Medicare A Connection

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A Newsletter for MAC Jurisdiction N Providers

December 2015

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Smooth the way to compliance with First Coast's Web tools

In a day's work, any number of things set Sarah Scott to action. As a Clinical Coding Auditor in Corporate Compliance with St. Vincent's HealthCare, how she responds to a call to action is critical for their St. Vincent's patients and the health system to ensure compliant billing and coding practices.

Scott is responsible for reviewing and auditing medical documentation for nearly 200 physicians and residents who provide care for patients covered by Medicare. She says Medicare claims represent a central focus in St. Vincent's compliance plans. Her work with physicians involves annual coding audits and ongoing education. She evaluates medical documentation and other patient data to ensure the assigned procedure and diagnosis codes reflect current Medicare policy and correct billing standards.

"I provide education to our providers on various topics. However, my primary focus is on evaluation and management services," Scott said. Helping providers stay on top of changes is a critical task for the health system getting reimbursed. "We educate our providers based on internal prospective and retrospective audits," Scott said.

To help physicians and residents understand Medicare rules and regulations, Scott turns to First Coast Service Options' Web tools.

"The First Coast tools are right at your fingertips. We use most of them on a regular basis. With our compliance program, the evaluation and management worksheet is perhaps the most used tool," she said. "We look at cases for accuracy and use the E/M worksheet with the providers and medical staff to help them arrive at the level of care based on the documentation."

The E/M interactive worksheet is a helpful checklist and interactive tool that aids providers in identifying the E/M code that best reflects the level of E/M services performed based on the 1995 and 1997 coding guidelines. Providers complete the online form, and the worksheet automatically calculates a suggested E/M code based on their entries.

"Medicare pays physicians based on diagnostic and procedure codes derived from medical documentation. We work closely with our EMR (emergency room) team and providers to improve their workflow, and stress the

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SMOOTH

From front page

importance of documenting pertinent data. Proper medical record documentation is critical to receiving accurate and timely reimbursement for furnished services," Scott said.

Once she has reviewed ways for providers to improve the accuracy of their coding or documentation, Scott also helps them proactively prevent denied claims by showing them how to use other First Coast Web tools.

"With the LCD look up tool, we stress its use before services are rendered. We suggest that our providers and medical staff become familiar with the LCD to determine medical necessity and if an advanced beneficiary notice will be needed," Scott said"

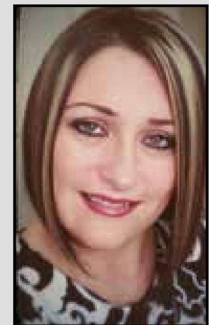
Scott cited the use of the LCD look up tool prior to rendering an EKG test for pre-op clearance as an example of how she shares the advantages of using First Coast's Web tools with medical staff, physicians and residents.

"As we demonstrate the LCD tool, we may ask questions like 'Are you doing an EKG as part of a routine pre-op clearance with no risk factors, or does the patient have some other underlying condition such as uncontrolled diabetes ,hypertension that will put the patient at risk for surgery'" Scott said. "If they are not familiar with the LCD, the physician may link the EKG to the pre-op clearance diagnosis when there were other diagnoses or risk factors on the patient record which would necessitate the test. We want to ensure the correct diagnosis is billed based on the documentation."

Her use of the LCD lookup also extends to other administrative uses. "First Coast's LCD tool is helpful for our practice administers to determine if medical necessity is supported before the service is rendered," Scott explained. "Often we have sales reps marketing services to our providers indicating the services are a covered Medicare benefit; however, they haven't checked to see if there is a local coverage determination."

In conjunction with the LCD look up, Scott says the First Coast fee schedule look up offers helpful information for evaluating new procedures. She assists the finance department and practice administers with research using First Coast tools. "With the fee schedule look up, we can assess the Medicare allowable amounts to determine reimbursement, policy indicators, global days, RVUs and identify if an LCD is associated with the procedure code."

"The First Coast tools are right at your fingertips. We use most of them on a regular basis. With our compliance program, the evaluation and management worksheet is perhaps the most used tool."



-Sarah Scott
Clinical Coding Auditor
St. Vincent's HealthCare
(Photo Courtesy: Sarah Scott, St. Vincent's HealthCare)

Scott has stayed informed about new additions to the First Coast website by serving on the First Coast Provider Outreach and Education Advisory Group and attending Medicare Speaks conferences for the past eight years.

"Participating in all of the First Coast activities allows me to network with peers and build relationships in the community," she said. "In this, I am able to offer firsthand information back to our providers. I believe being that voice not only benefits our ministry but helps other health systems and First Coast to hear the concerns and suggestions from the providers. We are all one team, working for the same common goal for our patients."

Guidelines for unsolicited/voluntary refunds

Medicare contractors receive unsolicited/voluntary refunds (i.e., monies received not related to an open account receivable).

Part A contractors generally receive unsolicited/voluntary refunds in the form of an adjustment bill, but may receive some unsolicited/voluntary refunds as checks.

Part B contractors generally received checks. Substantial funds are returned to the trust funds each year through such unsolicited/voluntary refunds.

The Centers for Medicare & Medicaid Services reminds providers that:

The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the federal government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Source: CMS Pub. 100-06, Chapter 5, Section 410.10

2016 Medicare deductible, coinsurance and premium rates

Provider types affected

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

Provider action needed

Change request (CR) provides instruction for MACs to update the claim processing system with the new 2016 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.

Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of skilled nursing facility (SNF) services furnished during a spell of illness.

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

Under Part B of the supplementary medical insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent

10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll. In addition, some beneficiaries may pay higher Part B premiums, based on their income.

2016 Part A - Hospital insurance (HI)

- Deductible: $1,288.00
- Coinsurance
  - $322.00 a day for 61st-90th day
  - $644.00 a day for 91st-150th day (lifetime reserve days)
  - $161.00 a day for 21st-100th day (skilled nursing facility coinsurance)
- Base premium (BP): $411.00 a month
- BP with 10 percent surcharge: $452.10 a month
- BP with 45 percent reduction: $226.00 a month (for those who have 30-39 quarters of coverage)
- BP with 45 percent reduction and 10 percent surcharge: $248.60 a month

2016 Part B - Supplementary medical insurance (SMI)

- Standard premium: $121.80 a month
- Deductible: $166.00 a year
- Pro rata data amount
  - $118.86 1st month
  - $47.14 2nd month
- Coinsurance: 20 percent

Additional information

The official instruction, CR 9410, issued to your MAC regarding this change is available at https://www.cms.

See **DEDUCTIBLE**, next page

Reporting place of service (POS) codes

Physicians are required to report the place of service (POS) on all health insurance claims they submit to Medicare Part B contractors. The POS code is used to identify where the procedure is furnished. Physicians are paid for services according to the Medicare physician fee schedule (MPFS). This schedule is based on a payment system that includes three major categories, which drive the reimbursement for physician services:

- Practice expense (reflects overhead costs involved in providing service(s))
- Physician work
- Malpractice insurance

To account for the increased practice expense physicians incur by performing services in their offices, Medicare reimburses physicians a higher amount for services performed in their offices (POS code 11) than in an outpatient hospital (POS 22-23) or an ambulatory surgical center (ASC) (POS 24). Therefore, it is important to know the POS also plays a factor in the reimbursement.

Note: Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies regarding POS codes.

Important facts when filing a claim to Medicare

- The POS is a required field, entered in the 2400 place of service code loop (segment SV105) of the 837P electronic claim or Item 24B on the CMS-1500 paper claim.
- The name, address and zip code of where the service(s) were actually performed is required for all POS codes, and is entered in Item 32 on the CMS 1500 claim form or in the corresponding loop on its electronic equivalent.
  - Must specify the correct location where the service(s) is performed and billed on the claim, since both the POS and the locality address are components of the MPFS.
- If the POS is missing, invalid or inconsistent with procedure code on claim form it will be returned as unprocessable (RUC).
  - For example, POS 21 (inpatient hospital) is not compatible with procedure code *99211* (Establish patient office or other outpatient visit).

Helpful hints for POS codes for professional claims

- Implement internal control systems to prevent incorrect billing of POS codes.
- Keep informed on Medicare coverage and billing requirements.
  - For example, billing physician's office (POS 11) for a minor surgical procedure that is actually performed in a hospital outpatient department (POS 22) and collecting a higher payment is inappropriate billing and may be viewed as program abuse.
- Check these links frequently for revisions to the listing and validate that you are coding according to the most current version.
  - A complete set of the national POS code set and instructions is provided in CMS Internet-only Manual (IOM) Publication 100-04, Chapter 26, Section 10.5 at: *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf*.
  - Additional information is available at: *https://www.cms.gov/Medicare/Coding/place-of-service-codes/index.html*.

DEDUCTIBLE

From previous page

gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R96GI.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: January 1, 2016
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Implementation Date: January 4, 2016

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Processing Issues

Smoking cessation claims editing incorrectly

Issue

A system error caused claims for smoking cessation with dates of service on or after October 1, 2015, to edit incorrectly.

Affected claims include those billed on:

- TOB 12x, 13x, 22x, 23x, 34x, or 85x,
- Contains HCPCS G0436 or G0437,
- Dates of service prior to October 1, 2015, and
- Contains ICD-9 diagnosis code 305.1 or V15.82.

Resolution

MACs shall reprocess any claims containing HCPCS G0436 or G0437 with dates of service on and after October 1, 2015, that were inappropriately assigned reason code 32382 or 32383, on or before December 15, 2015.

Your Medicare administrative contractor (MAC) will correct all affected claims.

Provider action

No provider action is required.

Current processing issues

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

Extracorporeal photophoresis and PTA claims editing incorrectly

Issue

The Centers for Medicare & Medicaid Services (CMS) discovered a system error causing claims related to extracorporeal photophoresis for the treatment of bronchiolitis obliterans syndrome (BOS) and percutaneous transluminal angioplasty (PTA), with dates of service on or after October 1, 2015, to edit incorrectly.

Resolution

The Centers for Medicare & Medicaid Services (CMS) will implement a fix with the January 2016 quarterly release. Medicare administrative contractors (MAC) will correct claims all affected claims.

Status/date resolved

Open.

Provider action

No provider action is required.

Current processing issues

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

Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the quarterly provider update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries. Providers may access the QPU by going to the CMS website at *http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html.* Providers may join the CMS-QPU electronic mail to ensure timely notification of all additions to the QPU.

Announcement of therapy cap values for 2016

Provider types affected

This *MLN Matters*® article is intended for physicians, therapists, and other providers, submitting claims to Medicare administrative contractors (MACs), including home health & hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9448, from which this article was developed, describes the amounts and the policy for outpatient therapy caps for 2016. For physical therapy and speech-language pathology combined, the 2016 therapy cap will be $1,960. For occupational therapy, the cap for 2016 will be $1,960. Please make sure your billing staffs are aware of these updates.

Background

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) applies, per beneficiary, annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B, commonly referred to as "therapy caps." The therapy caps are updated each year based on the Medicare economic index. An exceptions process to the therapy caps for reasonable and medically necessary services was required by Section 5107 of the Deficit Reduction Act of 2005. The exceptions process for the therapy caps has been continuously extended several times through subsequent legislation. Most recently, Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the therapy cap exceptions process through December 31, 2017.

