification/recertification**

Certifying/recertifying patient eligibility can include contacting the home health agency and reviewing of reports of patient status required by physicians to affirm the implementation of the plan of care that meets patient's needs.

1. **Healthcare Common Procedure Coding System (HCPCS) code G0180** − physician certification home health patient for Medicare-covered home health service under a home health plan of care (patient not present).
2. **HCPCS code G0179** − physician recertification home health patient for Medicare-covered home health services under a home health plan of care (patient not present)

Physician claims for certification/recertification of eligibility for home health services (G0180 and G0179 respectively) are not considered to be for "Medicare-covered" home health services if the HHA claim itself was non-covered because the certification/recertification of eligibility was not complete or because there was insufficient documentation to support that the patient was eligible for the Medicare home health benefit.

## Additional information

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

More information is available at the Medicare Home Health Agency website at *http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html.*

*MLN Matters*® Number: SE1436
Related Change Request (CR) #: NA
Related CR Release Date: NA
Effective Date: NA
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Implementation Date: NA

# CMS updates FAQs for ICD-10 testing

## Provider types affected

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

## Provider action needed

Physicians, providers, suppliers, clearinghouses, and billing agencies who participate in acknowledgement testing and who are selected to participate in Medicare ICD-10 end-to-end testing should review the questions and answers in the chart starting at the bottom of the page before preparing claims for ICD-10 acknowledgement testing and end-to-end testing to gain an understanding of the guidelines and requirements for successful testing.

When "you" is used in this publication, we are referring to ICD-10 acknowledgement testers or end-to-end testers.

**Important note**: Remember that you must be selected by the MAC in order to participate in end-to-end testing.

## Resources

The chart below provides ICD-10 resource information.

| For more information about… | Resource |
|---|---|
| ICD-10 | *http://www.cms.gov/Medicare/Coding/ICD10/index.html* |
| ICD-10 information for Medicare fee-for-service providers | *http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html* |
| ICD-10 implementation timelines | *http://www.cms.gov/Medicare/Coding/ICD10/ICD-10ImplementationTime.html* |
| ICD-10 statute and regulations | *http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html* |
| All Available *Medicare Learning Network*® (*MLN*) products | *Medicare Learning Network*® *Catalog of Products* located on the CMS website or scan the quick response (QR) code on the right |
| Provider-specific Medicare information | MLN publication titled "*MLN Guided Pathways*: Provider Specific Medicare Resources" located at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf* |
| Medicare information for patients | *http://www.medicare.gov* |

## Additional information

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

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## ICD-10 frequently-asked questions

| Question | Acknowledgment testing | End-to-end testing |
|---|---|---|
| **Do I need to register for testing?** | No, you do not need to register for acknowledgement testing. | Yes, end-to-end testing volunteers must register on their Medicare administrative contractor (MAC) website during specific time periods. |
| **Who can participate in testing?** | Acknowledgement testing is open to all Medicare fee-for-service (FFS) electronic submitters. | End-to-end testing is open to:<br>• Medicare FFS direct submitters;<br>• direct data entry (DDE) submitters who receive an electronic remittance advice (ERA);<br>• Clearinghouses; and<br>• Billing agencies. |

See **ICD-10**, next page

# ICD-10

From previous page

| Question | Acknowledgment testing | End-to-end testing |
|---|---|---|
| **How many testers will be selected?** | All Medicare FFS electronic submitters can acknowledgement test. | 50 end-to-end testers will be selected per MAC jurisdiction for each testing round. **You must be selected by the MAC for this testing**. |
| **What will the testing show?** | The goal of acknowledgement testing is to demonstrate that:<br>▪ Providers and submitters can submit claims with valid ICD-10 codes and ICD-10 companion qualifier codes;<br>▪ Providers submitted claims with valid national provider identifiers (NPIs)<br>▪ The claims are accepted by the Medicare FFS claims systems; and<br>▪ Claims receive 277CA or 999 acknowledgement, as appropriate, to confirm that the claim was accepted or rejected by Medicare. | The goal of end-to-end testing is to demonstrate that:<br>▪ Providers and submitters can successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems;<br>▪ Software changes the Centers for Medicare & Medicaid Services (CMS) made to support ICD-10 result in appropriately adjudicated claims; and<br>▪ accurate remittance advices are produced. |
| **Will the NCDs and LCDs be tested?** | No, acknowledgment testing will not test NCDs and LCDs. | Yes, end-to-end test claims will be subject to all NCDs and LCDs. |
| **Will the testing confirm payment and return an ERA to the tester?** | No, acknowledgement testing will not confirm payment. Test claims will receive 277CA or 999 acknowledgement, as appropriate, to confirm that the claim was accepted or rejected by Medicare. | Yes, end-to-end testing will provide an ERA based on current year pricing. |
| **How many claims can testers submit?** | There is no limit on the number of acknowledgement test claims you can submit. | You may submit 50 end-to-end test claims per test week. |
| **How do testers submit claims for testing?** | You submit acknowledgement test claims directly or through a clearinghouse or billing agency with test indicator “T” in the Interchange control structure (ISA) 15 field. | You submit end-to-end test claims directly with test indicator “T” in the ISA15 field or through DDE. |
| **When should testers submit test claims?** | You may submit acknowledgement test claims anytime. We encourage you to test during the highlighted testing weeks:<br>▪ March 2 – 6, 2015; and<br>▪ June 1 – 5, 2015. | You must submit end-to-end test claims during the following testing weeks:<br>▪ January 26 – 30, 2015;<br>▪ April 27 – May 1, 2015; and<br>▪ July 20 – 24, 2015. |
| **What dates of service do testers use during testing?** | You must use current dates of service during acknowledgement testing. | You must use the following future dates of service during end-to-end testing:<br>▪ Professional claims – Dates of service on or after October 1, 2015;<br>▪ Inpatient claims – Discharge dates on or after October 1, 2015;<br>▪ Supplier claims – Dates of service between October 1, 2015, and October 15, 2015; and<br>▪ Professional and institutional claims – Dates up to December 31, 2015. You cannot use dates in 2016 or beyond. |

Electronic Data Interchange

# RARC and CARC and remit easy print and PC print update

## Provider types affected

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

## Provider action needed

Change request (CR) 9004 updates the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists that are effective April 1, 2015. The CR instructs Medicare system maintainers to update Medicare remit easy print (MREP) and PC print. Make sure that your billing staffs are aware of these changes for 2015 and that they obtain the updated MREP or PC print software if they use that software.

## Background

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

The CARC and RARC changes that affect Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. Medicare contractors and shared system maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification.

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

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

If any new or modified code has an effective date past the implementation date specified in CR 9004, MACs will implement on the date specified on the WPC website. The WPC website is available at *http://www.wpcedi.com/Reference*.

CR 9004 lists only the changes that have been approved since the last code update CR 8855, Transmittal 2996, issued on July 25, 2014, with a related *MLN Matters*® article available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8855.pdf*), and does not provide a complete list of codes for these two code sets.

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

**Changes in CARC list since CR 8855**

These are changes in the CARC database since the last code update in CR 8855.

**New codes – CARC**:

| Code | Current narrative | Effective date |
|---|---|---|
| 262 | Adjustment for delivery cost. **Note**: To be used for pharmaceuticals only. | 11/1/2014 |
| 263 | Adjustment for shipping cost. Note: To be used for pharmaceuticals only. | 11/1/2014 |
| 264 | Adjustment for postage cost. **Note**: To be used for pharmaceuticals only. | 11/1/2014 |
| 265 | Adjustment for administrative cost. **Note**: To be used for pharmaceuticals only. | 11/1/2014 |
| 266 | Adjustment for compound preparation cost. **Note**: To be used for pharmaceuticals only. | 11/1/2014 |
| 267 | Claim spans multiple months. Rebill separate claim/service. | 11/1/2014 |
| 268 | Claim spans 2 calendar years. Please resubmit one claim per calendar year. | 11/1/2014 |

See **RARC**, next page

# RARC

From previous page

**Modified codes – CARC:**

| Code | Modified narrative | Effective date |
|---|---|---|
| 133 | The disposition of the claim/ service is pending further review. (Use only with group code OA). This change effective 11/01/2014: The disposition of this service line is pending further review. (Use only with group code OA). **Note**: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837). | 11/1/2014 |
| 201 | Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with group code PR) At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT.) | 11/1/2014 |

**Deactivated codes – CARC – none**

**Changes in RARC list since CR 8855**

These are changes in the RARC database since the last code update CR 8855.

**New codes – RARC:**

| Code | Narrative | Effective date |
|---|---|---|
| N729 | Missing patient medical/dental record for this service. | 11/1/2014 |
| N730 | Incomplete/invalid patient medical/ dental record for this service. | 11/1/2014 |
| N731 | Incomplete/Invalid mental health assessment. | 11/1/2014 |
| N732 | Services performed at an unlicensed facility are not reimbursable. | 11/1/2014 |
| N733 | Regulatory surcharges are paid directly to the state. | 11/1/2014 |
| N734 | The patient is eligible for these medical services only when unable to work or perform normal activities due to an illness or injury. | 11/1/2014 |

**Modified codes – RARC:**

| Code | Modified narrative | Effective date |
|---|---|---|
| N42 | Missing mental health assessment. | 11/1/2014 |
| MA118 | Alert: No Medicare payment issued for this claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. Coinsurance and/or deductible are applicable. | 11/1/2014 |
| MA09 | Claim submitted as unassigned but processed as assigned in accordance with our current assignment/participation agreement. | 11/1/2014 |

**Deactivated Codes – RARC**

| Code | Current narrative | Effective date |
|---|---|---|
| N483 | Missing periodontal charts | 05/01/2015 |
| N484 | Incomplete/invalid periodontal charts. | 5/1/2015 |

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

## Additional information

The official instruction, CR 9004, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3161CP.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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# January 2015 integrated outpatient code editor update

## Provider types affected

This *MLN Matters*® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs) for outpatient services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services when provided in a home health agency (HHA) not under the home health prospective payment system (HH PPS) or claims for services to a hospice patient for the treatment of a non-terminal illness.

