

C Medicare A CONNECTION

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A Newsletter for MAC Jurisdiction N Providers

January 2016



Emergency update to the 2016 Medicare physician fee schedule database

Provider types affected

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

What you need to know

Change request (CR) 9495 amends payment files that were issued to contractors based on the 2016 Medicare physician fee schedule (MPFS) final rule. The Centers for Medicare & Medicaid Services (CMS) amended these payment files in order to correct technical errors to the MPFS update files, and to include corrections described in the 2016 MPFS final rule correction notice. Your MAC will disclose the revised MPFS fees on their website as soon as possible, if they have not done so already.

Background

Some relative value units published in the 2016 MPFS final rule have been revised to align their values with the 2016 MPFS final rule policies. These changes are discussed in the 2016 MPFS final rule correction notice. In addition, there were corrections made to invalid or missing payment indicators for several procedure codes. The amended 2016 MPFS payment files reflect all these changes for services furnished on or after January 1, 2016.

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Additional information

The official instruction, CR 9495, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3438CP.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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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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Reorganization of Chapter 9, 'Medicare Claims Processing Manual'

Provider types affected

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

What you need to know

Change request (CR) 9397 advises you that the *Medicare Claims Processing Manual*, Chapter 9 – Rural Health Clinics/Federally Qualified Health Centers has been reorganized and updated. The revised chapter is attached to CR 9397.

Background

Chapter 9 of the *Medicare Claims Processing Manual*, RHCs and FQHCs, is revised to include more comprehensive billing information. There are no new policies contained in the updated manual chapter, which covers the following information:

- Rural health clinic (RHC) and federally qualified health center (FQHC) general information
- RHC and FQHC all-inclusive rate (AIR) payment system
- FQHC prospective payment system (PPS) payment system
- Deductible and coinsurance
- Billing and payment for general RHC and FQHC services
- Data required on the institutional claim sent to your MAC
- General billing and payment requirements for RHCs and FQHCs
- General billing requirements for preventive services

- Services non-covered on RHC and FQHC claims
- Frequency of billing and same day billing

Additional information

The official instruction, CR 9397, issued to your MAC regarding this change, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3434CP.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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2016 'Medicare Part B Participating Physician and Supplier Directory'

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

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

Source: Pub 100-04, Transmittal 3397, CR 9368

'Medicare Benefit Policy Manual' – RHC and FQHC update - Chapter 13

Provider types affected

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

What you need to know

Change request (CR) 9442 informs MACs that Chapter 13 of the *Medicare Benefit Policy Manual* is updated to include new information, clarification of existing policies, and editorial changes.

Background

New information includes:

- Section 30.1 states that a RHC can count the time of a nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM) when furnishing direct patient care in a patient's home or another location towards the requirement that an NP, PA, or CNM be available to furnish care at least 50 percent of the time the RHC is open to provide patient care.
- Section 110.5 states that payment for chronic care management (CCM) services is authorized for RHCs and FQHCs beginning on January 1, 2016, and provides an overview of the requirements.
- Sections 220.1 and 220.3 state that lung cancer screening using low-dose computed tomography is a covered preventive service and can be billed as a stand-alone visit if it is the only service furnished on that day with a RHC or FQHC practitioner, and applicable coinsurance and deductibles are waived.

Clarifying information includes:

- Use of modifier 59 (Section 40.3)
- Payment for procedures (Section 40.4)
- Description of ambulance services that are non-covered (Section 60.1)
- Description of group services that are non-covered (Section 60.1)
- Information on payment codes for FQHCs (Section 70.4)
- Cost reporting requirements (Section 80.1 and 80.2)



- Billable visits by dentists, podiatrist, optometrists, and chiropractors (Section 110.1)
- Description of mental health visits, billing for mental health visits, and payment for medication management (Section 170)
- Hepatitis C screening in RHCs and FQHCs (Sections 220.1 and 220.2).

Additional information

The official instruction, CR 9442, issued to your MAC regarding this change, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R217BP.pdf>.