Additional information

The official instruction, CR 9448, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3417CP.pdf*.

For more information on the therapy caps and other issues related to outpatient therapy services, please see the Therapy Services Web page at *https://www.cms.gov/Medicare/Billing/TherapyServices/index.html*.

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

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Puzzled about your enrollment status?

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

New influenza virus vaccine code

Provider types affected

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

Provider action needed

Change request (CR) 9357 provides instructions for Medicare systems to be updated to include influenza virus vaccine code *90630* (Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use) for claims with dates of service on or after August 1, 2015. Make sure your billing staffs are aware of this code change.

Background

CR 9357 provides that (effective for claims with dates of service on or after August 1, 2015, processed on or after April 4, 2016) Medicare will pay for vaccine *Current Procedural Terminology* (*CPT*®) code *90630* (Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use).

Your MAC will add influenza virus vaccine *CPT*® code *90630* to existing influenza virus vaccine edits and accept it for claims with dates of service on or after August 1, 2015.

Effective for dates of service on and after August 1, 2015, MACs will:

- Pay for vaccine code *90630* on institutional claims as follows:
  - **Hospitals** – types of bill (TOB) 12x and 13x, skilled nursing facilities (SNFs) –TOB 22x and 23x, home health agencies (HHAs) – TOB 34x, hospital-based renal dialysis facilities (RDFs) – TOB 72x, and critical access hospitals (CAHs) – TOB 85x, based on reasonable cost;
  - **Indian health service (IHS) hospitals** – TOB 12x, and 13x and IHS CAHs – TOB 85x, based on the lower of the actual charge or 95 percent of the average wholesale price (AWP); and
  - **Comprehensive outpatient rehabilitation facility (CORF)** – TOB 75x, and independent RDFs – TOB 72x, based on the lower of actual charge or 95 percent of the AWP.
- Pay for code *90630* on professional claims using the CMS seasonal influenza vaccines pricing Web page

at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html* to determine the payment rate for influenza virus vaccine code *90630*.

Note: In all of the above instances, annual Part B deductible and coinsurance do not apply.

In addition, until Medicare systems changes are implemented, MACs will hold institutional claims containing influenza virus vaccine *CPT*® codes *90630* (with dates of service on or after August 1, 2015) that they receive before April 4, 2016. Once the system changes described in CR 9357 are implemented, these institutional claims will be processed and paid.

Additional information

The official instruction, CR 9357, issued to your MAC regarding this change is available at *http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3403CP.pdf*.

MLN Matters® Number: MM9357
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Effective Date: August 1, 2015
Related CR Transmittal #: R3403CP
Implementation Date: April 4, 2016

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Local Coverage Determinations

This section of *Medicare A Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.

These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical coverage Web page at *http://medicare.fcso.com/Landing/139800.asp* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

More information

For more information, or, if you do not have Internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

Advance beneficiary notice

- **Modifier GZ** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an advance beneficiary notification (ABN) signed by the beneficiary.

  Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.
- **Modifier GA** must be used when providers, physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.
- All claims not meeting medical necessity of a local coverage determination (LCD) must append the billed service with **modifier GA or GZ.**

First Coast Service Options Inc provides current and draft local coverage determinations (LCDs), when they exist, for Medicare-covered procedure codes.

Not every procedure code is covered by an LCD. ***Click here*** **to look up current LCDs**

Revised LCDs

Bone mineral density studies – revision based on CR 9252

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

Based on change request (CR 9252), the local coverage determination (LCD) for bone mineral density studies was revised to add ICD-10-CM diagnosis codes Z79.3, Z79.83, and Z87.310 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after January 4, 2016**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Fundus photography – revision to the LCD

LCD ID number: L33670 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for fundus photography was revised to add ICD-10-CM diagnosis codes H59.031-H59.039 to the "Indications and Limitations of Coverage and/or Medical Necessity" and "ICD-10 Codes that Support Medical Necessity" sections of the LCD for *Current Procedural Terminology* (*CPT*®) code *92250*.

The updated LCD will be available on the Medicare coverage database (MCD) on or after November 19, 2015.

Effective date

This LCD revision is effective for claims processed **on or after November 19, 2015**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Noncovered Services – revision to the LCD

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

The local coverage determination (LCD) for noncovered services has been revised to remove *CPT*® codes *43206* (*Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure), with optical endomicroscopy); 43252 (esophagogastroduodenoscopy, flexible, transoral, diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure), with optical endomicroscopy*).

Additionally, the following two *CPT*® codes have been removed from the noncovered services LCD and placed in the recently revised LCD titled, polysomnography and sleep testing (L33405): *95803* (*Actigraphy testing, recording, analysis, interpretation, and report), and 95806 (sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow, and respiratory effort*).

As such, the 'Procedures for Part A and Procedures for Part B' sections of the LCD have been revised.

Removing a service from noncoverage should not be interpreted as a positive coverage statement and coverage by the contractor. It is expected that the procedure will be performed on qualified patients per standards of care for their condition. As always, the medical record must support the reasonable and necessary threshold for coverage and be available for audit if there is a pre or post payment medical review.

Effective date

This LCD revision is effective for claims processed **on or after December 21, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Ocular photodynamic therapy (OPT) with verteporfin – revision to the LCD

LCD ID number: L33705 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on change request (CR 9252), the local coverage determination (LCD) for ocular photodynamic therapy (OPT) with verteporfin was revised to add ICD-10-CM diagnosis code B39.5 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after January 4, 2016**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Strapping – diagnosis revision to the LCD

LCD ID number: L34023 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for strapping was revised to add numerous ICD-10-CM diagnosis code ranges within the M12, M20, M21, M24, M25, M65, M77, M84, S82, S86, S89, S90, S92, S93, S96, and S99 series of diagnoses and ICD-10 diagnosis code M72.2 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (*CPT*®) codes *29540* and *29550*. Also, numerous ICD-10-CM diagnosis code ranges were added within the S86, S93, and S96 series of diagnoses to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *CPT*® code *29580*.

In addition, ICD-10 diagnosis code ranges S86.011A-S86.011S, S86.012A-S86.012S, S93.411A-S93.411S, S93.412A-S93.412S, S93.421A-S93.421S, S93.422A-S93.422S, S93.431A-S93.431S, S93.432A-S93.432S, S93.491A-S93.491S, S93.492A-S93.492S, S93.511A-S93.511S, S93.512A-S93.512S, S93.514A-S93.514S, S93.515A-S93.515S, S93.521A-S93.521S, S93.522A-S93.522S, S93.524A-S93.524S, S93.525A-S93.525S, S93.611A-S93.611S, S93.612A-S93.612S, S93.621A-S93.621S, S93.622A-S93.622S, S93.691A-S93.691S, S93.692A-S93.692S, S96.011A-S96.011S, S96.012A-S96.012S, S96.111A-S96.111S, S96.112A-S96.112S, S96.199A –S96.199S, S96.211A-S96.211S, S96.212A-S96.212S, S96.811A-S96.811S, and S96.812A-S96.812S were removed from the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *CPT*® codes *29540* and *29550* as these diagnosis code ranges were expanded.

The updated LCD will be available on the Medicare coverage database (MCD) on or after November 26, 2015.

Effective date

This LCD revision is effective for claims processed **on or after November 18, 2015**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Visual field examination – revision to the LCD

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

The local coverage determination (LCD) for visual field examination was revised to add ICD-10-CM diagnosis codes E10.39, E11.39, E13.39, Z09, Z79.3, Z79.891, and Z79.899 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) on or after November 19, 2015.

Effective date

This LCD revision is effective for claims processed **on or after November 12, 2015**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Additional Information

2016 HCPCS local coverage determination changes – Part A

First Coast Service Options Inc. has revised local coverage determinations (LCDs) impacted by the 2016 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted accordingly:\

LCD title	Changes
Allergy Testing	**Descriptor change** for *CPT®* code *88346*
Colorectal Cancer Screening	**Deleted** HCPCS code G0464 and replaced it with *CPT®* code *81528*
Controlled Substance Monitoring and Drugs of Abuse Testing	**Descriptor change** for *CPT®* code *83789* **Deleted** HCPCS codes G0431, G0434, and G6030-G6058 **Added** HCPCS codes G0477-G0483
CYP2C19, CYP2D6, CYP2C9, and VKORC1 Genetic Testing	**Descriptor change** for *CPT®* code *81355*
Diagnostic Aerosol or Vapor Inhalation	**Descriptor change** for *CPT®* code *94640*
Diagnostic Colonoscopy	**Deleted** HCPCS codes G6019, G6020, G6021, G6024, and G6025

LCD title	Changes
Erythropoiesis Stimulating Agents	**Deleted** HCPCS codes J0886 and J0888
G-CSF (Neupogen®, Granix™, Zarxio™)	**Descriptor change** for HCPCS code J1442 **Deleted** HCPCS code J1446 and replaced it with HCPCS code J1447
Genetic Testing for Lynch Syndrome	**Descriptor change** for *CPT®* code *81210*
Hemophilia Clotting Factors	**Deleted** HCPCS codes Q9975 and replaced it with HCPCS code J7205 **Removed** unlisted HCPCS codes C9399/J7199 and replaced them with HCPCS code J7188
Hepatitis B Surface Antibody and Surface Antigen	**Descriptor change** for *CPT®* code *87340*

See **HCPCS**, next page

HCPCS

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LCD title	Changes
Implantable Infusion Pump for the Treatment of Chronic Intractable Pain (Coding Guidelines only)	**Deleted** HCPCS code Q9977 and replaced it with HCPCS code J7999
Implantable Miniature Telescope (IMT)	Descriptor change for *CPT®* code *0308T*
Intravenous Immune Globulin	**Added** HCPCS code J1575
Intravitreal Bevacizumab (Avastin®)	**Deleted** HCPCS code Q9977 and replaced it with HCPCS code J7999
Molecular Pathology Procedures	**Descriptor change** for *CPT®* codes *81210*, *81275*, and *81355*. **Added** *CPT®* codes *81162, 81170, 81218, 81219, 81272, 81273, 81276, 81311* and *81314*
Noncovered Procedures - Endoscopic Treatment of Gastroesophageal Reflux disease (GERD)	**Deleted** HCPCS code C9724 and replaced it with *CPT®* code *43210*
Noncovered Services	**Descriptor change** for *CPT®* codes *87320*, *90644*, *90650*, *90681*, and *0358T* **Deleted** *CPT®* code *0103T* (replaced with unlisted *CPT®* code *84999*), *CPT®* code *0223T*, *0224T*, and *0225T* (replaced with unlisted *CPT®* code *93799*), *CPT®* code *0233T* (replaced with unlisted *CPT®* code *88749*), *CPT®* code *0243T* and *0244T* (replaced with unlisted *v* code *94799*), *CPT®* code *0311T* (replaced with *CPT®* code *93050*), and HCPCS codes G0627 and G0628 (replaced with *CPT®* codes *46601* and *46607*)
Plerixafor (Mozobil®)	**Deleted** HCPCS code J1446 and replaced it with HCPCS code J1447
Radiation Therapy for T1 Basal Cell and Squamous Cell Carcinomas of the Skin	**Descriptor change** for *CPT®* code *77789* **Deleted** *CPT®* codes *77785* and *77786* and replaced with *v* codes *77767* and *77768* **Deleted** *CPT®* code *0182T* (referenced in the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD as a noncovered service) was replaced with *CPT®* code *0394T*. Additionally, *CPT®* code *0394T* was added to the "*CPT®*/HCPCS Codes" section under 'Group 2 codes" as a noncovered service. In addition, the statement containing *CPT®* code *77787* was **removed**, as this code was deleted.
Screening and Diagnostic Mammography	**Descriptor change** for *CPT®* code *77057*
Spinal Cord Stimulation for Chronic Pain	**Descriptor change** for *CPT®* code *95972* **Deleted** *v* code *95973*

Percutaneous electrical nerve stimulation (PENS) and percutaneous neuromodulation therapy (PNT)

Due to multiple claims received related to inappropriate billing of percutaneous electrical nerve stimulation (PENS) and percutaneous neuromodulation therapy (PNT), this article is being published to provide clarification.