## Provider action needed

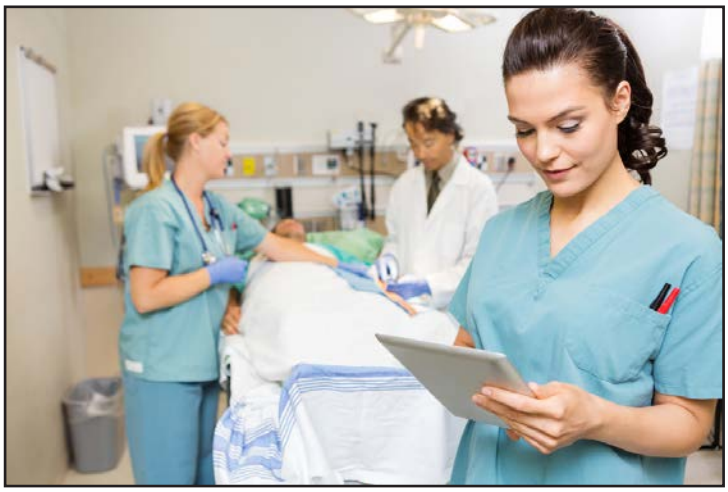
Change request (CR) 9005 which informs MACs about the changes to the integrated outpatient code editor (I/OCE) instructions and specifications for the Integrated OCE that will be utilized under the OPPS and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the home health prospective payment system or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes.

## Background

CR 9005 instruction informs the MACs and the Fiscal Intermediary Shared System (FISS) that the I/OCE is being updated for January 1, 2015. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, which eliminates the need to update, install, and maintain two separate OCE software packages on a quarterly basis. The full list of I/OCE specifications can now be found at *http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html*. There is a summary of the changes for January 2015 in Appendix O (located in Appendixes M or N of prior releases) of Attachment A of CR 9005 and that summary is captured in the following table.

**Summary of modifications**

| Type | Effective date | Edits affected | Modification |
|---|---|---|---|
| Logic | 1/1/2015 | 24 | Modify the software to maintain 28 prior quarters (7 years) of programs in each release. Remove older versions with each release. (The earliest version date included in this January 2015 release is 4/1/2008) |



| Type | Effective date | Edits affected | Modification |
|---|---|---|---|
| Logic | 1/1/2015 | | Status indicator (SI) changes:<br>▪ New SI - J1 (Hospital Part B services paid through a comprehensive APC)<br>▪ Deactivate SI X<br>▪ Modify description for SI Q1 to remove reference to SI X (STV– Packaged Codes) |
| Logic | 1/1/2015 | 92 | Implement new edit 92 (Device-dependent procedure reported without device code)<br>Edit criteria: A device-dependent procedure is reported without a device code - return to provider (RTP) |

See **OUTPATIENT**, next page

# OUTPATIENT

From previous page

| Type | Effective date | Edits affected | Modification |
|---|---|---|---|
| Logic | 1/1/2015 | | ▪ Implement Comprehensive Ambulatory Payment Classification (APC) logic (new Appendix L):<br>▪ Specified device-dependent procedures (SI = J1) are assigned to a comprehensive APC<br>▪ Multiple J1 procedures may be subject to a complexity adjustment which assigns a different comprehensive APC<br>▪ Package all other procedures (change the SI to N) present on the same claim, with exceptions for services that are not covered under OPPS (SI = B, E, M) and services that are excluded by statute |
| Logic | 1/1/2015 | | Add new payment adjustment flag value 11 (Multiple units of service present paid at single comprehensive APC rate) and update Appendix G to include new value. |
| Logic | 1/1/2015 | | Updates to Appendix F(a) for January 2015:<br>▪ Add edit 86 for home health bill type 32x<br>▪ Add new edit 92 for applicable bill types |
| Logic | 1/1/2014 | | Update Appendix F(a): Remove edits 61 and 72 from hospice bill types (81x, 82x), effective retroactively to 1/1/2014. |
| Logic | 1/1/2015 | 71, 77 | Deactivate edits 71 and 77 (procedure/device; device/procedure). |
| Logic | 1/1/2015 | | Deactivate special logic for CRT-D (Cardioverter Defibrillator with Pacing Electrode) which conditionally packaged procedure *33225* with *33249*. |
| Logic | 1/1/2015 | 84 | Remove code pairs associated with *33225* from the edit logic for edit 84. |
| Logic | 1/1/2015 | | Revise program logic to remove reference to SI X from conditional packaging (STVX-packaging). |
| Logic | 1/1/2015 | | Updates to Appendix K on page 39 to note the deactivation of composite APC 8000. |
| Logic | 1/1/2015 | 8 | Update to the sex conflict list by adding codes *0357T* and *89337* to the female only list. |

See **OUTPATIENT**, next page

# OUTPATIENT

From previous page

| Type | Effective date | Edits affected | Modification |
|---|---|---|---|
| Logic | 10/1/2014 | | Modify the federally qualified health clinic (FQHC) PPS logic to ignore modifier *59* when reported with an established patient mental health visit (G0469). |
| Logic | 10/1/2014 | | Update the following for FQHC PPS:<br>▪ Add HCPCS Q0091 as a qualifying visit code for new and established patient visits<br>▪ Add HCPCS G0472 as a preventive service<br>▪ Remove HCPCS M0064 from qualifying visit code pair (Appendix M) for G0467; code is deleted. |
| Logic | 1/1/2015 | 22 | Add new modifiers to the valid modifier list:<br>▪ PO: Serv/proc off-campus pbd<br>▪ XE: Separate Encounter<br>▪ XP: Separate Practitioner<br>▪ XS: Separate Structure<br>▪ XU: Unusual Non-Overlapping Service<br>**Note:** XE, XP, XS, XU are designated as National Correct Coding Initiative (NCCI) modifiers |
| Logic | 1/1/2015 | 75 | Edit 75 (Incorrect billing of modifier FB or FC) is deactivated. |
| Logic | 1/1/2015 | 87 | Updated skin substitute product lists (Lists A and B in Appendix P). |
| Logic | 6/2/2014 | 68 | Implement mid-quarter approval for G0472. |
| Logic | 1/9/2014 | 68 | Implement mid-quarter approval for G0276. |
| Logic | 8/1/2014 | 67 | Implement mid-quarter approval for *90687*. |
| Content | 1/1/2015 | | Make HCPCS/APC/SI changes as specified by CMS (data change files). |
| Content | 1/1/2015 | 20, 40 | Implement version 21.0 of the NCCI (as modified for applicable institutional providers). |
| Doc | 1/1/2015 | | Rename Appendices from Appendix L forward, to accommodate new comprehensive APC processing logic (new Appendix L);<br>Appendix M – FQHC processing,<br>Appendix N: OCE overview,<br>Appendix O: Summary of modifications,<br>Appendix P: Code lists. |
| Doc | 1/1/2015 | | Update to Appendix D to include notes regarding modifier 50 and comprehensive APCs. |
| Doc | 1/1/2015 | | Update Appendix E (payment method flag) to add SI = J1 and note deactivation of SI = X. |

See **OUTPATIENT**, next page

# OUTPATIENT

From previous page

| Type | Effective date | Edits affected | Modification |
|---|---|---|---|
| Doc | 1/1/2015 | | Updated IOCE specification document to remove any reference to fiscal intermediary or "FI" (includes edit descriptions for edits 11 and 72, and any field description that included a reference to FI/MAC). |
| Doc | 10/1/2014 | | Updates related to FQHC PPS:<br>–Correct the output buffer placement of edit 90 from the procedure edits buffer to the revenue edits buffer (only a change to IOCE output placement in the mainframe software)<br>▪ Added documentation to the specifications regarding bill type 770 (no payment claim), all claim lines are assigned line item action flag 5 but edit 91 is not returned (Appendix M)<br>▪ Added documentation to the specifications regarding the use of SI of E for FQHC non-covered services (Appendix M) |
| Other | 1/1/2015 | | Create 508-compliant versions of the specifications & summary of data changes documents for publication on the CMS web site. |


| Type | Effective date | Edits affected | Modification |
|---|---|---|---|
| Other | 1/1/2015 | | Deliver quarterly software update & all related documentation and files to users via electronic means. |

## Additional information

The official instruction, CR 9005 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3153CP.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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# Remittance information when Medicare systems recode health insurance prospective payment system codes

*Note: This article was revised December 19, 2014, to reflect the revised change request (CR) 8950 issued December 17. In the article, all references to CARC 169 have been replaced with CARC 186. In addition, the CR release date, transmittal number, and the Web address for accessing CR 8950 are revised. All other information remains the same. This article was previously published in the November 2014 edition of Medicare A Connection, Page 18.*

## Provider types affected

This *MLN Matters*® article is intended for inpatient rehabilitation facilities (IRFs), home health agencies (HHAs), and skilled nursing facilities (SNFs) submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs, for services provided to Medicare beneficiaries.

## Provider action needed

Change request (CR) 8950 contains no new payment policy. CR 8950 improves the implementation of existing policies. CR 8950:

1. Provides approved remittance advice code pairs to apply to claims in which only a remittance advice remark code (RARC) is currently used. This correction is required for compliance with operating rules of the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules, for Information Exchange (CORE).

2. Reflects changes to the home health (HH) pricer logic that were implemented as part of the 2015 home health prospective payment system (HH PPS) payment update.

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

## Background

The Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules, for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set was implemented by January 1, 2014, as the Affordable Care Act required. In order to be compliant with these operating rules, the processing of Medicare claims must use remittance advice code combinations that are included in this list that CAQH CORE developed.

Recently, MACs informed the Centers for Medicare & Medicaid Services (CMS) of two situations in which past instructions specified only a single code for a payment adjustment, rather than a compliant pair.

1. Since 2000, Medicare systems have re-coded the health insurance prospective payment system (HIPPS) code submitted on home HH PPS claims in various circumstances. Under prior instructions, Medicare systems applied only RARC N69 (PPS code changed by claims processing system) without a corresponding claim adjustment reason code (CARC).

2. In 2012, CR 7760 began the implementation of a process to validate HIPPS codes against the assessment records submitted to the quality improvement evaluation system (QIES). This process currently applies to inpatient rehabilitation facility claims and will be expanded to HH and skilled nursing facility claims in the future.CR 7760 only required Medicare systems to apply RARC N69 to claims recoded based on QIES data, also without a corresponding claim adjustment reason code (CARC). You can find the associated *MLN Matters*® article at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7760.pdf*.