Providers are required to bill procedure codes that exactly describe the service performed and currently there are no specific *Current Procedural Terminology*® (*CPT*®) codes for PENS or PNT. Therefore, unlisted *CPT*® code *64999* (Unlisted procedure, nervous system) should be used to report percutaneous electrical nerve stimulation and percutaneous neuromodulation therapy. *CPT*® codes for percutaneous implantation of neurostimulator electrodes (i.e., *CPT*® *64553* - *64565*) are also not appropriate given PENS and PNT use percutaneously inserted needles and wires rather than percutaneously implanted electrodes. Additionally, the stimulation devices used in PENS and PNT are not implanted, therefore *CPT*® code *64590* is also not appropriate.

Of note, *CPT*® code *64999* billed for percutaneous neuromodulation using a percutaneous electrode array (PEA) (e.g., BioWave) has been evaluated by First Coast and added to the noncovered services LCD in 2008. Therefore, there is insufficient evidence to support coverage of Biowave's Deepwave percutaneous neuromodulation pain therapy system at this time.

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

Self-administered drug (SAD) list – Praluent® (alirocumab), repatha™ (evolocumab), and natpara® (parathyroid hormone) J3490/J3590/C9399

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

Effective for services rendered on or after January 18, 2016, the following drugs have been added to the MAC J-N Part A SAD list.

- J3490/J3590/C9399
  Alirocumab (Praluent®)
- J3490/J3590/C9399
  Evolocumab (Repatha™)
- J3490/J3590/C9399
  Parathyroid hormone (Natpara®)

The evaluation of drugs for addition to the self-administered drug (SAD) list is an ongoing process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

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

Claim status category and claim status code update

Provider types affected

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

What you need to know

Change request (CR) 9427 informs MACs about the changes to claim status category and claim status codes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only claim status category and claim status codes approved by the National Code Maintenance Committee (NCMC) in the Accredited Standards Committee (ASC) X12 276/277 health care claim status request and response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s).

Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The NCMC meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The NCMC has decided to allow the industry six months for implementation of newly added or changed codes.

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

All code changes approved during the January 2016 committee meeting shall be posted on these sites on or about February 1, 2016. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes, by the implementation date of CR 9427.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR 9427.

CMS and the MACs must comply with the requirements contained in the current standards adopted under

HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 health care claim status request and response. These contractors must use valid claim status category and claim status codes when sending ASC X12 277 health care claim status responses and when sending ASC X12 277 healthcare claim acknowledgments. References in this CR to “277 responses” and “claim status responses” encompass both the ASC X12 277 health care claim status response and the ASC X12 277 healthcare claim acknowledgment transactions.

Additional information

The official instruction, CR 9427, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3413CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number 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 9427
Related CR Release Date: November 20, 2015
Effective Date: April 1, 2016
Related CR Transmittal #: R3413CP
Implementation Date: April 4, 2016

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Remittance advice remark and claim adjustment reason code and MREP and PC Print update

Provider types affected

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

Provider action needed

Change request (CR) 9374 updates the claim adjustment reason code (CARC) and remittance advice remark code (RARC) lists. It also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print software. Make sure your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if you use it.

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 RARCs, as appropriate, 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 Centers for Medicare & Medicaid Services (CMS) instructs the MACs to conduct updates based on the code update schedule that results in publication three times a year – around March 1, July 1, and November 1.

CR 9374 is a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Shared system maintainers (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. MACs make necessary program changes so that deactivated reason and remark codes are allowed in derivative messages after the deactivation implementation date per CR 9374 or as posted on the WPC website when:

- Medicare is not primary;
- The COB claim is received after the deactivation effective date; and
- The date in DTP03 in Loop 2430 or 2330B in COB 837 transaction is less than the deactivation effective date as posted on the WPC website.

MACs make necessary programming changes so that deactivated reason and remark codes are allowed even after the deactivation implementation date in a reversal and correction situation, when a value of 22 in CLP02 identifies the claim to be a corrected claim, and in Medicare secondary payer (MSP) claims, when forwarded to Medicare by primary payers before the deactivation date and Medicare adjudication is done after the deactivation date.

SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the WPC website, found at http://wpc-edi.com/Reference/. If any new or modified code has an effective date past the implementation date specified in CR 9374, MACs must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only three times per year and may not match the CMS systems release schedule. For this recurring CR, MACs and SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update CR (CR 9278, with a related *MLN Matters*® article available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9278.pdf.)

In accordance with HIPAA Legislation Published in the *Federal Register* (45 CFR Part 162), covered entities are required to comply with established standards and code set regulations. Furthermore, the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) further defines the requirements for the 835 transaction by specifying phase III operating rules, the 835 transaction (health care claim payment/advice) and standard paper remittance advice which require the use of CARCs and RARCs.

Additional information

The official instruction, CR 9374, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3418CP.pdf.

If you have any questions, please contact your MAC at

Instructions for using claim adjustment segment for Medicare secondary payer Part A claims

Provider types affected

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

Provider action needed

Stop – impact to you

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 8486 to inform you about the changes necessary for MSP payment calculations from incoming DDE and the paper claim transactions.

Caution – what you need to know

CR 8486 is limited to providers billing Part A claims.

Go – what you need to do

Include your CAS segment adjustments from the primary payer(s) remittance advice report (835 electronic remittance advice (ERA) or paper remittance) on your 837I transaction, DDE, or your paper claim when you send your claim to Medicare for secondary payment. These adjustments are needed to process your MSP Part A claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which explains why the claim's billed amount was not fully paid.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides have been established as the standards of compliance for claim transactions, and the implementation guides for each transaction are available at *http://www.wpc-edi.com*.

The instructions in CR 8486 ensure Medicare's compliance with HIPAA transaction and code set requirements and ensure that MSP claims are properly calculated, using payment information derived from the paper, DDE, or incoming 837I, Institutional claim. This updates instructions from CR 6426 which did not allow the acceptance of DDE claims. Additionally, paper, DDE, and 837I claims can be adjusted or corrected utilizing the DDE.

The instructions detailed by CR 8486 ensure that Medicare's secondary payment for Part A MSP claim is based on:

1. Provider charges, or the amount the provider is obligated to accept as payment in full (OTAF), whichever is lower. In the case where there are multiple primary payers to Medicare the lowest OTAF is used, unless the Medicare covered charges are lower;
2. What Medicare would have paid as the primary payer; and
3. The primary payer(s) payment.

MSP policy also defines what must be considered when processing MSP claims. This includes adjustments made by the primary payer(s), which, for example, explains why the claim's billed amount was not fully paid. Adjustments made by the payer are reported in the CAS segments on the 835 ERA or paper remittance. The provider must take the CAS segment adjustments, as found on the 835 standard format or crosswalk them if they were not received in the standard format, and report these adjustments with the paper, DDE, or 837I, unchanged, when sending the claim to Medicare for secondary payment. To review specific examples of 837I claims transactions see the MSP manual revisions in the attachment in CR 8486.

Additional information

The official instruction, CR 8486, issued to your A/B/MAC regarding this change may be viewed at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R116MSP.pdf*.

See **MSP**, next page

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their toll-free number. That number is available at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html* under - How Does It Work.

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Related CR Release Date: November 25, 2015
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Implementation Date: April 4, 2016

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Implement operating rules - phase III ERA EFT: CORE 360 uniform use CARC and RARC rule - update from CAQH CORE

Provider types affected

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

Provider action needed

Change request (CR) 9350 instructs MACs and Medicare's shared system maintainers (SSMs) to update systems based on the Committee on Operating Rules for Information Exchange (CORE) 360 uniform use of claim adjustment reason codes (CARC) and remittance advice remark codes (RARC) rule publication. These system updates are based on the CORE code combination list to be published on or about February 1, 2016.

Background

The Department of Health & Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE electronic funds transfer (EFT) & electronic remittance advice (ERA) operating rule set that must be implemented by January 1, 2014, under the Patient Protection and Affordable Care Act of 2010.

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

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction, and efficiency improvements, by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CR 9350 deals with the regular update in CAQH CORE defined code combinations per operating rule 360 - uniform use of claim adjustment reason codes and remittance advice remark codes (835) rule.

CAQH CORE will publish the next version of the code combination list on or about February 1, 2016. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about November 1, 2015.

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

Additional information

The official instruction, CR 9350, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3411CP.pdf*.

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

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

For a fact sheet detailing Medicare secondary payer for provider, physician, and other supplier billing staff you may go to: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MSP_Fact_Sheet.pdf*.

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Related Change Request (CR) #: CR 8486
Related CR Release Date: November 24, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R116MSP
Implementation Date: January 4, 2016

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ICD-10 conversion/coding infrastructure revisions to NCDs–3rd maintenance CR

***Note**: This article was revised December 3, 2015, to reflect an updated change request (CR) that: 1) Removed invalid TOB 52x from NCD250.5; 2). Removed invalid TOB 25c from NCD80.11 and added TOB 85c; and 3) included complete history in NCD 160.18. In the article, CR release date, transmittal number, and the Web address for accessing CR 9252 are revised. All other information remains the same. This information was previously published in the October 2015 Medicare A Connection, Page 17.*

Provider types affected

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

What you need to know

CR 9252 is the third maintenance update of ICD-10 conversions/updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, Specifically, they were contained in CR 7818, CR 8109, CR 8197, CR 8691, and CR 9087. Related *MLN Matters*® articles are MM7818, MM8109, MM8197, MM8691, and MM9087. Some are the result of revisions required to other NCD-related CRs released separately that included ICD-10 coding.

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

Background

CR 9252 creates and updates NCD editing, both hard-coded shared system edits as well as local MAC edits that contain ICD-10 diagnosis/procedure codes, plus all associated coding infrastructure such as HCPCS/*CPT*® codes, reason/remark codes, frequency edits, place of service (POS)/type of bill (TOB)/provider specialties, and so forth. The requirements described in CR 9252 reflect the operational changes that are necessary to implement the conversion of the Medicare local and shared system diagnosis and procedure codes specific to the 26 Medicare NCD spreadsheets, which are available at https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9252.zip.

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

You should be aware that nationally covered and non-covered diagnosis code lists are finite and cannot be revised without a subsequent CR. Discretionary code lists are to be regarded as CMS' compilation of discretionary codes based on current analysis/interpretation. MACs may or may not expand discretionary lists based on their individual local authority within their respective jurisdictions.

Some coding details are as follows:

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

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- Group code CO (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier (The provider or supplier expects a medical necessity denial; however, did not provide an advance beneficiary notice (ABN) to the patient), indicating no signed ABN is on file)
- For modifier GZ, your MAC will use CARC 50.

Additional information

The official instruction, CR 9252, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1580OTN.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.

Document history

Date	Description
12/3/15	Article was revised to reflect new CR that: 1) Removed invalid TOB 52x from NCD250.5, 2) Removed invalid TOB 25x from NCD80.11 and added TOB 85x and, 3) Included complete history in NCD160.18.

Date	Description
10/6/15	Article was revised to reflect new CR issued October 5, 2015. In the article, the CR release date, transmittal number, and the Web address for accessing CR 9252 are revised.

MLN Matters® Number: MM9252 *Revised*
Related Change Request (CR) #: CR 9252
Related CR Release Date: December 3, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R1580OTN
Implementation Date: January 4, 2016, exceptions: FISS will implement the following NCDs: April 4, 2016: 260.1, 80.11, 270.6, 160.18, 110.10, 110.21, 250.5, 100.1, 160.24

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2016 annual update for clinical laboratory fee schedule and laboratory services subject to reasonable charge payment

Provider types affected

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

Provider action needed

Change request (CR) 9465 provides instructions for the 2016 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), the annual update to the local clinical laboratory fees for 2016 is 0.10 percent. The annual update to payments made on a reasonable charge basis for all other laboratory services for 2016 is 0.10 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).The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

Key points of CR 9465

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. Further, payment may not exceed the actual charge. The 2016 national minimum payment amount is $14.39 ($14.38 times 0.10 percent update for 2016). 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 2016 clinical laboratory fee schedule data file is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/clinlab.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 2016 clinical laboratory fee schedule; available in multiple formats: Excel, text, and comma delimited.

Public comments and final payment determinations

On July 16, 2015, CMS hosted a public meeting to solicit input on the payment relationship between 2015 codes and new 2016 *CPT*® codes. 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 website at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html*. Additional written comments from the public were accepted until October 26, 2015. 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/CY2016-CLFS-Codes-Final-Determinations.pdf*.

Pricing information

The 2016 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes *36415*, P9612, and P9615). The fees have been established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated on an annual basis. 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 2016, CMS will issue a separate instruction on the clinical laboratory travel fees.

The 2016 clinical laboratory fee schedule also includes codes that have a “QW” modifier to both identify codes and 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

Similar to prior years, the 2016 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

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each individual test code included in the panel code. The NLA field on the data file is zero-filled.

Mapping Information

New code G0477 is priced at the same rate as 0.75 times code G0434.

New code G0478 is priced at the same rate as code G0434.

New code G0479 is priced at the same rate as 4.00 times code G0434.

New code G0480 is priced at the same rate as 3.25 times code *82542*.

New code G0481 is priced at the same rate as 5.00 times code *82542*.

New code G0482 is priced at the same rate as 6.75 times code *82542*.

New code G0483 is priced at the same rate as 8.75 times code *82542*.

New code *87651*QW is priced at the same rate as code *87651*.

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

New code *87502*QW is priced at the same rate as code *87502*.

New code *86780*QW is priced at the same rate as code *86780*.

New code *87650*QW is priced at the same rate as code *87650*.

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

New code *86850* is priced at the same rate as code *86902*.

New code *80081* is priced at the same rate as the sum of codes *85025, 87340, 87389, 86762, 86592, 86850, 86900*, and *86901*.

New code *80055* is priced at the same rate as the sum of codes *85025, 87340, 86762, 86592, 86850, 86900*, and *86901*.

New code G0472 is priced at the same rate as code *86803*.

New code G0472QW is priced at the same rate as code *86803*.

New code *81162* is priced at the same rate as the sum of 0.90 times code *81211*, and 0.90 times code *81213*.

New code *81170* is priced at the same rate as code *81235*.

New code *81218* is priced at the same rate as code *81235*.

New code *81219* is priced at the same rate as code *81245*.

New code *81272* is priced at the same rate as code *81235*.

New code *81273* is priced at the same rate as code *81270*.

New code *81276* is priced at the same rate as code *81275*.

New code *81311* is priced at the same rate as 1.50 times code *81275*.

New code *81314* is priced at the same rate as code *81235*.

New code *81528* is priced at the same rate as the sum of codes *81315*, *81275*, and *82274*.

New code *81535* is priced at the same rate as the sum of 2.00 times code *88239* and code *87900*.

New code *81536* is priced at the same rate as code *87900*.

New codes to be gap filled are: *81412, 81432, 81433, 81434, 81437, 81438, 81442, 81490*, *81493, 81525, 81538, 81540, 81545, 81595, 0009M*, and *0010M*.

The following existing codes are to be deleted: G0431, G0434, G0434QW, G0464, G6030, G6031, G6032, G6034, G6035, G6036, G6037, G6038, G6039, G6040, G6041, G6042, G6043, G6044, G6045, G6046, G6047, G6048, G6049, G6050, G6051, G6052, G6053, G6054, G6055, G6056, G6057, G6058, *82486, 82487, 82488, 82489, 82491, 82492, 82541, 82543, 82544*, and *83788*.

Laboratory costs subject to reasonable charge payment in 2011

For outpatients, the following codes are paid under a reasonable charge basis (See Section 1842(b)(3) of the Act). In accordance with 42 CFR 405.502 through 42 CFR 405.508, 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 2016 is 0.1 percent.

Manual instructions for determining the reasonable charge payment are available in the *Medicare Claims Processing Manual*, *Chapter 23* (Fee Schedule Administration and Coding Requirements), Sections 80 through 80.8. 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

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Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, *Medicare Claims Processing Manual*, Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), Section 60.3, instructs that the reasonable charge basis applies. However, 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 the following codes should be applied to the blood deductible as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3 (Deductibles, Coinsurance Amounts, and Payment Limitations), Sections 20.5 through 20.5.4: P9010, P9016, P9021, P9022, P9038, P9039, P9040, P9051, P9054, P9056, P9057, and P9058.

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: 86*850, 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 procedure codes

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*.

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

Additional information

The official instruction, CR 9465, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3420CP.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: MM9465
Related Change Request (CR) #: CR 9465
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Effective Date: January 1, 2016
Related CR Transmittal #: R3420CP
Implementation Date: January 4, 2016

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2016 update for DMEPOS fee schedule

Provider types affected

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

Provider action needed

Change request (CR) 9431 provides the CY 2016 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedule on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Chapter 23, Section 60.

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

The Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas for the items, based on information from the National Competitive Bidding Program (CBP). The Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP.

CMS issued a final rule November 6, 2014 (79 FR 66223) on the methodologies for adjusting DMEPOS fee schedule amounts using information from competitive bidding programs. Program instructions on these changes are also available in Transmittal 3350, CR 9239 September 11, 2015. The CBP product categories, HCPCS codes and single payment amounts (SPAs) included in each round of the CBP are available on the competitive bidding implementation contractor (CBIC) website.

There are three general methodologies used in adjusting the fee schedule amounts:

1. **Adjusted fee schedule amounts for areas within the contiguous United States**

The average of SPAs from CBPs located in eight different regions of the contiguous United States are used to adjust the fee schedule amounts for the states located in each of the eight regions. These regional SPAs or RSPAs are also subject to a national ceiling (110 percent of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90 percent of the average of the RSPAs for all contiguous states plus the District of Columbia). This methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (i.e., those included in more than 10 CBAs).

Also, the fee schedule amounts for areas within the contiguous United States that are designated as rural areas are adjusted to equal the national ceiling amounts described above. Regulations at §414.202 define a rural areas to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any metropolitan statistical area (MSA). A rural area also includes any ZIP code within an MSA that is excluded from a competitive bidding area established for that MSA.

2. **Adjusted fee schedule amounts for areas outside the contiguous United States**

Areas outside the contiguous United States (i.e., noncontiguous areas such as Alaska, Guam, Hawaii) receive adjusted fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

3. **Adjusted fee schedule amounts for items included in 10 or fewer areas**

DME items included in 10 or fewer CBAs receive adjusted fee schedule amounts so that they are equal to 110 percent of the straight average of the SPAs for the 10 or fewer CBAs. This methodology applies to all areas (i.e.,

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non-contiguous and contiguous).

Phasing in fee schedule amounts

The adjustments to the fee schedule amounts will be phased in for claims with dates of service January 1, 2016, through June 30, 2016, so that each fee schedule amount is based on a blend of 50 percent of the fee schedule amount that would have gone into effect on January 1, 2016, if not adjusted based on information from the CBP, and 50 percent of the adjusted fee schedule amount.

For claims with dates of service on or after July 1, 2016, the July quarterly update files will include the fee schedule amounts based on 100 percent of the adjusted fee schedule amounts.

Fee schedule amounts that are adjusted using SPAs will not be subject to the annual DMEPOS covered item update and will only be updated when SPAs from the CBP are updated. Updates to the SPAs may occur at the end of a contract period, as additional items are phased into the CBP, or as new CBPs in new areas are phased in. In cases where the SPAs from CBPs no longer in effect are used to adjust fee schedule amounts (§414.210(g)(4)), the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment would go into effect (for example, 2016 for this update) and for each subsequent year (such as 2017 or 2018) claims with dates of service on or after July 1, 2016, the fee schedule amount on the DMEPOS file is based on 100 percent of the adjusted fee schedule amount.

Fee schedule and rural ZIP code files

The DMEPOS fee schedule file will contain HCPCS codes that are subject to the adjusted payment amount methodologies discussed above as well as codes that are not subject to the fee schedule CBP adjustments taking effect January 1, 2016. In order to apply the rural payment rule for areas within the contiguous United States, the DMEPOS fee schedule file has been updated to include rural payment amounts for those HCPCS codes where the adjustment methodology is based on average regional SPAs. Also, on the PEN file the national fee schedule amounts for enteral nutrition will transition to statewide fee schedule amounts. For parenteral nutrition, the national fee schedule amount methodology will remain unchanged. The DMEPOS and PEN fee schedules and the Rural ZIP code file public-use files (PUFs) will be available for state Medicaid agencies, managed care organizations, and other interested parties after October 29, 2015 at *www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched*.

New codes added effective January 1, 2016

The HCPCS codes A4337, E1012, E0465, E0466, and L8607. are being added to the HCPCS effective January 1, 2016. Codes E1012, E0465, E0466, and L8607 will be added to the DMEPOS fee schedule file effective January 1, 2016.

Codes deleted

The following codes will be deleted from the DMEPOS fee schedule files effective January 1, 2016: E0450, E0460, E0461, E0463, and E0464.

Shoe modification codes

Effective January 1, 2016, CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2016. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of 2004. For 2016, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during 2014.

Update to CR 8566 — wheelchair accessory

Also as part of CR 9431, CMS is adding HCPCS code E1012 (wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type). Code E1012 is eligible for

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payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair, effective January 1, 2016.