CR 8950 seeks to correct these oversights. However, CAQH CORE has not yet assigned approved code pairs for RARC N69. Medicare will request the approval of RARC N69 to be paired with CARC 186, Medicare systems will apply CARC 186 with RARC N69 in both situations described above.

Your MAC will:

1. Apply the following remittance advice codes on claims with type of bill (TOB) 032x (home health services under a plan of treatment) when the output HIPPS code returned by the HH Pricer is different from the input HIPPS code:
   - Group code: CO
   - CARC: 186
   - RARC: N69

2. Apply the following remittance advice codes on claims with TOBs 011x (hospital inpatient (Part A)) with CMS certification numbers (CCNs) XX3025 - XX3099, XXTXXX, or XXRXXX, or TOBs 018x (Hospital swing bed), 021x (SNF inpatient) or 032x (Home health) when a HIPPS code is changed due to response file information received from QIES:
   - Group code: CO
   - CARC: 186
   - RARC: N69

See **CORRECTION**, next page

# Part A claims hold for select preventive and screening services – updated

**Intensive behavioral therapy for obesity, screening digital tomosynthesis mammography, and anesthesia with screening colonoscopy**

Part A claims will be held for the following reason codes:

31784, 31785, 31842, 31843, 31838, 31840, 31841, 31844, and 31839.

The computer fix will be installed into production on February 23, 2015. No action needed by providers.

# Proper use of 'Medicare Treatment Authorization' field

Starting January 5, 2015, the "Medicare Treatment Authorization" field must contain blanks or valid Medicare data in the first 14 bytes of the treatment authorization field for direct data entry (DDE) and hardcopy claims and at the loop 2300 REF02 (REF01=G1) segment for the ASC x12 837 claim.

Institutional claims submitted without blanks or valid data (see list below) will be returned to the provider with reason code 30729 for correction. Providers should work with their system representatives or vendors to ensure the field complies with these instructions.

**Valid data for the 'Medicare Treatment Authorization' field**

The following list represents the current valid data used in the "Medicare Treatment Authorization field"; any other data (other than blanks or the valid data values listed below) will be returned to the provider (RTP) with reason code 30729. Valid data in the loop 2300 REF02 (REF01=G1) segment for the ASC X12 837 claim may be any of the following values:

- Unique Tracking Number (UTN) = FIRST TWO POSITIONS OF UTN MUST BE ALPHA-NUMERIC AND NOT CONTAIN SPACES, THIRD POSITION OF UTN IS AN A OR H, LAST 11 POSITIONS OF UTN MUST BE NUMERIC AND NOT CONTAIN SPACES.
- TRIAL 49
- SPN66
- 64
- 56
- A/B REBILLING
- 54
- SPN65
- 07
- 08
- Valid 18-byte OASIS treatment number for home health claims

## CORRECTION

From previous page

HIPPS codes changed on the basis of validation with QIES data are not currently displayed to providers on direct data entry (DDE) screens and are not being sent to the remittance advice.

CR 8950 also reflects changes to the HH Pricer logic that were implemented as part of the 2015 HHPPS payment update. You can find these changes in the updated *Medicare Claims Processing Manual*, Chapter 10 (Home Health Agency Billing), Section 70.4 (Decision Logic Used by the Pricer on Claims), which is attached to CR 8950.

### Additional information

The official instruction, CR 8950 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3151CP.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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Reimbursement

# CMS releases physician fee schedule policies and telehealth payment amounts for 2015

## Provider types affected

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

## Provider action needed

This article is based on change request (CR) 9034 which provides a summary of the policies in the 2015 MPFS final rule and announces the telehealth originating site facility fee payment amount. Make sure that your billing staff are aware of these updates for 2015.

## Background

The Social Security Act (Section 1848(b)(1); (see *http://www.ssa.gov/OP_Home/ssact/title18/1848.htm*) requires the Centers for Medicare & Medicaid Services (CMS) to establish a fee schedule of payment amounts for physicians' services for the subsequent year. CMS issued a final rule with comment period October 13, 2014 (see *https://www.federalregister.gov/articles/2014/11/13*), that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) that are paid under the MPFS in 2015.

The final rule also addresses public comments on Medicare payment policies that were described in the proposed rule earlier this year: "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare & Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule" was published in the *Federal Register* July 11, 2014. (See *http://www.gpo.gov/fdsys/pkg/FR-2014-07-11/pdf/2014-15948.pdf*).

The final rule also addresses interim final values established in the 2014 MPFS final rule with comment period. (See *http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf*). The final rule assigns interim final values for new, revised, and potentially misvalued codes for 2015 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until December 30, 2014.

### Sustainable growth rate (SGR)

The Protecting Access to Medicare Act of 2014 (see *http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf*) provides for a zero percent update from the 2014 rates for services furnished between January 1, 2015, and March 31, 2015. Adjusting by .06 percent to achieve required budget neutrality, the conversion factor for this period is $35.8013.

Under current law, the conversion factor will be adjusted April 1, 2015. In the final rule CMS announced a conversion factor of $28.2239 for this period, resulting in an average reduction of 21.2 percent from the 2014 rates. In most prior years, Congress has taken action to avert large across-the-board reductions in PFS rates before they went into effect. The Administration supports legislation to permanently change SGR to provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care.

### Screening and diagnostic digital mammography

To ensure that the higher resources needed for 3D mammography are recognized, Medicare will pay for 3D mammography using add-on codes that will be reported in addition to the 2D mammography codes when 3D mammography is furnished. See *MLN Matters*® article MM8874 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8874.pdf)* for more information.

### Primary care and chronic care management

Medicare continues to emphasize primary care by making payment for chronic care management (CCM) services – non-face-to-face services to Medicare beneficiaries who have two or more chronic conditions – beginning January 1, 2015.

CCM services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management. CCM can be billed once per month per qualified beneficiary, provided the minimum level of services is furnished.

CMS is finalizing its proposal to allow greater flexibility in the supervision of clinical staff providing CCM services. The proposed application of the "incident to" supervision rules was widely supported by the commenters. Payment for CCM is only one part of a multi-faceted CMS initiative to improve Medicare beneficiaries' access to primary care. Models being tested through the Innovation Center will continue to explore other primary care innovations.

Finally, CMS will require that in order to bill CCM, a practitioner must use a certified electronic health record (EHR) that meets the requirements for the EHR incentive program as of December 31 of the prior calendar year.

See **TELEHEALTH**, next page

# TELEHEALTH

From previous page

**Application of beneficiary cost sharing to anesthesia related to screening colonoscopies**

The Medicare statute waives the Part B deductible and coinsurance applicable to screening colonoscopy. In the 2015 final rule, CMS revised the definition of a "screening colonoscopy" to include separately provided anesthesia as part of the screening service so that the coinsurance and deductible do not apply to anesthesia for a screening colonoscopy, reducing beneficiaries' cost-sharing obligations under Part B. For more information, review *MLN Matters*® article MM8874 (*http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8874.pdf*).

**Enhanced transparency in setting PFS rates**

Since the beginning of the physician fee schedule in 1992, CMS adopted rates for new and revised codes for the following calendar year in the final rule on an interim basis subject to public comment. This policy was necessary because CMS did not receive the codes in time to include in the PFS proposed rule.

Until recently, the only services that were affected by this policy were services with new and revised codes. In recent years, CMS began receiving new and revised codes and revaluing existing services under the misvalued codes initiative. Establishing payment in the final rule for misvalued codes often led to implementation of payment reductions before the public had the opportunity to comment.CMS finalized its proposal to change the process for valuing new, revised and potentially misvalued codes for 2016, so that payment for the vast majority of these codes goes through notice and comment rulemaking prior to being adopted. After a transition in 2016, the process will be fully implemented in 2017.

**Potentially misvalued services**

Consistent with amendments to the Affordable Care Act (see *http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf*), CMS has been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes, and to make adjustments where appropriate.

The following are 2015 major misvalued code decisions:

- **Radiation therapy and gastroenterology**: Consistent with the final rule policy and in response to public comments, CMS is not adopting the *CPT*® coding changes for 2015 for gastroenterology and radiation therapy services so that CMS can propose and obtain comments on the revised coding prior to using them for payment. As a result, CMS will not recognize some new *CPT*® codes, and created G-codes in place of changed and new *CPT*® codes.
- **Radiation treatment vault**: CMS proposed to refine the way it accounts for the infrastructure costs associated with radiation therapy equipment, specifically to remove the radiation treatment vault as a direct expense when valuing radiation therapy services. After considering public comments, CMS did not finalize this proposal.
- **Epidural pain injections**: CMS reduced payment for these services in 2014 under the misvalued code initiative. In response to concerns from pain physicians regarding the accuracy of the valuation, CMS proposed to raise the values in 2015 based on their prior resource inputs before adopting further changes after considering RUC recommendations. However, because the inputs for these services included those related to image guidance, CMS also proposed to prohibit separate billing for image guidance for 2015. CMS finalized the policy as proposed to avoid duplicate payment for image guidance. CMS has asked the RUC to further review this issue and make recommendations to us on how to value epidural pain injections.
- **Film to digital substitution**: CMS finalized its proposal to update the practice expense inputs for X-ray services to reflect that X-rays are currently done digitally rather than with analog film.

**Global surgery**

The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) has identified a number of surgical procedures that include more visits in the global period than are being furnished. CMS is also concerned that post-surgical visits are valued higher than visits that were furnished and billed separately by other physicians such as general internists or family physicians.

CMS finalized a proposal to transform all 10-day and 90-day globals to 0-day globals, beginning with 10-day global services in 2017 and following with the 90-day global services in 2018. As CMS revalues these services as zero-day global periods, CMS will actively assess whether there is a better construction of a bundled payment for surgical services that incentivizes care coordination and care redesign across an episode of care.

**Access to telehealth services**

CMS is adding the following services to the list of services that can be furnished to Medicare beneficiaries under the telehealth benefit:

- Annual wellness visits
- Psychoanalysis
- Psychotherapy

See **TELEHEALTH**, next page

# TELEHEALTH

From previous page

- Prolonged evaluation and management services

For the list of telehealth services, visit: *http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html.*

**Telehealth origination site facility fee payment amounts**

The Social Security Act (Section 1834(m)(2)(B) (see *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm)* establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20.