The 2015 deflation factors for gap-filling purposes

For gap-filling pricing purposes, the 2015 deflation factors by payment category are: 0.459 for oxygen, 0.462 for capped rental, 0.463 for prosthetics and orthotics, 0.588 for surgical dressings, 0.639 for parental and enteral nutrition, 0.978 for splints and casts and 0.962 for intraocular lenses.

Ventilators

Fee schedules are being added for the following ventilator HCPCS codes:

- E0465 Home ventilator, any type, used with invasive interface (e.g., tracheostomy tube); and
- Code E0466 Home ventilator, any type, used with non-invasive interface (e.g., mask, chest shell).

Code E0465 is added to the HCPCS for billing Medicare claims previously submitted under E0450 and E0463. Code E0466 is added to the HCPCS for billing Medicare claims previously submitted under E0460, E0461, and E0464. The fee schedule amounts for codes E0465 and E0466 are established using the Medicare fee schedule amounts for HCPCS code E0450, based on updated average reasonable charges for ventilators from July 1, 1986, through June 30, 1987.

Diabetic testing supplies (DTS)

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

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated. The CBP for mail order diabetic supplies is effective July 1, 2013-June 30, 2016. The program instructions reviewing these changes are Transmittal 2709, CR 8325, dated May 17, 2013, and Transmittal 2661, CR 8204, dated February 22, 2013. (See related *MLN Matters*® articles MM8325 and MM8204.)

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data only for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts will be updated annually by the covered item update factor adjusted for multi-factor productivity. The mail order DTS fee schedule amounts are not used in determining the Medicare allowed payment amounts for mail order DTS. The single payment amount Public Use File (PUF) for the national mail order CBP is available at *http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts*.

The Northern Mariana Islands are not considered an area eligible for inclusion under a national mail order competitive bidding program. However, in accordance with The Act, the fee schedule amounts for mail order DTS furnished in the Northern Mariana Islands are adjusted to equal 100 percent of the single payment amounts established under the national mail order competitive bidding program (79 FR 66232).

Because the Northern Mariana Islands adjustment is subject to the six-month phase-in period, the adjusted Northern Mariana Island DTS mail order fees, which are based on 50 percent of the unadjusted mail order fee schedule amounts and 50 percent of the adjusted mail order single payment amounts, will be provided on the DMEPOS fee schedule file in the Hawaii column of the mail order (KL) DTS (A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259) codes for dates of service January 1, 2016, through June 30, 2016. Beginning July 1, 2016, the fully adjusted mail order fees (the SPAs) will apply for mail order DTS furnished in the Northern Mariana Islands. The Northern Mariana Island DTS mail order payment amounts will no longer appear in the Hawaii column and the DTS mail order (KL) fee schedules for all states and territories will be removed from the DMEPOS fee schedule file as of July 1, 2016.

2016 fee schedule update factor of -0.4 percent

For 2016, an update factor of 0.1 percent is applied to certain DMEPOS fee schedule amounts. For the majority of fee schedule amounts, in accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2016 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June 2015, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi[AG5] -factor productivity (MFP). The MFP adjustment is 0.5 percent and the CPI-U percentage increase is 0.1 percent. Thus, the 0.1 percentage increase in the CPI-U is reduced by the 0.5 percentage increase in the MFP resulting in a net decrease of -0.4 percent for the update factor.

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2016 update labor payment rates for HCPCS codes K0739, L4205, and L7520 January 1, 2016, through December 31, 2016.

The 2016 labor payment amounts are effective for claims submitted using HCPCS codes K0739, L4205, and L7520 with dates of service from January 1, 2016, through December 31, 2016. Those amounts are as follows:

State	K0739	L4205	L7520
AK	$28.01	$31.91	$37.54
AL	$14.87	$22.16	$30.08
AR	$14.87	$22.16	$30.08
AZ	$18.39	$22.13	$37.01
CA	$22.81	$36.38	$42.39
CO	$14.87	$22.16	$30.08
CT	$24.83	$22.65	$30.08
DC	$14.87	$22.13	$30.08
DE	$27.38	$22.13	$30.08
FL	$14.87	$22.16	$30.08
GA	$14.87	$22.16	$30.08
HI	$18.39	$31.91	$37.54
IA	$14.87	$22.13	$36.01
ID	$14.87	$22.13	$30.08
IL	$14.87	$22.13	$30.08
IN	$14.87	$22.13	$30.08
KS	$14.87	$22.13	$37.54
KY	$14.87	$28.37	$38.47
LA	$14.87	$22.16	$30.08
MA	$24.83	$22.13	$30.08
MD	$14.87	$22.13	$30.08
ME	$24.83	$22.13	$30.08
MI	$14.87	$22.13	$30.08
MN	$14.87	$22.13	$30.08
MO	$14.87	$22.13	$30.08
MS	$14.87	$22.16	$30.08
MT	$14.87	$22.13	$37.54
NC	$14.87	$22.16	$30.08
ND	$18.53	$31.84	$37.54
NE	$14.87	$22.13	$41.94
NH	$15.97	$22.13	$30.08
NJ	$20.06	$22.13	$30.08
NM	$14.87	$22.16	$30.08
NV	$23.69	$22.13	$41.00
NY	$27.38	$22.16	$30.08
OH	$14.87	$22.13	$30.08
OK	$14.87	$22.16	$30.08
OR	$14.87	$22.13	$43.25
PA	$15.97	$22.79	$30.08
PR	$14.87	$22.16	$30.08
RI	$17.72	$22.81	$30.08
SC	$14.87	$22.16	$30.08
SD	$16.62	$22.13	$40.22
TN	$14.87	$22.16	$30.08
TX	$14.87	$22.16	$30.08
UT	$14.91	$22.13	$46.84
VA	$14.87	$22.13	$30.08
VI	$14.87	$22.16	$30.08
VT	$15.97	$22.13	$30.08
WA	$23.69	$32.47	$38.57
WI	$14.87	$22.13	$30.08
WV	$14.87	$22.13	$30.08
WY	$20.73	$29.53	$41.94

2016 national monthly fee schedule amounts for stationary oxygen equipment

CMS is implementing the 2016 national monthly fee schedule payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service from January 1, 2016, through June 2016. The updated national 2016 monthly payment amount of $180.10 for the stationary oxygen equipment codes will not appear on the 2016 DMEPOS fee schedule. Instead, for dates of service January 1, 2016, through June 30, 2016, the 2016 fee schedule rate of $180.10 blends with the stationary oxygen regional SPAs based on 50 percent of the un-adjusted stationary oxygen fee schedule amounts and 50 percent of the adjusted oxygen regional SPAs.

Beginning July 1, 2016, the stationary oxygen equipment fee schedule amounts on the quarterly update to the 2016 DMEPOS fee schedule file will reflect 100 percent of the adjusted oxygen regional SPAs.

When updating the stationary oxygen equipment amounts, corresponding updates are made to the fee schedule

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amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the payment amounts for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2016 maintenance and servicing payment amount for certain oxygen equipment

Also updated for 2016 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, change request (CR) 6792, dated February 5, 2010, and Transmittal 717, CR 6990, dated June 8, 2010. (See related *MLN Matters*® articles MM6792 and MM6990.) To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every six months beginning six months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any six-month period.

Per 42 CFR §414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in §1834(a)(14) of the Act. Thus, the 2016 maintenance and servicing fee is adjusted by the -0.4 percent MFP-adjusted covered item update factor to yield a 2016 maintenance and servicing fee of $69.48 for oxygen concentrators and transfilling equipment.

Additional information

The official instruction, CR 9431, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3416CP.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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Medicare signature requirements

The Medicare requirement to authenticate the medical record is to ensure the services rendered have been thoroughly documented and authenticated by the author of the medical record entry. *Click here* for information on Medicare's signature requirements and how adhering to these requirements can prevent impacts to your claims.

Implementation of adjusted DMEPOS fee schedule amounts using information from the national competitive bidding program

Provider types affected

This *MLN Matters*® article is intended for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers submitting claims to durable medical equipment Medicare administrative contractors (DME MACs) for services provided to Medicare beneficiaries.

Provider action needed

Stop – impact to you

The adjusted fee schedule amounts for the applicable Healthcare Common Procedure Coding System (HCPCS) codes will be used to pay claims with dates of service on or after January 1, 2016, and will be included in the DMEPOS fee schedule files beginning January 1, 2016.

Caution – what you need to know

Section 1834(a)(1)(F) of the Act mandates adjustments to the fee schedule amounts for DME furnished on or after January 1, 2016, based on information from the competitive bidding program (CBP). Section 1842(s)(3(B) of the Social Security Act (the Act) provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the competitive bidding program (CBP). Change request (CR) 9239 implements the adjusted DMEPOS fees schedule from the CBP.

Go – what you need to do

Make sure that your billing staffs are aware of the adjusted DMEPOS fee schedule amounts from the CBP.

Background

Medicare payment for most DMEPOS is based on either fee schedules or single payment amounts (SPAs) established under the CBP in certain specified geographic areas, as mandated by 1847(a) and (b) the Act.

Competitive bidding was phased in with the round 1 rebid contracts beginning January 1, 2011, in nine competitive bid areas (CBAs). Contracts for the round one rebid expired December 31, 2013. The Centers for Medicare & Medicaid Services (CMS) is required by law to recompete contracts for the DMEPOS CBP at least once every three years. The same nine CBAs were rebid under the round 1 recompete with the contracts and process claims with date of service beginning January 1, 2014. Competitive bidding was phased in with the round two contracts beginning July 1, 2013, in 100 additional CBAs. Beginning with the round two recompete scheduled to take effect July 1, 2016, CBAs covering more than one state will be subdivided into CBAs that do not cross state lines, resulting in an increase in the total number of CBAs.

The product categories and HCPCS codes included in each tound of the CBP are available at *http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home*.

Section 1834(a)(1)(F) of the Act mandates adjustments to the fee schedule amounts for DME furnished on or after January 1, 2016, based on information from the CBP. Section 1842(s)(3(B) of the Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP. The methodologies for using information from the CBP to adjust the fee schedule amounts for DME and enteral nutrition are set forth in regulations at *42 Code of Federal Regulations* (*CFR*) 414.210(g). There are three general methodologies:

- Adjustment of fee schedule amounts for areas within the contiguous United States, with a special rule for rural areas;
- Adjustment of fee schedule amounts for areas outside the contiguous United States; and
- Adjustment of fee schedule amounts for certain items for all areas in cases where the items have been included in competitive bidding programs in 10 or fewer CBAs.

Fee schedule amounts for areas within the contiguous United States

This methodology for adjusting the fee schedule amounts uses the average of SPAs from CBPs located in eight different regions of the contiguous United States to adjust the fee schedule amounts for the states located in each of the eight regions. These regional SPAs or RSPAs are also subject to a national ceiling (110 percent of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90 percent of the average of the RSPAs for all contiguous states plus the District of Columbia). This methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (that is, those included in more than 10 CBAs).