For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare economic index (MEI) as defined in the Social Security Act (Section 1842(i)(3) (see *http://www.ssa.gov/OP_Home/ssact/title18/1842.htm*).

The MEI increase for 2015 is 0.8 percent. Therefore, for 2015, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $24.83. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

**Revisions to malpractice relative value units (RVUs)**

As required by the Medicare law, CMS conducted a five-year review and updated the resource-based malpractice RVUs based on updated professional liability insurance premiums, largely paralleling the methodology used in the 2010 update. The final rule indicated that anesthesia RVUs will be updated in 2016.

**Revisions to geographic practice cost indices (GPCIs)**

As required by the Medicare law, CMS adjusts payments under the PFS to reflect local differences in the cost of operating a medical practice. For 2015, CMS is using territory-level wage data to calculate the work GPCI and employee wage component of the PE GPCI for the Virgin Islands.

The 2015 GPCIs also reflect the application of the statutorily mandated of 1.5 work GPCI floor in Alaska, and 1.0 work GPCI floor for all other physician fee schedule areas, and the 1.0 PE GPCI floor for frontier states (Montana, Nevada, North Dakota, South Dakota, and Wyoming).

However, given that the statutory 1.0 work GPCI floor is scheduled to expire under current law on March 31, 2015, the GPCIs reflect the elimination of the 1.0 work GPCI floor from April 1, 2015, through December 31, 2015.

**Services performed in off-campus provider-based departments**

CMS will collect data on services furnished in off-campus provider-based departments by requiring hospitals to report a modifier for those services furnished in an off-campus provider-based department of the hospital and by requiring physicians and other billing practitioners to report these services using a new place of service code on professional claims.

Data collection will be voluntary for hospitals in 2015 and required beginning January 1, 2016. The new place of service codes will be used for professional claims as soon as it is available, but not before January 1, 2016.

The official instruction, CR 9034, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3157CP.pdf.*

For more information about the EHR program, go to *http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html.*

The final rule, published on November 13, 2014, is available at *http://www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.pdf*.

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

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# Clinical laboratory fee schedule 2015 update

## Provider types affected

This *MLN Matters*® article is intended for clinical diagnostic laboratories who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

## Provider action needed

Change request (CR) 9028 provides instructions for the 2015 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Make sure your billing staffs are aware of these updates.

## Background

In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, and further amended by Section 3401 of the Affordable Care Act of 2010, the annual update to the local clinical laboratory fees for 2015 is (-0.25) percent. The annual update to local clinical laboratory fees for 2015 reflects an additional multi-factor productivity adjustment and a (-1.75) percentage point reduction as described by the Affordable Care Act.

The annual update to payments made on a reasonable charge basis for all other laboratory services for 2015 is 2.10 percent (See *42 CFR 405.509(b)(1)*). Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the national limitation amount (NLA).

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge. The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

## Key Points of CR 9028

### National minimum payment amounts

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The 2015 national minimum payment amount is $14.38 ($14.42 plus (-0.25) percent update for 2015).

The affected codes for the national minimum payment amount are *88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175*, G0123, G0143, G0144, G0145, G0147, G0148, and P3000.

### National limitation amounts (maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Act.

### Access to data file

Internet access to the 2015 clinical laboratory fee schedule data file is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html.*

Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, may use the Internet to retrieve the 2015 clinical laboratory fee schedule; available in multiple formats, including Excel, text, and comma delimited.

### Public comments

On July 14, 2014, the Centers for Medicare & Medicaid Services (CMS) hosted a public meeting to solicit input on the payment relationship between 2014 codes and new 2015 *Current Procedural Terminology CPT*® codes. Notice of the meeting was published in the *Federal Register* on March 25, 2014, and on the CMS website approximately April 1, 2014. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies.

CMS posted a summary of the meeting and the tentative payment determinations on the web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html?redirect=/ClinicalLabFeeSched*.

See **CLINICAL**, next page

# CLINICAL

From previous page

Additional written comments from the public were accepted until October 30, 2014. CMS has posted a summary of the public comments and the rationale for the final payment determinations at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2015-CLFS-Codes-Final-Determinations.pdf*.

**Pricing information**

The 2015 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes *36415*, P9612, and P9615). The fees are established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated annually. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for 2015, CMS will issue a separate instruction on the clinical laboratory travel fees.

The 2015 clinical laboratory fee schedule also includes codes that have a "QW" modifier to both identify codes and to determine payment for tests performed by a laboratory having only a certificate of waiver under the clinical laboratory improvement amendments (CLIA).

**Organ or disease oriented panel codes**

As in prior years, the 2015 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

**Mapping information**

Existing code *83516*QW is priced at the same rate as code *83516*.

New code *80163* is priced at the same rate as code *80162*.

New code *80165* is priced at the same rate as code *80164*.

New codes to be gap filled are *81161, 81246, 81287, 81288, 81313, 81410, 81411, 81415, 81416, 81417, 81420, 81425, 81426, 81427, 81430, 81431, 81435, 81436, 81440, 81445, 81450, 81455, 81460, 81465, 81470, and 81471*.

New code *83006* is priced at the same rate as code *82777*.

New code *87505* is priced at the same rate as code *87631*.

New code *87506* is priced at the same rate as code *87632*.

New code *87507* is priced at the same rate as code *87633*.

New code *87623* is priced at the same rate as code *87621*.

New code *87624* is priced at the same rate as code *87621*.

New code 87625 is priced at the same rate as code *87621*.

New code *87806* is priced at the same rate as code *87389*.

New code G6030 is priced at the same rate as code *80152*.

New code G6031 is priced at the same rate as code *80154*.

New code G6032 is priced at the same rate as code *80160*.

New code G6034 is priced at the same rate as code *80166*.

New code G6035 is priced at the same rate as code *80172*.

New code G6036 is priced at the same rate as code *80174*.

New code G6037 is priced at the same rate as code *80182*.

New code G6038 is priced at the same rate as code *80196*.

New code G6039 is priced at the same rate as code *82003*.

New code G6040 is priced at the same rate as code *82055*.

New code G6041 is priced at the same rate as code *82101*.

New code G6042 is priced at the same rate as code *82145*.

New code G6043 is priced at the same rate as code *82205*.

New code G6044 is priced at the same rate as code *82520*.

New code G6045 is priced at the same rate as code *82646*.

New code G6046 is priced at the same rate as code *82649*.

New code G6047 is priced at the same rate as code *82651*.

New code G6048 is priced at the same rate as code *82654*.

New code G6049 is priced at the same rate as code *82666*.

New code G6050 is priced at the same rate as code *82690*.

New code G6051 is priced at the same rate as code *82742*.

New code G6052 is priced at the same rate as code *83805*.

See **CLINICAL**, next page

# CLINICAL

From previous page

New code G6053 is priced at the same rate as code *83840*.

New code G6054 is priced at the same rate as code *83858*.

New code G6055 is priced at the same rate as code *83887*.

New code G6056 is priced at the same rate as code *83925*.

New code G6057 is priced at the same rate as code *84022*.

New code G6058 is priced at the same rate as code *80102*.

New code G0464 is priced at the same rate as sum of codes *81315, 81275*, and *82274*.

The following existing codes are to be deleted: *80440, 82000, 82055, 82055*QW, *82953, 82975, 82980, 83008, 83055, 83071, 83634, 83866, 84127, 87001, 87620, 87621, 87622, 80102, 80152, 80154, 80160, 80166, 80172, 80174, 80182, 80196, 82003, 82101, 82145, 82205, 82520, 82646, 82649, 82651, 82654, 82666, 82690, 82742, 83805, 83840, 83858, 83887, 83925*, and *84022*.

**Laboratory costs subject to reasonable charge payment in 2011**

For outpatients, the following codes are paid under a reasonable charge basis. The reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update.

The inflation-indexed update is calculated using the change in the applicable consumer price index for the 12-month period ending June 30 of each year as set forth in *42 CFR 405.509(b)(1)*. The inflation-indexed update for 2015 is 2.1 percent.

Manual instructions for determining the reasonable charge payment can be found in Publication 100-4, *Medicare Claims Processing Manual*, Chapter 23, Section 80 through 80.8, available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf*. If there is sufficient charge data for a code, the instructions permit considering charges for other similar services and price lists.

When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, the *Medicare Claims Processing Manual*, Chapter 8, Section 60.3, which is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf*, instructs that the reasonable charge basis applies.

When these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

**Blood product codes**

Blood product codes are P9010, P9011, P9012, P9016, P9017, P9019, P9020, P9021, P9022, P9023, P9031, P9032, P9033, P9034, P9035, P9036, P9037, P9038, P9039, P9040, P9044, P9050, P9051, P9052, P9053, P9054, P9055, P9056, P9057, P9058, P9059, and P9060.

Also, payment for codes P9010, 9016, P9021, P9022, P9038, P9039, P9040, P9051, P9054, P9056, P9057, and P9058 should be applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3, Section 20.5 through 20.5.4 (available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c03.pdf*):

**Note**: Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9045, P9046, and P9047 should be obtained from the Medicare Part B drug pricing files

**Transfusion medicine codes**

Transfusion medicine codes are *86850, 86860, 86870, 86880, 86885, 86886, 86890, 86891, 86900, 86901, 86902, 86904, 86905, 86906, 86920, 86921, 86922, 86923, 86927, 86930, 86931, 86932, 86945, 86950, 86960, 86965, 86970, 86971, 86972, 86975, 86976, 86977, 86978*, and *86985*.

**Reproductive medicine procedures**

Reproductive Medicine procedure codes are *89250, 89251, 89253, 89254, 89255, 89257, 89258, 89259, 89260, 89261, 89264, 89268, 89272, 89280, 89281, 89290, 89291, 89335, 89342, 89343, 89344, 89346, 89352, 89353, 89354*, and *89356*.

MACs will not search their files to either retract payment or retroactively pay claims; however, they should adjust claims that you bring to their attention.