There is also a special rule for areas within the contiguous United States that are designated as rural areas. The fee schedule amounts for these areas will be adjusted to equal the national ceiling amounts described above. Regulations at §414.202 define a rural area to be a geographical area represented by a postal ZIP Code where at least 50 percent of the total geographical area of the ZIP code is

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estimated to be outside any metropolitan statistical area (MSA). A rural area also includes any ZIP code within an MSA that is excluded from a competitive bidding area established for that MSA.

As a result of these adjustments, the national fee schedule amounts for enteral nutrition will transition to statewide fee schedule amounts.

Fee schedule amounts for areas outside the contiguous United States

Areas outside the contiguous United States (noncontiguous areas such as Alaska, Guam, Hawaii) are subject to a different methodology that adjusts the fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

Fee schedule amounts for items included in 10 or fewer CBAs

DME items included in 10 or fewer CBAs are subject to a different methodology that adjusts the fee schedule amounts so that they are equal to 110 percent of the average of the SPAs for the 10 or fewer CBAs. This methodology applied to all areas (non-contiguous and contiguous).

Phasing in and updating fee schedule amounts

The adjustments to the fee schedule amounts will be phased in for claims with dates of service January 1, 2016, through June 30, 2016, so that the fee schedule amount is based on a blend of 50 percent of the current fee schedule amounts (the fee schedule amounts that would have gone into effect on January 1, 2016, if they had not been adjusted based on information from the CBP) and 50 percent of the adjusted fee schedule amount.

For claims with dates of service on or after July 1, 2016, the fee schedule is based on 100 percent of the adjusted fee schedule amount.

In most cases, the adjusted fee schedule amounts will not be subject to the annual DMEPOS covered item update and will only be updated when SPAs from the CBP are updated. Updates to the SPAs may occur at the end of a contract period, as additional items are phased into the CBP, or as new CBPs in new areas are phased in. In cases where SPAs from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment is made (for example, 2016) and for each subsequent year (for example, 2017, 2018).

The DME MAC and Part B MAC DMEPOS fee schedule file shall be adjusted to include the rural fee and rural fee indicator and these changes will be reflected in the file format and data requirements specified in Chapter 23, Section 60.1 of the *Medicare Claims Processing Manual* Similarly, the fiscal intermediary (FI) DMEPOS fee schedule file format, outlined in Chapter 23, Section 50.2 of the *Medicare Claims Processing Manual* will be updated to include the rural fee and rural fee indicator. Beginning January 1, 2016, the DMEPOS fee schedule file will contain HCPCS codes that are subject to the adjusted payment amount methodology as well as codes that are not subject to the adjustments. The DMEPOS fee schedule file will continue to be updated and available for download on a quarterly basis as necessary.

The parenteral and enteral nutrition (PEN) fee schedule file will accommodate adjusted fees for the enteral HCPCS codes that are state specific. The PEN file layout is outlined in Chapter 23, Section 70.1 of the *Medicare Claims Processing Manual*.

Additional information

The official instruction, CR 9239, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3350CP.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 of changes in the ESRD prospective payment system for 2016

Provider types affected

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

Provider action needed

Change request (CR) 9367 implements the 2016 rate updates for the ESRD PPS. Please make sure your billing staffs are aware of these changes.

Background

Effective January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) implemented the ESRD PPS based on the requirements of Section 1881(b)(14) of the Social Security Act (the Act) as added by Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) and amended by Section 3401(h) of the Affordable Care Act established that beginning 2012, and each subsequent year, the Secretary shall annually increase payment amounts by an ESRD market basket increase factor, reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act. The ESRD bundled (ESRDB) market basket increase factor minus the productivity adjustment will update the ESRD PPS base rate. Section 217(b)(2) of the Protecting Access to Medicare Act of 2014 (PAMA) included a provision that dictated how the market basket should be reduced for 2016.

For 2016, in accordance with Section 632(c) of the American Taxpayer Relief Act of 2012 (ATRA), CMS conducted an analysis of the case-mix adjustments being used under the ESRD PPS and finalized revisions. Specifically, CMS updated the two-equation regression used to develop the payment adjustments for the 2011 ESRD PPS final rule using 2012 and 2013 Medicare cost report and claims data.

In addition to case-mix adjustments, CMS also updated the low-volume payment adjustment and is implementing a rural payment adjustment. ESRD facilities that submit an attestation to their respective MACs prior to the payment year and meet the criteria at *42 CFR 413.232(b)* are eligible to receive the low-volume payment adjustment.

In accordance with Section 217(c) of the Protecting Access to Medicare Act of 2014 (PAMA), CMS implemented a drug designation process for:

1) Determining when a product is no longer an oral-only drug; and
2) Including new injectable and intravenous products into the ESRD PPS.

CMS is completing a two-year transition to the updated labor-related share and the most recent core-based statistical area (CBSA) delineations as described in the February 28, 2013, *Office of Management and Budget (OMB) Bulletin No. 13-01*.

In addition, Section 204 of the Achieving a Better Life Experience Act of 2014, provided that payment for oral-only renal dialysis services cannot be made under the ESRD PPS bundled payment prior to January 1, 2025.

The ESRD PPS includes consolidated billing (CB) requirements for limited Part B services included in the ESRD facility's bundled payment. CMS periodically updates the list of items and services that are subject to Part B CB and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities.

Effective January 1, 2016, Healthcare Common Procedure Coding System (HCPCS) Code J0886 (Injection, epoetin alfa, 1000 units (for esrd on dialysis)) will be terminated. All drugs and biologicals used for the treatment of ESRD are the responsibility of the ESRD facility. Practitioners treating Medicare ESRD beneficiaries with erythropoiesis stimulating agents (ESAs) for reasons other than the beneficiary's ESRD must use the appropriate HCPCS code. Specifically, practitioners should use HCPCS code J0885 (Injection, epoetin alfa, (for non-esrd use), 1000 units).

2016 ESRD PPS updates – ESRD PPS base rate

- A 0.15 percent update to the 2015 payment rate. ($239.43 x 1.0015 = $239.79) • A wage index budget-neutrality adjustment factor of 1.000495. • A refinement budget-neutrality adjustment factor of 0.960319. Therefore, the 2016 ESRD PPS base rate is $230.39 ($239.43 x 1.0015 x 0.960319 = $230.39).

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Wage index

- The wage index adjustment will be updated to reflect the latest available wage data.
- The most recent OMB CBSA delineations is fully implemented; therefore, CMS is no longer transitioning the wage index and use of the special wage indicator is no longer necessary for those ESRD facilities that experienced a change in CBSA.
- The wage index floor will remain at 0.4000.

Labor-related share

The revised labor-related share of 50.673 is fully implemented.

Update to the patient-level and facility-level payment adjustments

For the 2016 ESRD PPS refinement, CMS is changing the adjustment payment amounts to reflect the updated regression analysis that was completed using 2012 and 2013 ESRD claims and cost report data for adult and pediatric patients.

In addition, for adult beneficiaries, CMS has removed two comorbidity categories (bacterial pneumonia and monoclonal gammopathy) from being eligible for a payment adjustment and is implementing a rural payment adjustment for those ESRD facilities that are located in a rural CBSA (that is, a non-urban CBSA).

The patient-level and facility-level payment adjustments are available in Tables 1 (adult) and 2 (pediatric) below.

Table 1: Adult ESRD beneficiaries

Variable	Separately billable multipliers for PY 2016	Expanded bundle multipliers for PY 2016
Age 18-44	1.044	1.257
Age 45-59	1.000	1.068
Age 60-69	1.005	1.070
Age 70-79	1.000	1.000
Age 80+	0.961	1.109
Body surface area (per 0.1 m2)	1.000	1.032
Underweight (BMI < 18.5)	1.090	1.017
Time since onset of renal dialysis < four months	1.409	1.327

Table 2: Pediatric ESRD beneficiaries

Cell	Patient characteristics		PY 2016 final rule	
	Age	Modality	Separately billable multipliers	Expanded bundle multipliers
1	<13	PD	0.410	1.063
2	<13	HD	1.406	1.306
3	13-17	PD	0.569	1.102
4	13-17	HD	1.494	1.327

Outlier policy

As a result of the 2016 ESRD PPS refinement, CMS is also changing the adjusters used for determining the Medicare allowable payment (MAP) amount in the outlier calculation. These values are available in Tables 1 and 2 above in the separately billable multipliers column.

CMS made the following updates to the adjusted average outlier service MAP amount per treatment:

1. For adult patients, the adjusted average outlier service MAP amount per treatment is $50.81.
2. For pediatric patients, the adjusted average outlier service MAP amount per treatment is $39.20.

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

1. The fixed dollar loss amount is $86.97 for adult patients.
2. The fixed dollar loss amount is $62.19 for pediatric patients.

CMS made the following changes to the list of outlier services:

1. Renal dialysis drugs that are oral equivalents to injectable drugs are based on the most recent prices retrieved from the Medicare Prescription Drug Plan Finder, are updated to reflect the most recent mean unit cost. In addition, CMS will add or remove any renal dialysis items and services that are eligible for outlier payment. See Attachment B of *CR 9367*.
2. The mean dispensing fee of the national drug codes (NDC) qualifying for outlier consideration is revised to $0.97 per NDC per month for claims with dates of service on or after January 1, 2016. See Attachment B of *CR 9367*.

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Consolidated billing requirements

1. The consolidated billing requirements for drugs and biologicals included in the ESRD PPS is updated by: a. Removing *Current Procedural Terminology* code *80061* (Lipid panel) as it has been determined that this laboratory test is routinely furnished for reasons other than for the treatment of ESRD. Therefore, for dates of service on or after January 1, 2016, the lipid panel is no longer subject to the ESRD PPS consolidated billing requirements. b. Removing HCPCS J0886 injection, epoetin alfa, 1000 units (for ESRD on dialysis) since the code will be terminated effective December 31, 2015. c. Removing HCPCS Q9976 – Injection, Ferric Pyrophosphate Citrate Solution; 0.1 mg of iron since this code will be terminated effective December 31, 2015. d. Adding HCPCS J1443 - Injection, Ferric Pyrophosphate Citrate Solution; 0.1 mg of iron since this code will be replacing Q9976 and is effective January 1, 2016.

   i. J1443 is a drug that is used for anemia management. Anemia management is an ESRD PPS functional category where drugs and biologicals that fall in this category are always considered to be used for the treatment of ESRD. ESRD facilities will not receive separate payment for J1443 with or without the AY modifier and the claims shall process the line item as covered with no separate payment under the ESRD PPS.

   ii. J1443 is administered via dialysate. Therefore, when billing for J1443, it should be accompanied by the JE modifier as discussed in CR 8256 issued April 26, 2013.

   iii. In accordance with 42 CFR 413.237(a)(1), HCPCS J1443 is considered to be eligible outlier services and will be included in the outlier calculation when CMS provides a fee amount on the average sales price fee schedule.

Attachment C of CR 9367 reflects the items and services

that are subject to the ESRD PPS consolidated billing requirements.

Additional information

The official instruction, CR 9367, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R214BP.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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Payment for grandfathered tribal FQHCs that were provider-based clinics on or before April 7, 2000

Provider types affected

This *MLN Matters*® article is intended for grandfathered tribal federally qualified health centers (FQHCs) that were provider-based clinics on or before April 7, 2000, submitting institutional claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 9267 updates instructions to the Medicare administrative contractors (MACs) for payment to grandfathered tribal FQHCs that were provider-based clinics on or before April 7, 2000.