## Additional information

The official instruction, CR 9028, issued to your MAC

See **CLINICAL**, Next Page

# Emergency update to the physician fee schedule database

## Provider types affected

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

## Provider action needed

This article is based on change request (CR) 9081, to announce an emergency update to payment files issued to contractors based on the *2015 Medicare Physician Fee Schedule Database (MPFSDB) Final Rule*. CR 9081 amends those payment files, including an updated conversion factor of $35.7547 for services furnished between January 1, 2015, and March 31, 2015, consistent with the Protecting Access to Medicare Act of 2014 that provides for a zero percent update from 2014 rates. Make sure that your billing staffs are aware of these changes.

## Background

Payment files were issued to contractors based upon the *2015 MPFS Final Rule*, displayed on October 31, 2014 (and published in the *Federal Register* on November 13, 2014). CR 9081 amends those payment files in order to correct technical errors to the MPFS update files, including an updated conversion factor of $35.7547 for services furnished between January 1, 2015, and March 31, 2015, consistent with the Protecting Access to Medicare Act of 2014 that provides for a zero percent update from the 2014 rate.

In preparing the 2015 final rates, errors were made in work, practice expense and malpractice RVUs. In correcting these errors and making adjustments to reflect the policies in the 2015 final rule with comment period, relativity adjustments were required across the fee schedule, and the conversion factor was adjusted from that published in the final rule. The amended payment files reflect all these changes and a conversion factor of $35.7547 for services furnished on or after January 1, 2015, and on or before March 31, 2015.

Under current law, a new conversion factor will be required for services furnished on or after April 1, 2015. These files will be provided with the April quarterly update.

## Additional information

The official instruction, CR 9081, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3166CP.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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# CLINICAL

From previous page

regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3152CP.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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Hospitals

# 2015 inpatient prospective payment system and long term care hospital PPS changes

***Note**: This article was revised January 6, 2015, to reflect a revised change request (CR). The CR was issued to correct information related to technical errors cited in the correction notice, CMS-1607-CN, published October 3, 2014. A list of the changes included in the CR may be found in the Additional Information Section of this article. The CR date, transmittal number and link to the CR also changed. All other information remains the same. This article was previously published in the September 2014 edition of Medicare A Connection, Page 51.*

## Provider types affected

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

## Provider action needed

CR 8900 provides FY 2015 updates to the acute care hospital IPPS and the LTCH PPS. All items covered in CR 8900 are effective for hospital discharges occurring on or after October 1, 2014, unless otherwise noted. Make sure your billing staff are aware of these changes.

## Background

The policy changes for FY 2015 were published in the *Federal Register* on August 22, 2014. You can find the home page for the FY 2015 Hospital Inpatient PPS final rule at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html*. The IPPS home page centralizes file(s) related to the IPPS final rule, and it contains links to the final rule and all subsequent published correction notices (if applicable); and includes:

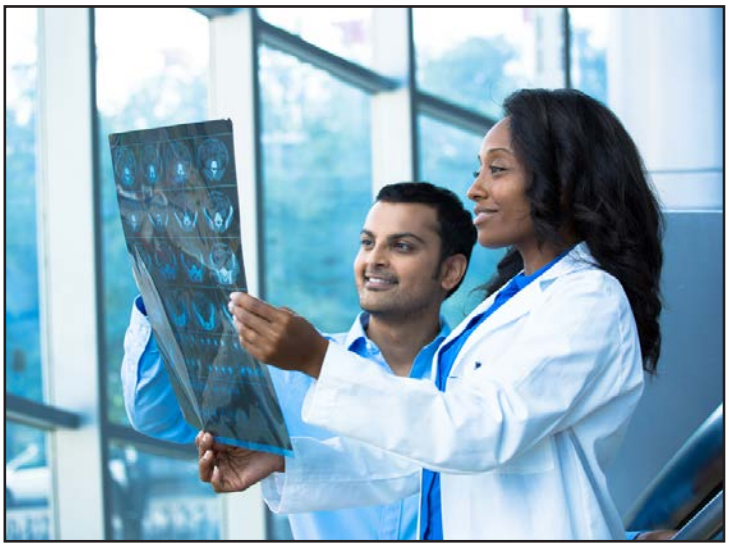
- All tables;
- Additional data and analysis files; and
- The impact file.

Files related to the long term care PPS can be found at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html*.

## Key points of CR 8900

### IPPS updates

**Medicare severity diagnosis related group grouper and Medicare code editor changes**



The grouper contractor, 3M Health Information Systems (3M-HIS), developed the new MS-DRG Grouper, Version 32.0, software package effective for discharges on or after October 1, 2014.The MCE selects the proper internal code edit tables based on discharge date. Note that the MCE version continues to match the grouper.

CMS created the following new MS-DRGs for endovascular cardiac valve replacements:

- MS-DRG 266 (Endovascular cardiac valve replacement w MCC); and
- MS-DRG 267 (Endovascular cardiac valve replacement w/o MCC).

CMS deleted:

- MS-DRG 490 (Back & neck procedures except spinal fusion with CC/MCC or disc device/neurostimulator); and
- MS-DRG 491 (Back & neck procedures except spinal fusion without CC/MCC).

CMS created the following three new MS-DRGs to account for a separate CC severity level:

- MS-DRG 518 (Back & neck procedure except spinal fusion w MCC or disc device/neurostimulator);
- MS-DRG 519 (Back & neck procedure except spinal fusion w CC); and
- MS-DRG 520 (Back & neck procedure except spinal fusion w/o CC/MCC).

See **IPPS**, next page

# IPPS

From previous page

Lastly, CMS modified MS-DRG 483 (Major joint/limb reattachment procedure of upper extremities with CC/MCC) by deleting MS-DRG 484 (Major joint/limb reattachment procedure of upper extremities without CC/MCC) and revising the title for MS-DRG 483 (Major joint/limb reattachment procedure of upper extremities) to create one base DRG.

**Post-acute transfer and special payment policy**

As a result of changes to MS-DRGs for FY 2015 the following MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy and special payment policy:

- 266, 267 (Endovascular cardiac valve replacement with and without MCC, respectively); and
- 518, 519, and 520 (Back & neck procedure except spinal fusion with MCC or disc device/neurostimulator, with CC, and without MCC/CC, respectively).

MS-DRG 483 (Major joint/limb reattachment procedure of upper extremities) will be removed from the list of MS-DRGs subject to the post-acute care transfer policy.

See corrected Table 5 of the FY 2015 IPPS/LTCH PPS final rule for a listing of all post-acute and special post-acute MS-DRGs available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html*.

**New technology add-on**

The following items will continue to be eligible for new-technology add-on payments in FY 2015:

- Zenith® fenestrated graft – Cases involving the Zenith Fenestrated Graft that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 39.78. The maximum add-on payment for a case involving the Zenith® fenestrated graft is $8,171.50. (For your information the ICD-10-CM procedure codes are: 04U03JZ - supplement abdominal aorta with synthetic substitute, percutaneous approach; 04U04JZ - Supplement abdominal aorta with synthetic substitute, percutaneous endoscopic approach; 04V03DZ -Restriction of abdominal aorta with intraluminal device, percutaneous approach or 04V04DZ - Restriction of abdominal aorta with intraluminal device, percutaneous endoscopic approach.
- Voraxaze® – Cases involving Voraxaze that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 00.95. The corrected maximum add-on payment for a case involving the Voraxaze® is $47,250. (For your information the ICD-10-CM procedure codes are: 3E033GQ - Introduction of glucarpidase into peripheral vein, percutaneous approach or 3E043GQ - Introduction of glucarpidase into central vein, percutaneous approach.)

- Argus® – Cases involving the Argus®II System that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 14.81. The maximum add-on payment for a case involving the Argus®II System is $72,028.75. (For your information the ICD-10-CM procedure codes are: 08H005Z - Insertion of epiretinal visual prosthesis into right eye, open approach or 08H105Z - Insertion of epiretinal visual prosthesis into left eye, open approach.)
- Kcentra™ – Cases involving Kcentra™ that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 00.96. The maximum add-on payment for a case of Kcentra™ is $1,587.50. DO NOT MAKE THIS NEW TECH PAYMENT IF ANY OF THE FOLLOWING DIAGNOSIS CODES ARE ON THE CLAIM: 286.0, 286.1, 286.2, 286.3, 286.4, 286.5, 286.7, 286.52, 286.53, or 286.59. (For your information the ICD-10-CM procedure codes are: 30280B1 - Transfusion of nonautologous 4-factor prothrombin complex concentrate into vein, open approach or 30283B1 - Transfusion of nonautologous 4-factor prothrombin complex and the ICD-10-CM diagnosis codes are: D66, D67, D68.1, D68.2, D68.0, D68.311, D68.312, D68.318, D68.32, and D68.4.)
- Zilver® – Cases involving the Zilver® PTX® that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 00.60. The maximum add-on payment for a case of the Zilver® PTX® is, $1,705.25.
(For your information the ICD-10-CM procedure codes are: 047K04Z - Dilation of right femoral artery

See **IPPS**, next page

# IPPS

From previous page

with drug-eluting intraluminal device, open approach; 047K34Z - Dilation of right femoral artery with drug-eluting intraluminal device, percutaneous approach; 047K44Z - Dilation of right femoral artery with drug-eluting intraluminal device, percutaneous endoscopic approach; 047L04Z - Dilation of left femoral artery with drug-eluting intraluminal device, open approach; 047L34Z - Dilation of left femoral artery with drug-eluting intraluminal device, percutaneous approach or 047L44Z - Dilation of left femoral artery with drug-eluting intraluminal device, percutaneous endoscopic approach.)

The following items will be eligible for new-technology add-on payments in FY 2015:

- CardioMEMS™ HF monitoring system – Cases involving the CardioMEMS™ HF monitoring system that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 38.26. The maximum add-on payment is $8,875. (For your information the ICD-10-CM procedure code is: 02HQ30Z–Insertion of pressure sensor monitoring device into right pulmonary artery, percutaneous approach.)
- MitraClip® system – Cases involving the MitraClip® System that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 35.97. The maximum add-on payment is $15,000. (For your information, the ICD-10-CM procedure code is: 02UG3JZ Supplement mitral valve with synthetic substitute, percutaneous approach.)
- RNS® system – Cases involving the RNS® system that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 01.20 in combination with 02.93. The maximum add-on payment is $18,475. (The ICD-10-CM procedure codes are: 0NH00NZ-Insertion of neurostimulator generator into skull, open approach in combination with 00H00MZ-Insertion of neurostimulator lead into brain, open approach.)

## Cost of living adjustment update for IPPS PPS

The IPPS incorporates a cost-of-living adjustment (COLA) for hospitals located in Alaska and Hawaii.

There are no changes to the COLAs for FY 2015, and are the same COLAs established for FY 2014.

For reference, a table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2014, is in the FY 2015 IPPS/LTCH PPS final rule and is also displayed in the following tables:

### FY 2015 cost-of-living adjustment factors: Alaska hospitals

| Area | Cost of living adjustment factor |
|---|---|
| City of Anchorage and 80-kilometer radius by road (50-mile) | 1.23 |
| City of Fairbanks and 80-kilometer radius by road (50-mile) | 1.23 |
| City of Juneau and 80-kilometer (50-mile) radius by road | 1.23 |
| Rest of Alaska | 1.25 |

### FY 2015 cost-of-living adjustment factors: Hawaii hospitals

| Area | Cost of living adjustment factor |
|---|---|
| City and County of Honolulu | 1.25 |
| County of Hawaii | 1.19 |
| County of Kauai | 1.25 |
| County of Maui and County of Kalawao | 1.25 |

## FY 2015 wage index changes and issues

### New wage index labor market areas and transitional wage indexes

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

CMS is adopting a one-year transition for FY 2015 for hospitals that are experiencing a decrease in their wage index exclusively due to the implementation of the new OMB delineations. This mitigates potential negative payment impacts due to the adoption of the new OMB delineations.

Under the new OMB delineations for the few hospitals that have been located in an urban county prior to October 1, 2014, that are becoming rural effective October 1, 2014, CMS is assigning a hold-harmless urban wage index value of the labor market area in which they are physically located for FY 2014 for three years beginning in FY 2015. That is, for FYs 2015, 2016, and 2017, assuming no other form of wage index reclassification or re-designation is granted, these hospitals are assigned the area wage index value of the urban CBSA in which they were geographically located in FY 2014.

See **IPPS**, next page

# IPPS

From previous page

For FY 2015, for hospitals that are eligible for the three-year hold-harmless transition, it is possible that receiving the FY 2015 wage index of the CBSA where the hospital is geographically located for FY 2014 might still be less than the FY 2015 wage index that the hospital would have received in the absence of the adoption of the new OMB delineations. The assignment of the three-year transitional wage index is included in the calculation of the FY 2015 portion of the blended wage index for that hospital. After FY 2015, such a hospital will revert to the second year of the three-year transition (assuming no other form of wage index reclassification or re-designation is granted).

Note that for hospitals that are receiving a one-year transition blended wage index or the three-year hold-harmless wage index, these transitions are only for the purpose of the wage index and do not affect a hospital's urban or rural status for any other payment purposes.

To ensure hospitals are paid correctly under the IPPS for the policies noted above, MACs followed the steps specified in CR 8900 titled, "Updating the PSF for Wage Index, Reclassifications and Re-designations" to update the PSF.

**Treatment of certain providers redesignated under Section 1886(d)(8)(B) of the Act 42**

CFR 412.64(b)(3)(ii) implements Section 1886(d)(8)(B) of the Social Security Act, which re-designates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as "Lugar counties".) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are re-designated.

**Section 505 hospital (out-commuting adjustment)**

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

**Treatment of certain urban hospitals reclassified as rural hospitals under 42 CFR 412.103**

An urban hospital that reclassifies as a rural hospital under 412.103 is considered rural for all IPPS purposes. Note that hospitals reclassified as rural under 412.103 are not eligible for the capital disproportionate share hospital (DSH) adjustment since these hospitals are considered rural under the capital PPS (see 412.320(a)(1)). Please reference Table 9C of FY 2015 final rule available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html*.

**Medicare-dependent, small rural hospital program expiration**

The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. The MDH program is currently effective through March 31, 2015, as provided by Section 106 of the Protecting Access to Medicare Act of 2014. Provider types 14 and 15 continue to be valid through March 31, 2015.

Under current law, beginning in April 1, 2015, all previously qualifying hospitals will no longer have MDH status and will be paid based solely on the federal rate. (CMS notes that the "sole community hospital" (SCH) policy at Section 412.92(b) allows MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program.) Provider types 14 and 15 will no longer be valid beginning April 1, 2015.

**Hospital specific rate update for sole community hospitals and Medicare-dependent, small rural hospitals**

For FY 2015, hospital-specific (HSP) amount in the PSF for SCHs and MDHs will continue to be entered in FY 2012 dollars. Pricer will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2014 of 0.9480 and make all updates to the HSP amount for FY 2013 and beyond. (As noted above, under current law, the MDH program expires March 31, 2015.)

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

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

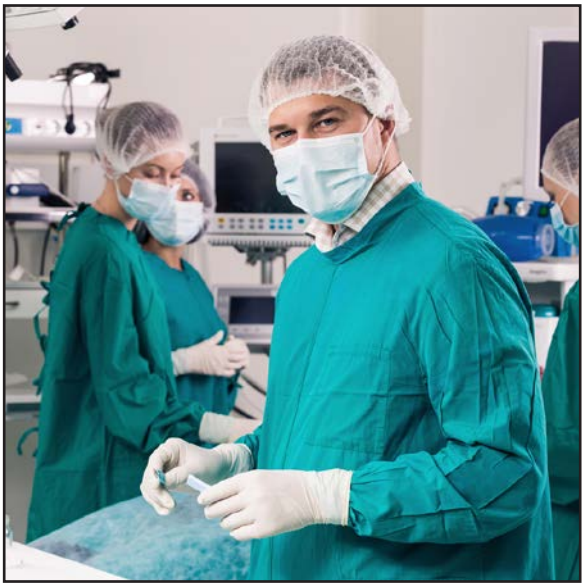
See **IPPS**, next page

# IPPS

From previous page

modified the methodology for determining the payment adjustment for hospitals meeting that definition. Section 105 of the Protecting Access to Medicare Act of 2014 extended the temporary changes to the low-volume hospital payment adjustment through March 31, 2015. The regulations implementing the hospital payment adjustment policy are at 412.101.

Beginning with FY 2015 discharges occurring on or after April 1, 2015, the low-volume hospital qualifying criteria and payment adjustment methodology will revert to that which was in effect prior to the amendments made by the Affordable Care Act and subsequent legislation (that is, the low-volume hospital payment adjustment policy in effect for FYs 2005 through 2010).



Effective October 1, 2014, through March 31, 2015, in order to qualify as a low-volume hospital, a hospital must be located more than 15 road miles from another "subsection (d) hospital" and have less than 1600 Medicare discharges (which includes Medicare Part C discharges) during the fiscal year.

For FY 2015 discharges occurring through March 31, 2015, the applicable low-volume percentage increase is determined using a continuous linear sliding scale equation that results in a low-volume hospital payment adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more Medicare discharges.

For FY 2015 discharges occurring before April 1, 2015, qualifying low-volume hospitals and their payment adjustment are determined using Medicare discharge data from the March 2014 update of the FY 2013 MedPAR file. Table 14 of the FY 2015 IPPS/LTCH PPS final rule (which is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html*) lists the "subsection (d)"' hospitals with fewer than 1,600 Medicare discharges based on the March 2014 update of the FY 2013 MedPAR file and their low-volume payment adjustment for FY 2015 discharges occurring before April 1, 2015 (if eligible).

CMS notes that the list of hospitals with fewer than 1,600 Medicare discharges in Table 14 does not reflect whether or not the hospital meets the mileage criterion (that is, the hospital is located more than 15 road miles from any other "subsection (d) hospital," which, in general, is an IPPS hospital).

Effective April 1, 2015, in order to qualify as a low-volume hospital, a hospital must be located more than 25 road miles from another "subsection (d) hospital" and have less than 200 total discharges (including both Medicare and non-Medicare discharges) during the fiscal year. For FY 2015 discharges occurring on or after April 1, 2015, the low-volume hospital adjustment for all qualifying hospitals is 25 percent.

For FY 2015 discharges occurring on or after April 1, 2015, the MAC will make the discharge determination based on the hospital's number of total discharges, that is, Medicare and non-Medicare discharges as reported on the hospital's most recently submitted cost report. To meet the mileage criterion to qualify for the low-volume hospital payment adjustment for FY 2015 discharges occurring on or after April 1, 2015, a hospital must be located more than 25 road miles (as defined at § 412.101(a)) from the nearest " subsection (d) hospital" (that is, in general, an IPPS hospital).

A hospital must notify and provide documentation to its MAC that it meets the mileage criterion. The use of a Web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion for low-volume hospitals, is acceptable.

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

To receive a low-volume hospital payment adjustment under 412.101, a hospital must notify and provide documentation to its MAC that it meets the discharge and distance requirements under 412.101(b)(2)(ii) for FY 2015 discharges occurring before April 1, 2015, and 412.101(b)(2)(i) for FY 2015 discharges occurring on or after April 1, 2015, if also applicable.

See **IPPS**, next page

# IPPS

From previous page

Specifically, for FY 2015, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2014, in order for the applicable low-volume hospital payment adjustment to be applied to payments for its discharges occurring on or after October 1, 2014, and through March 31, 2015, or through September 30, 2015, for hospitals that also meet the low-volume hospital payment adjustment qualifying criteria for discharges occurring during the second half of FY 2015.

A hospital that qualified for the low-volume payment adjustment in FY 2014 may continue to receive a low-volume payment adjustment for FY 2015 discharges occurring before April l, 2015, without reapplying if it continues to meet the Medicare discharge criterion established for FY 2015 and the distance criterion.

However, the hospital must send written verification that is received by its MAC no later than September 1, 2014, stating that it continues to be more than 15 miles from any other "subsection (d)" hospital." If a hospital's written request for low-volume hospital status for FY 2015 is received after September 1, 2014, and if the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital's FY 2015 discharges, effective prospectively within 30 days of the date of its low-volume hospital status determination.

The low-volume hospital payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH (including the uncompensated care payment), indirect medical education (IME) and outliers. For SCHs and MDHs, the low-volume hospital payment is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

**Hospital quality initiative**

The hospitals that will receive the quality initiative bonus are listed at the following Web site: *www.qualitynet.org*. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website.