Background

Effective for dates of service on or after January 1, 2016, Indian Health Services (IHS) and tribal facilities and organizations that met the conditions of 42 CFR 413.65(m) on or before April 7, 2000, and have a change in their status on or after April 7, 2000. from IHS to tribal operation, or vice versa, or the realignment of a facility from one IHS or tribal hospital to another IHS or tribal hospital such that the organization no longer meets the conditions of participation (CoPs), may seek to become certified as grandfathered tribal FQHCs. These grandfathered tribal FQHCs would be required to meet all FQHC certification and payment requirements.

The FQHC prospective payment system (PPS) adjustment for grandfathered tribal clinics would not apply to a currently certified tribal FQHC, a tribal clinic that was not provider-based as of April 7, 2000, or an IHS-operated clinic that is no longer provider-based to a tribally-operated hospital. This provision would also not apply in those instances where both the hospital and its provider-based clinic(s) are operated by the tribe or tribal organization.

Grandfathered tribal FQHCs will be paid the lesser of their charges or a grandfathered tribal FQHC PPS rate for all FQHC services furnished to a beneficiary during a medically-necessary, face-to-face FQHC visit. The grandfathered PPS rate equals the Medicare outpatient per visit payment rate paid to them as a provider-based department, as set annually by the IHS.

From January 1, 2015, through December 31, 2015, the grandfathered tribal FQHC PPS rate is $307. The grandfathered tribal FQHC PPS rate will not be adjusted by the FQHC PPS geographic adjustment factor (GAF) or be eligible for the special payment adjustments under the FQHC PPS for new patients, patients receiving an IPPE or an AWV. The rate is also ineligible for exceptions to the single per diem payment that is available to FQHCs paid under the FQHC PPS. In addition, the Medicare economic index (MEI) or a FQHC market basket adjustment that is applied annually to the FQHC PPS base rate, will not apply to the grandfathered tribal FQHC PPS rate.

Grandfathered tribal FQHCs will be paid for services included in the FQHC benefit, even if those services are not included in the IHS Medicare outpatient all-inclusive rate. Services that are included in the IHS outpatient all-inclusive rate but not in the FQHC benefit will not be paid.

Grandfathered tribal FQHCs are subject to the payment requirements under the FQHC PPS. The five FQHC payment G-codes shall be used by grandfathered tribal FQHCs when submitting claims under the PPS based on the services furnished. Grandfathered tribal FQHCs shall use the specific payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment. Each grandfathered tribal FQHC shall report a charge for the visit code that would reflect the sum of regular rates charged to both beneficiaries and other patients for a typical bundle of services that would be furnished per diem to a Medicare beneficiary. Additional information on the coverage and payment requirements for FQHC visits is available in the *Medicare Benefit Policy Manual*, Chapter 13. Additional information regarding the services that are qualifying visits is available on the FQHC PPS center page at *http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html*.

MACs shall generally pay 80 percent of the lesser of the grandfathered tribal FQHC's charge for the FQHC payment code or the grandfathered tribal FQHC PPS rate. Coinsurance will generally be 20 percent of the lesser of the actual charge or the grandfathered tribal FQHC PPS rate. For claims that consist solely of preventive services that are exempt from beneficiary coinsurance, contractors shall pay 100 percent of the lesser of the actual charge or the grandfathered tribal FQHC PPS rate, and no beneficiary coinsurance would be assessed.

For claims that include a mix of preventive and non-preventive services, MACs shall use the current methodology established under the FQHC PPS to calculate coinsurance.

Additional information

The official instruction, CR 9267, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3415CP.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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Chronic care management services for RHCs and FQHCs

Provider types affected

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

What you need to know

This article is based on change request (CR) 9234, which provides instructions to MACs regarding payment for CCM services for dates of service on or after January 1, 2016, to RHCs billing under the RHC all-inclusive rate (AIR) and FQHCs billing under the FQHC prospective payment system (PPS).

Background

The Centers for Medicare & Medicaid Services (CMS) recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending. On January 1, 2015, CMS began making separate payment under the Medicare physician fee schedule (PFS) for CCM services under American Medical Association (AMA) *Current Procedural Terminology* (*CPT*®) code *99490*.

CMS finalized aspects of the payment methodology, scope of services, and requirements for billing and supervision for practitioners permitted to bill Medicare under the PFS in the 2014 PFS final rule (78 74414 through 74427) and made further refinements in the 2015 final rule (79 67715 through 67730).

As authorized by the Social Security Act (Section 1861(aa)), RHCs and FQHCs are paid for physician services and services and supplies incident to physician services. In the 2016 PFS proposed rule (80 FR 41793), CMS proposed requirements and a payment methodology for CCM services furnished by RHCs and FQHCs. In the 2016 PFS final (80 FR 71080), CMS finalized the requirements and payment methodology for CCM services furnished by RHCs and FQHCs.

Beginning on January 1, 2016, RHCs and FQHCs may receive an additional payment for the costs of CCM services that are not already captured in the RHC AIR or the FQHC PPS for CCM services to Medicare beneficiaries having multiple (two or more) chronic conditions that are expected to last at least 12 months (or until the death of the patient), and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

RHCs and FQHCs can bill for CCM services when a RHC or FQHC practitioner furnishes a comprehensive evaluation and management (E/M) visit, annual wellness visit (AWV), or initial preventive physical examination (IPPE) to the patient prior to billing the CCM service, and initiates the CCM service as part of this visit.

CCM payment will be based on the Medicare PFS national average non-facility payment rate when *CPT*® code *99490* is billed alone or with other payable services on a RHC or FQHC claim. The rate will be updated annually and has no geographic adjustment. The RHC and FQHC face-to-face requirements are waived when CCM services are furnished to a RHC or FQHC patient.

Coinsurance would be applied as applicable to FQHC claims, and coinsurance and deductibles would apply as applicable to RHC claims. RHCs and FQHCs would continue to be required to meet the RHC and FQHC conditions of participation and any additional RHC or FQHC payment requirements.

RHCs and FQHCs cannot bill for CCM services for a beneficiary during the same service period as billing for transitional care management or any other program that provides additional payment for care management services (outside of the RHC AIR or FQHC PPS payment) for the same beneficiary.

Patient agreement requirements - overview

The RHC or FQHC must inform eligible patients of the availability of CCM services and obtain consent for the CCM service before furnishing or billing the service. Some of the patient agreement provisions require the use of certified electronic health record (EHR) technology. See Table 1 for more detailed information.

Patient consent requirements include:

See **CHRONIC**, next page

TRIBAL

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MLN Matters® Number: MM9267
Related Change Request (CR) #: CR 9267
Related CR Release Date: November 23, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3415CP

Implementation Date: January 4, 2016

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.

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CHRONIC

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- Informing the patient of the availability of the CCM service and obtaining written agreement to have the services provided, including authorization for the electronic communication of medical information with other treating practitioners and providers.
- Explaining and offering the CCM service to the patient and documenting this discussion in the patient's medical record, noting the patient's decision to accept or decline the service.
- Explaining how to revoke the service.
- Informing the patient that only one practitioner can furnish and be paid for the service during a calendar month.

This agreement process should include a discussion with the patient, and caregiver when applicable, about:

- What the CCM service is;
- How to access the elements of the service;
- How the patient's information will be shared among practitioners and providers;
- How cost-sharing (co-insurance and deductibles) applies to these services; and
- How to revoke the service. Informed patient consent should only be obtained once prior to furnishing the CCM service, or if the patient chooses to change the practitioner who will furnish and bill the service.

CCM scope of service elements - overview

The CCM service includes the structured recording of patient health information, an electronic care plan addressing all health issues, access to care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice. Some of the CCM scope of service elements require the use of a certified EHR or other electronic technology. For a complete listing of the CCM scope of service elements and electronic technology requirements that must be met in order to bill the service, see Table 1.

Structured data recording

- Record the patient's demographics, problems, medications, and medication allergies and create structured clinical summary records using certified EHR technology.

Care plan

- Create a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues).
- Provide the patient with a written or electronic copy of the care plan and document its provision in the medical record.
- Ensure the care plan is available electronically at all times to anyone within the practice providing the CCM service.
- Share the care plan electronically outside the practice as appropriate.

A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list;
- Expected outcome and prognosis;
- Measurable treatment goals;
- Symptom management;
- Planned interventions and identification of the individuals responsible for each intervention;
- Medication management;
- Community/social services ordered;
- A description of how services of agencies and specialists outside the practice will be directed/coordinated; and
- Schedule for periodic review and, when applicable, revision of the care plan.

Access to care

- Ensure 24-hour-a-day, 7-day-a-week (24/7) access to care management services, providing the patient with a means to make timely contact with health care practitioners in the practice who have access to the patient's electronic care plan to address his or her urgent chronic care needs.
- Ensure continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care. Do this through telephone, secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods, in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Care management

Care management services such as:

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- Systematic assessment of the patient's medical, functional, and psychosocial needs;`
- System-based approaches to ensure timely receipt of all recommended preventive care services;
- Medication reconciliation with review of adherence and potential interactions; and`
- Oversight of patient self-management of medications.

Manage care transitions between and among health care providers and settings, including referrals to other providers, including:

- Providing follow-up after an emergency department visit, and after discharges from hospitals, skilled nursing facilities, or other health care facilities.

Coordinate care with home and community based clinical service providers.

EHR and other electronic technology requirements

CMS requires the use of certified EHR technology to satisfy some of the CCM scope of service elements. In furnishing these aspects of the CCM service, CMS requires the use of a version of certified EHR that is acceptable under the EHR incentive programs as of December 31st of the calendar year preceding each Medicare PFS payment year (referred to as "CCM certified technology"). For more information, visit *http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms*.

For CCM payment in 2016, practitioners may use EHR technology certified to the 2014 edition(s) of certification criteria.

At this time, CMS does not require the use of certified EHR technology for some of the services involving the care plan and clinical summaries, allowing for broader electronic capabilities. These are described in Table 1, CCM Scope of Service and Billing Requirements.

Table 1: CCM Scope of Service and Billing Requirements in RHCs and FQHCs

CCM scope of service element/billing requirement	Certified EHR or other electronic technology requirement
Initiation during an AWV, IPPE, or comprehensive E/M visit (billed separately).	None.
Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care.	Structured recording of demographics, problems, medications, medication allergies, and creation of structured clinical summary records using CCM certified technology.
Access to care management services 24/7 that provides the beneficiary with a means to make timely contact with health care practitioners in the practice who have access to the patient's electronic care plan to address his or her urgent chronic care needs regardless of the time of day or day of the week.	None.
Continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments.	None.
Care management for chronic conditions including systematic assessment of the beneficiary's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medications.	None.

See **CHRONIC**, next page

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CCM scope of service element/billing requirement	Certified EHR or other electronic technology requirement
Creation of a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re) assessment and an inventory of resources and supports; a comprehensive care plan for all health issues. Share the care plan as appropriate with other practitioners and providers.	Must at least electronically capture care plan information; make this information available on a 24/7 basis to all practitioners within the practice whose time counts towards the time requirement for the practice to bill the CCM code; and share care plan information electronically (other than by fax) as appropriate with other practitioners and providers.
Provide the beneficiary with a written or electronic copy of the care plan and document its provision in the electronic medical record.	Document provision of the care plan as required to the beneficiary in the EHR using CCM certified technology.
Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.	Format clinical summaries according to CCM certified technology. Not required to use a specific tool or service to exchange/ transmit clinical summaries, as long as they are transmitted electronically (other than by fax).
Coordination with home and community based clinical service providers.	Communication to and from home and community based providers regarding the patient's psychosocial needs and functional deficits must be documented in the patient's medical record using CCM certified technology.
Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary's care through not only telephone access, but also through the use of secure messaging, Internet or other asynchronous non-face-to-face consultation methods.	None.
Beneficiary consent—Inform the beneficiary of the availability of CCM services and obtain his or her written agreement to have the services provided, including authorization for the electronic communication of his or her medical information with other treating providers.	Document the beneficiary's written consent and authorization in the EHR using CCM certified technology.
Document in the beneficiary's medical record that all of the CCM services were explained and offered, and note the beneficiary's decision to accept or decline these services.	
Beneficiary consent—Inform the beneficiary of the right to stop the CCM services at any time (effective at the end of the calendar month) and the effect of a revocation of the agreement on CCM services.	None.
Beneficiary consent—Inform the beneficiary that only one practitioner can furnish and be paid for these services during a calendar month.	None

Examples are provided to assist RHCs and FQHCs in billing for CCM services at the end of this article: (Table 2)

See **CHRONIC**, next page

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Additional information

The official instruction, CR 9234, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1576OTN.pdf*.

The following documents and websites provide additional information about CCM:

- **CCM services**: See *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf*.
- **PFS and OPPS frequently asked questions on CCM**: See *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Payment-Chronic-Care-Management-Services-FAQs.pdf*.
- **Chronic conditions**: See *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions*.
- **Chronic conditions data warehouse**: See *https://www.ccwdata.org/web/guest*
- **Final rules in the *Federal Register* (policies governing CCM services)**:
  - **2014 Medicare PFS final rule (CMS-1600-FC) pages 74414-74427**: See *http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28696.pdf*.
  - **2015 Medicare PFS final rule (CMS-1612-FC) pages 67715-67730**: See *http://www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.pdf*.
  - **2015 Medicare PFS final rule; correction amendment (CMS-1612-F2), page 14853**: See *http://www.gpo.gov/fdsys/pkg/FR-2015-03-20/pdf/2015-06427.pdf*.

MLN Matters® Number: MM9234 *Revised*
Related Change Request (CR) #: CR 9234
Related CR Release Date: November 18, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R1576OTN
Implementation Date: January 4, 2016

Table 2: Billing examples for CCM services

Examples are provided to assist RHCs and FQHCs in billing for CCM services at the end of this article:

CCM furnished as a stand-alone service

Revenue code	HCPCS	Service date	Service units	Total	Payment	Coinsurance/ deductible applied (when applicable)
52x[1]	*99490*		1	$XX.XX[3]	Based on the PFS national average non-facility payment rate	Yes
52x[1]	A FQHC		1	$XX.XX[3]	FQHC prospective payment system (PPS) methodology for FQHCs or All-inclusive rate (AIR) for RHCs	Yes[4]
52x[1]	*99490*		1	$XX.XX[3]	Based on the PFS national average non-facility payment rate	Yes

[1]Use the revenue code most appropriate for the service
[2]Any date of service on or after 1/1/2016
[3]Enter charge amount
[4]Coinsurance and/or deductible is waived when an approved preventive service is billed

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Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our "*Website enhancements*" page. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's Web team.

October update in the Medicare physician fee schedule database

***Note**: This article was revised November 25, 2015, to reflect the revised change request (CR) 9266 issued November 18. In the article, several codes were removed from the list of codes with bilateral surgery indicator changes. The CR release date, transmittal number, and the Web address for CR 9266 are also revised. This information was previously published in the Medicare A Connection, Page 35.*

Provider types affected

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

What you need to know

Changes included in the October update to the 2015 MPFSDB are effective for dates of service on and after January 1 (unless otherwise stated). The key change is to the malpractice relative value units (RVU) of the following *CPT*®/HCPCS codes: *33471, 33606, 33611, 33619, 33676, 33677, 33692, 33737, 33755, 33762, 33764, 33768, 33770, 33771, 33775, 33776, 33777, 33778, 33779, 33780, 33781, 33783, 33786, 33803, 33813, 33822, 33840*, and *33851*; and the work RVUs for G0105 and G0121. The RVU changes for these codes are retroactive to January 1, 2015. In addition, effective January 1, 2015, codes *95866*, *95866*-TC, and *95866-26* have a revised bilateral surgery indicator = 3.

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

Background

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

Payment files were issued to the MACs based upon the 2015 Medicare physician fee schedule (MPFS) final rule, published in the *Federal Register* December 19, 2014, to be effective for services furnished between January 1, 2015, and December 31, 2015.

Additional information

The official instruction, CR 9266 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3407CP.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.

Document history

- On September 29, 2015, additional codes (G0105 and G0121) were added in the "What you need to know" section listing RVU changes.
- On November 25, the "What you need to know" section listing RVU changes was revised to remove several codes (*76641*, *76641*-TC, *76641-26*, *76642*, *76642*-TC, *76642-26*) that had been listed with bilateral surgery indicator changes.

MLN Matters® Number: MM9266 *Revised*
Related CR Release Date: November 18, 2015
Related Transmittal #: R3407CP
Change Request (CR) #: CR 9266
Implementation Date: January 1, 2015
Effective Date: October 5, 2015

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Educational Events

Provider outreach and educational events – January 2016

Oxygen, coverage and documentation requirements: Presented by CGS Administrators, LCC – the DME MAC for JC

When: Thurday, January 21
Time: 11:30 a.m. -1:00 p.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/0309645.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 November 25, 2015

MLN Connects® Provider eNews for November 25, 2015
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In this edition:

MLN Connects® Events

- National Partnership to Improve Dementia Care and QAPI Call — Last Chance to Register
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call — Register Now
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call — Register Now
- ESRD QIP: Payment Year 2019 Final Rule Call — Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

Announcements

- Release of the 2016 DMEPOS Fee Schedules
- December 1 is World AIDS Day: The Time to Act is Now
- Comments on Tobacco Treatment Measures due December 4
- 2016 Value Modifier Informal Review Deadline Extended to December 16
- 2016 PQRS Payment Adjustment: Informal Review Deadline Extended to December 16

Claims, Pricers, and Codes

- Smoking Cessation Claims Editing Incorrectly
- Home Health Billing Codes Changing January 1

Medicare Learning Network® Educational Products

- Clarification of Patient Discharge Status Codes and Hospital Transfer Policies *MLN Matters*® Article — Revised
- Verify Your Profile Information in the Learning Management/Product Ordering System
- New Educational Web Guides Fast Fact

Medicare Learning Network®

The *Medicare Learning Network*® (*MLN*) is the home for education, information, and resources for the health care professional community. The *MLN* provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients. Find out what the *MLN* has to offer you and your staff at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html*.

MLN Connects® Provider eNews for December 3, 2015

MLN Connects® Provider eNews for December 3, 2015
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In this edition:

MLN Connects® Events

- National Partnership to Improve Dementia Care and QAPI Call — Last Chance to Register
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call — Register Now
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call — Register Now
- ESRD QIP: Payment Year 2019 Final Rule Call — Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

Other CMS Events

- Comparative Billing Report on Physical Therapy Webinar

Announcements

- CMS Updates Quality Strategy
- CMS Awards $110 Million in ESRD Network Funding
- Corrections Made to 2016 DMEPOS Fee Schedules
- CMS to Release Comparative Billing Report on Home E/M Services in December
- Hospital IQR and Medicare EHR Incentive Programs: Data Submission Deadline Extended
- PQRS Changes in 2016 Physician Fee Schedule Final Rule
- National Influenza Vaccination Week: December 6 through 12

Claims, Pricers, and Codes

- Extracorporeal Photophoresis and PTA Claims Editing Incorrectly

Medicare Learning Network® Educational Products

- Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool — New
- ICD-10 Website Wheel Educational Tool — Revised
- Hospital Reclassifications Fact Sheet — Revised
- PECOS for DMEPOS Suppliers Fact Sheet – Revised
- Medicare Disproportionate Share Hospital Fact Sheet — Revised
- DMEPOS Quality Standards Booklet — Revised

Expand your knowledge of Medicare

Visit the *Medicare Learning Network®* (MLN) Educational Web Guides Overview page, for educational and informational resources to improve your knowledge of Medicare billing and policies.

The *MLN Educational Web Guides* provides information on evaluation and management (E/M) services; guided pathways to resources and topics of interest; lists of health care management products; as well as easy-to-understand billing and coding products.

Click here to explore educational Web guides.

MLN Connects® Provider eNews for December 10, 2015

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

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call — Register Now

MLN Connects® Videos

- ICD-10 Post-Implementation: Coding Basics Revisited

Announcements

- CMS Releases 2014 National Health Expenditures
- ICD-10 Specialty Resources Guide
- EHR Incentive Programs: 2015 Program Requirement Resources
- Hospital Compare Website Refresh
- New ST PEPPER Available
- Hospice Item Set Record Submissions: CASPER Reports Available
- Long-Term Care Facilities: Mandatory Electronic Staffing Data Submission Begins in 2016
- 2016 Value Modifier Informal Review Deadline December 16
- 2016 PQRS Payment Adjustment: Informal Review Deadline December 16
- Corrections Made to 2016 DMEPOS Fee Schedules

Medicare Learning Network® Educational Products

- Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Revised
- Health Care Professional Frequently Used Web Pages Educational Tool — Revised
- Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet — Revised
- Reading the Institutional Remittance Advice Fact Sheet — Revised

MLN Connects® Provider eNews for December 17, 2015

MLN Connects® Provider eNews for December 17, 2015
View this edition as a PDF

In this edition:

Editor’s Note

Happy holidays from the eNews staff! The next regular edition of the eNews will be released on Thursday, January 7, 2016.

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call — Register Now
- Collecting Data on Global Surgery as Required by MACRA Listening Session — Registration Now Open
- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Registration Opening Soon
- New Audio Recording and Transcript Available

Announcements

- CMS Expands Quality Data on Physician Compare and Hospital Compare
- CMS Hospital-Acquired Conditions Reduction Program: FY 2016 Results
- Corrections Made to 2016 DMEPOS Fee Schedules

Claims, Pricers, and Codes

- January 2016 Average Sales Price Files Available
- FY 2016 Inpatient PPS PC Pricer Update Available
- Claims Processing Issue for Reference Laboratory and Anti-markup Payment Limitation Services Resolved

MLN Connects® Videos

- CMS Provider Minute: Hospital Discharge Day Management Services Video — New
- What is the HIPAA Privacy Rule? Tips to Protect Your Patients’ Privacy Video — New

Medicare Learning Network® Educational Products

- Reading a Professional Remittance Advice Booklet — Revised
- New MLN Provider Compliance Fast Fact

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