**Electronic health record incentive program (EHR)**

Section 1886(b) (3) (B) of the Social Security Act as amended by Section 4102(b) (1) of the Health Information Technology for Economic and Clinical Health (HITECH) Act requires CMS to apply a reduced annual payment update to the IPPS update for subsection(d) hospitals that are not meaningful EHR users or have not been granted a hardship exception. The statute also requires payment adjustments for eligible hospitals in states where hospitals

are paid under Section 1814(b) (3) of the Act (waiver).

For FY2015, the applicable percentage increase to the IPPS payment rate is adjusted downward for those eligible hospitals that are not meaningful EHR users for the associated EHR reporting period for a payment year. This reduction applies to three-quarters of the percentage increase otherwise applicable. The reduction to three-quarters of the applicable update for an eligible hospital that is not a meaningful EHR user is 33 1/3 percent for FY 2015. In other words, for eligible hospitals that are not meaningful EHR users, the percentage increase is reduced for the entire FY by 25 percent (33 1/3 percent of 75 percent) in 2015.

A list of hospitals that will receive the EHR incentive payment reduction for FY 2015 is available in *Attachment 1* in the official instruction to CR 8900.

**Hospital acquired conditions (HAC)**

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

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

The HAC reduction program adjustment amount (that is, the one-percent payment reduction) is calculated after all other IPPS per discharge payments, which includes adjustments for DSH (including the uncompensated care payment), IME, outliers, new technology, readmissions,

See **IPPS**, next page

# IPPS

From previous page

value-based purchasing (VBP), low-volume hospital payments, and capital payments. This amount will be displayed in the PPS-FLX6-PAYMENT field in the IPPS PRICER output record. For SCHs and MDHs, the HAC reduction program adjustment amount applies to either the federal rate payment amount or the hospital-specific rate payment amount, whichever results in a greater operating IPPS payment.

CMS did not make the list of providers subject to the HAC reduction program for FY 2015 public in the final rule because hospitals had until September 2014 to notify CMS of any errors in the calculation of their total HAC score under the review and correction period. Updated hospital level data for the hospital-acquired condition (HAC) reduction program was made publicly available on December 18, 2014, in Table 17 at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html*.

**Hospital value based purchasing**

Section 3001 of the Affordable Care Act added Section 1886(o) to the Social Security Act, establishing the VBP program. This program began adjusting base operating DRG payment amounts for discharges from subsection (d) hospitals, beginning in FY 2013. CMS has continued to exclude Maryland hospitals from the hospital VBP program for the FY 2015 program year. The regulations that implement this provision are in subpart I of 42 CFR Part 412 (Sections 412.160 through 412.162).

Under the hospital VBP program, CMS reduces base operating DRG payment amounts for subsection (d) hospitals by the applicable percent defined in statute .The applicable percent for payment reductions for FY 2015 is 1.50 percent. This percent is gradually increasing each fiscal year from 1.0 in FY 2013 to 2.0 percent in FY 2017. These payment reductions fund value-based incentive payment to hospitals that meet or exceed performance standards on the measures selected for the program. By law, CMS must base value-based incentive payments on hospitals' performance under the hospital VBP program, and the total amount available for value-based incentive payments must be equal to the amount of payment reductions, as estimated by the Secretary.

CMS calculates a total performance score (TPS) for each hospital eligible for the hospital VBP program. CMS then uses a linear exchange function to convert each hospital's TPS into a value-based incentive payment. Based on that linear exchange function's slope, as well as an individual hospital's TPS, the hospitals' own annual base operating DRG payment amount, and the applicable percent reduction to base operating DRG payment amounts, CMS

calculates a value-based incentive payment adjustment factor that is applied to each discharge at a hospital, for a given fiscal year.

In the FY 2013 IPPS/LTCH PPS final rule, CMS established the methodology to calculate the hospital value-based incentive payment adjustment factor, the portion of the IPPS payment that will be used to calculate the value-based incentive payment amount, and review and corrections and appeal processes wherein hospitals can review information used to calculate their TPSs and submit requests for corrections to the information before it is made public.

For FY 2015 CMS will continue to implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2015.

Table 16B of the FY 2015 IPPS/LTCH PPS final rule (which is available on the CMS website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html*) contains the value-based incentive payment adjustment factors for FY 2015.

Table 16B data is used by the MACs to update the hospital VBP program participant indicator (VBP Participant) to hold a value of 'Y' if the provider is included in the hospital VBP program and the hospital VBP program adjustment field (VBP adjustment) to hold the value-based incentive payment adjustment factor for FY 2015.

**Note**: The values listed in Table 16A of the IPPS/LTCH PPS final rule are proxy values. These values are not used to adjust payments.

**Hospital readmissions reduction program**

For FY 2015, the readmissions adjustment factor is the

See **IPPS**, Next Page

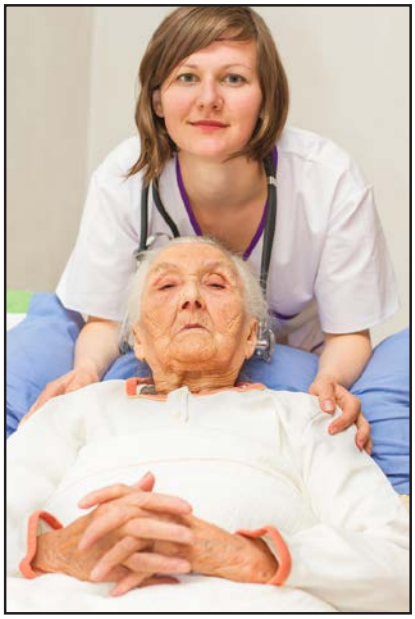
# IPPS

From previous page

higher of a ratio or 0.97 (-3 percent). The readmissions adjustment factor is applied to a hospital's "base operating DRG payment amount", or the wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable), to determine the amount reduced from a hospital's IPPS payment due to excess readmissions. Add-on payments for IME, DSH (including the uncompensated care payment), outliers and low-volume hospitals are not adjusted by the readmissions adjustment factor.

In addition, for SCHs, the difference between the SCH's operating IPPS payment under the hospital-specific rate and the federal rate is not adjusted by the readmissions adjustment factor.

However, the portion of a MDH's payment reduction due to excess readmissions that is based on 75 percent difference between payment under the hospital-specific rate and payment under the federal rate will be determined at cost report settlement. In determining the claim payment, the pricer will only apply the readmissions adjustment factor to a MDH's wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable) to determine the payment reduction due to excess readmissions.



Hospitals that are not subject to a reduction under the hospital readmissions reduction program in FY 2015 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. (Hospitals located in Puerto Rico are not subject to the hospital readmissions reduction program). For FY 2015, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.

The hospital readmissions reduction program (HRRP) adjustment factors for FY 2015 are available in Table 15B of the FY 2015 IPPS final rule, which is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html*.

Claims will be reprocessed if a hospital's HRR adjustment factor changes when the actual factors are available in the near future. (Note: the values listed in Table 15A of the IPPS/LTCH PPS final rule are proxy values. These values are not used to adjust payments.)

**Medicare disproportionate share hospitals program**

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

The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of this uncompensated care pool based on its share of total uncompensated care reported by Medicare DSH hospitals.

A Medicare DSH hospital's share of uncompensated care is based on its share of insured low income days, defined as the sum of Medicare SSI days and Medicaid days, relative to all Medicare DSH hospitals' insured low income days.

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

For FY 2015, the total uncompensated care payment amount to be paid to Medicare DSH hospitals is $7,647,644,885.18, as calculated as the product of 75 percent of Medicare DSH (estimated CMS Office of the Actuary) and the change in percent of uninsured individuals and an additional statutory adjustment at 76.19 percent.

The total uncompensated care payment amount to be paid to the Medicare DSH hospitals was finalized in the FY 2015 IPPS final rule. The uncompensated care payment will be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2015. The estimated per claim amount is determined by dividing the total uncompensated care payment by the average number of claims from the most recent three years of claims data (FYs 2011-2013).

The hospitals that were located in urban counties that are becoming rural under our adoption of the new OMB delineations are subject to a transition for their Medicare DSH payment. For a hospital with more than 99 beds and less than 500 beds that was re-designated from urban to rural, it would be subject to a DSH payment adjustment cap of 12 percent.

See **IPPS**, Next Page

# IPPS

From previous page

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

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

This adjustment will be determined at cost report settlement and will apply the DSH payment adjustment based on its urban/rural status according to the re-designation.

**Recalled devices**

As a reminder, Section 2202.4 of the *Provider Reimbursement Manual*, Part I states, "charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient."

Accordingly, hospital charges with respect to medical devices must be reasonably related to the cost of the medical device.

If a hospital receives a replacement medical device for free, the hospital should not be charging the patient or Medicare for that device.

The hospital should not be including costs on the cost report or charges on the Medicare claim. If that medical device was received at a discount, the charges should also be appropriately reduced.

To review the *Provider Reimbursement Manual* - Part 1 visit *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html*.

**LTCH PPS FY 2015 update**

FY 2015 LTCH PPS rates and factors are located in the final rule and are displayed in the chart to the right.

The LTCH PPS pricer has been updated with the version 32.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2014, and on or before September 30, 2015.

| Factors | Rates |
|---|---|
| Federal rate for discharges from 10/1/14, through 09/30/15 | Rates based on successful reporting of quality data.<br>• Full update (quality indicator on PSF = 1): $41,043.71<br>• Reduced update (quality indicator on PSF = 0 or blank): $40,240.51 |
| Labor share | 62.306 percent |
| Non labor share | 37.694 percent |
| High cost outlier fixed-loss amount | $14,972 |

**LTCH quality reporting (LTCHQR) program**

Section 3004(a) of the Affordable Care Act requires the establishment of the long-term care hospital quality reporting (LTCHQR) program. Beginning in FY 2015, the annual update to a standard federal rate will be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance with the LTCHQR Program for that year.

**Cost of living adjustment (COLA) update for LTCH PPS**

There are no changes to the COLAs for FY 2015, and are the same COLAs established for FY 2014. For reference, a table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2014, can be found in the FY 2015 IPPS/LTCH PPS final rule and is also shown above in the table under cost of living adjustment (COLA) update for IPPS PPS.

**Core-based statistical area (CBSA)-based labor market area updates**

CMS is updating the CBSA based labor market area definitions (and associated CBSA codes) used under the LTCH PPS for FY 2015. These revisions to the LTCH PPS geographic classifications are based on the most recent metropolitan statistical area (MSA) delineations issued by OMB using 2010 census data.

In order to mitigate potential negative payment impacts due to the adoption of the new OMB delineations, CMS adopted a one-year transition for LTCHs that would experience a decrease in their wage index exclusively due to the implementation of the new OMB delineations.

Under this transition policy, for discharges occurring in FY 2015, affected LTCHs will get a "50/50 blended area wage index" value that is calculated as the sum of 50 percent of the wage index computed under the FY 2014 CBSA designations (from Tables 12C and 12D, as applicable,

See **IPPS**, Next Page

# IPPS

From previous page
of the FY 2015 IPPS/LTCH PPS final rule) and 50 percent of the wage index computed under the new OMB delineations for FY 2015 (from Tables 12A and 12B, as applicable, of the FY 2015 IPPS/LTCH PPS final rule).

**Additional LTCH PPS policy changes for FY 2015**

The statutory moratoria on the full implementation of the "25 percent threshold" payment adjustment originally put in place by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) is extended until the start of LTCH cost reporting periods beginning on either July or October, 2014, as applicable as provided by the Pathway for the Sustainable Growth Rate (SGR) Reform Act.

The new extension generally maintained the same policies that have been in place, except that "grandfathered" LTCH hospitals-within-hospitals (HwH) are totally exempt from the application of the 25 percent threshold. For additional details, refer to the discussion in the FY 2015 IPPS/LTCH PPS final rule.

The FY 2015 IPPS/LTCH final rule also included the removal of the "5 percent" policy adjustment. Therefore, the policy specified at 42 CFR 412.532, Special Payment Provisions for Patients Who are Transferred to Onsite Providers and Readmitted to an LTCH, is no longer in effect beginning October 1, 2014.

## Additional information

The official instruction CR 8900 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3138CP.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*.

The following is a list of changes to CR 8900 that were made in the November 26, 2014, release:

- Renamed attachments and changed reference to attachments throughout policy section
- Revised Table 1 for the corrected FY 2015 IPPS rates and factors in attachment three, FY 2015 rate tables
- Corrected maximum new technology add-on payment for a case involving the Voraxaze®
- Revised attachment two, special wage index CR 8900
- Added information on updating the PSF for IPPS wage index, reclassifications and redesignations
- Included a new attachments for wage index redesignations and reclassifications
- Revised reference to hospital acquired condition (HAC) reduction program data
- Revised reference to Table 16b, Hospital inpatient value-based purchasing (VBP) program adjustment factors for FY 2015
- Revised reference to corrected Table 15B, FY 2015 readmissions adjustment factors
- Updated attachment five, uncompensated care payment per claim amounts for provider specific file revised CR 8900
- Revised reference to corrected Table 8B, FY 2015 statewide average capital cost-to-charge ratios (CCRs) for acute care hospitals-CN

*MLN Matters*® Number: MM8900
Related Change Request (CR) #: CR 8900
Related CR Release Date: November 26, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R3138CP
Implementation October 6, 2014

*Disclaimer - This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.*

# 2015 Part B Participating Physician and Supplier Directory

The *Medicare Part B Participating Physician and Supplier Directory* (MEDPARD) contains names, addresses, telephone numbers, and specialties of physicians and suppliers who have agreed to participate in accepting assignment on all Medicare Part B claims for covered items and services.

The MEDPARD listing will be available no later than January 30 on the First Coast Medicare provider website at *http://medicare.fcso.com/MEDPARD/*.

Source: Pub 100-04, Transmittal 3102, CR 8967

# Educational Events

## Provider outreach and educational events – March 2015

### Ask-the-contractor teleconference (ACT): 2015 OPPS updates

**When:** Friday, March 6, 2014
**Time:** 10:00 p.m. -11:30 a.m. ET – Delivery language: English
**Type of Event:** Webcast
*http://medicare.fcso.com/Events/277551.asp*

### Medicare Part A – changes and regulations

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

# CMS MLN Connects™ Provider eNews

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

# MLN Connects™ Provider eNews for January 8, 2015

*MLN Connects™ Provider eNews for January 8, 2015*

*View this edition as a PDF*

## MLN Connects™ National Provider Calls

- Medicare Quality Reporting Programs: Data Submission Process – Last Chance to Register
- IRF PPS: New IRF-PAI Items Effective October 1, 2015 – Last Chance to Register
- ESRD QIP Payment Year 2017 and 2018 Final Rule – Register Now
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts
- Continuing Education for Participation in MLN Connects™ National Provider Calls

## MLN Connects™ Videos

- Monthly Spotlight: The Two-Midnight Benchmark Rule

## CMS Events

- Volunteer for ICD-10 End-to-End Testing in April – Deadline Extended to January 21
- Open Payments Question & Answer Session
- Physician Compare Virtual Office Hour Session
- ICD-10 Clinical Documentation Improvement Webinar Recording Available

## Announcements

- Get Your Patients Off to a Healthy Start in 2015 with the AWV and the IPPE
- Public Reporting of 2013 Quality Measures on the Physician Compare and Hospital Compare Websites
- FY 2015 Results for the HAC Reduction Program and Hospital VBP Program
- ACOs Moving Ahead: New Participants in Medicare Shared Savings Program
- CMS Updates Open Payments Data
- Open Payments System Unavailable in January
- January Quarterly Provider Update Available
- Teaching Hospitals Receiving FTE Resident Caps Under Section 5506 of the Affordable Care Act
- IRF-PAI Training Manual Updated with Information on New Items Effective October 1, 2015
- CMS is Accepting Suggestions for Potential PQRS Measures

## Claims, Pricers, and Codes

- Hold on Certain CAH Method II Claims for Anesthesiologist and CRNA Services
- Hospice Claims Returned in Error for Edit U5181
- Part A Claims Hold for Select Preventive and Screening Services

## Medicare Learning Network® Educational Products

- "Certifying Patients for the Medicare Home Health Benefit" *MLN Matters®* Article – Released

## January 8

From previous page

- "Modifications to Medicare Part B Coverage of Pneumococcal Vaccinations" *MLN Matters*® Article – Released
- "The 2013 Physician Quality Reporting System (PQRS)" Booklet – Released
- "FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing" *MLN Matters*® Article – Revised
- "Inpatient Psychiatric Facility Prospective Payment System" Fact Sheet -- Revised
- "Discharge Planning" Booklet – Revised
- "The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation" Fact Sheet – Reminder
- "The Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners" Fact Sheet – Reminder
- *Medicare Learning Network*® Products Available In Electronic Publication Format

# MLN Connects™ Provider eNews for January 15, 2015

*MLN Connects™ Provider eNews for January 15, 2015*

*View this edition as a PDF*

### Editor's Note

Thank you for providing feedback about the *MLN Connects*™ Provider eNews in 2014. We take your feedback seriously and have used it to enhance the eNews throughout the year. It is easier than ever to give us feedback on your eNews experience in 2015. Please continue to let us know how the eNews is helping you or provide us any suggestions you may have. Have a great year.

### MLN Connects™ National Provider Calls

- ESRD QIP Payment Year 2017 and 2018 Final Rule – Last Chance to Register

### CMS Events

- Volunteer for ICD-10 End-to-End Testing in April – Forms Due January 21
- Webinar for Comparative Billing Report on Modifier 59: Dermatology
- Open Payments Program Overview Video Tutorial Now Available

### Announcements

- Help Protect the Vision of Your Medicare Patients – Recommend Annual Glaucoma Screening
- Hospice Providers: Continue to Collect and Submit HIS Data in 2015
- Open Payments System Unavailable through Late January

### Claims, Pricers, and Codes

- Adjustment of Some Home Health Claims: Update

### *Medicare Learning Network*® Educational Products

- "FAQs – International Classification of Diseases, 10th Edition (ICD-10) Acknowledgement Testing and End-to-End Testing" *MLN Matters*® Article – Released
- "Ambulance Fee Schedule" Fact Sheet – Revised
- "Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff" Fact Sheet – Revised
- "Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians" Web-Based Training Course – Revised
- *Medicare Learning Network*® Products Available In Electronic Publication Format

# MLN Connects™ Provider eNews for January 22, 2015

*MLN Connects™ Provider eNews for January 22, 2015*

*View this edition as a PDF*

## In this edition:

### Editor's Note

Thank you for providing feedback about the MLN Connects™ Provider eNews in 2014. We take your feedback seriously and have used it to enhance the eNews throughout the year. It is easier than ever to give us feedback on your eNews experience in 2015. Please continue to let us know how the eNews is helping you or provide us any suggestions you may have. Have a great year.

### MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes and QAPI – Upcoming 2015 Calls

### CMS Events

- eHealth Webinar: QRDA I Submission for Eligible Hospitals

### Announcements

- Bidding Open for the Round 2 Recompete/National Mail-Order Recompete of the DMEPOS Competitive Bidding Program
- Cervical Health Awareness Month
- Major Improvements to the Internet-based PECOS System
- Submission Timeframes for 2014 PQRS Data
- Hospitals Must Start Medicare EHR Participation in 2015 to Earn Incentives
- Updated Information on Reporting Menu Objectives for the EHR Incentive Programs
- January ICD-10 End-to-End Testing Participants Are Pre-Registered For April Testing
- Share Your ICD-10 Story

### Claims, Pricers, and Codes

- January 2015 PPS Provider Data Available
- FY 2015 Inpatient PPS PC Pricer Update Available
- FY 2015 Inpatient PPS 2015.3 Mainframe Pricer Update Available
- January 2015 Outpatient Prospective Payment System Pricer File Update
- Part A Claims Hold for Select Preventive and Screening Services – Updated

### *Medicare Learning Network*® Educational Products

- "Medicare Quarterly Provider Compliance Newsletter [Volume 5, Issue 2]" Educational Tool – Released
- "2015 Medicare Part C and Part D Reporting Requirements and Data Validation" Web-Based Training Course – Released
- "Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries" *MLN Matters*® Article – Revised
- New *Medicare Learning Network*® Educational Web Guides Fast Fact
- *Medicare Learning Network*® Product Available In Electronic Publication Format

## 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