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

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Prompt payment interest rate revision

Medicare must pay interest on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt. The applicable number of days is also known as the payment ceiling. For example, a clean claim received March 1, 2015, must be paid before the end of business March 31, 2015.

The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a six-month basis, effective every January and July 1. Providers may access the Treasury Department Web page <https://www.fiscal.treasury.gov/fsservices/gov/pmt/promptPayment/rates.htm> for the correct rate. The interest period begins on the day after payment is due and ends on the day of payment.



The rate of 2.5 percent is in effect through June 30, 2016.

Interest is not paid on:

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

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

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.

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.

Processing Issues

Additional ICD-10 diagnosis codes for J0717 (certolizumab pegol, 1 mg)

Issue

Claims for HCPCS code J0717 (certolizumab pegol, 1 mg) billed with ICD-10 codes L40.50-L40.59 for dates of service on or after October 1, 2015, were denied.

Resolution

ICD-10 codes L40.50-L40.59 (Arthropathic psoriasis) will be added as payable diagnosis codes for J0717. Both Part A and B claim processing systems has been updated and claims that were denied incorrectly have been adjusted.

Status

Closed.

Provider action

None.

Current processing issues

Here is a link to [a table of current processing issues](#) for both Part A and Part B.



Pharmacogenomic testing for warfarin responsiveness claims editing incorrectly

Issue

A system error caused claims submitted with HCPCS code G9143 for dates of service on or after October 1, 2015, to edit incorrectly.

Resolution

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

Status/date resolved

Open

Provider action

None. Your Medicare administrative contractor (MAC) will correct all affected claims.

Current processing issues

Here is a link to a table of [current processing issues](#) for both Part A and Part B.



New drug testing laboratory codes editing incorrectly

Issue

The Centers for Medicare & Medicaid Services (CMS) discovered systems errors affecting claims with new drug testing laboratory codes (HCPCS codes G0477 through G0483) with dates of service on or after January 1, 2016.

Resolution

Your Medicare administrative contractor (MAC) will correct any claims previously returned to you in error with these codes and reason code W7006. CMS will



be holding these claims until April 4, 2016.

Status/date resolved

Open

Provider action

No action is required by the provider.

Current processing issues

Here is a link to a table of [current processing issues](#) for both Part A and Part B.

Transcatheter mitral valve repair claims editing incorrectly

Issue

A system error caused claims related to transcatheter mitral valve repair (TMVR), with dates of service on or after October 1, 2015, to edit incorrectly.

Resolution

A fix is scheduled to be implemented January 25, 2016.

Status/date resolved

Open. A fix is scheduled January 25, 2016.

Provider action

None. Your Medicare administrative contractor (MAC) will temporarily hold any affected claims and release them once the system is corrected.



Current processing issues

Here is a link to a table of [current processing issues](#) for both Part A and Part B.

Provider enrollment application fee amount for 2016

On December 3, CMS issued a notice: Provider Enrollment Application Fee Amount for 2016 [CMS-6066-N] (<http://go.usa.gov/ckj8Z>). Effective January 1, 2016, the 2016 application fee is \$554 for institutional providers that are:

- Initially enrolling in the Medicare or Medicaid program or the Children's Health Insurance Program (CHIP)
- Revalidating their Medicare, Medicaid, or CHIP enrollment
- Adding a new Medicare practice location

This fee is required with any enrollment application submitted from January 1 through December 31, 2016.

Online Medicare refreshers

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

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

Click here to explore the wide array of training opportunities.



Advance care planning as an optional element of an annual wellness visit

Provider types affected

This *MLN Matters*[®] article is intended for providers who submit claims to Medicare administrative contractors (MACs) for advance care planning (ACP) services provided as an optional element of the annual wellness visit (AWV) to Medicare beneficiaries.

Provider action needed

Change request (CR) 9271 informs providers to waive the deductible and the coinsurance for ACP when furnished as an optional element of an AWV. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) made the *Current Procedural Terminology* (CPT[®]) codes for ACP separately payable for Medicare. The change in policy will be implemented through the annual Medicare physician fee schedule database (MPFSDB) update.

In addition, CMS is also including voluntary ACP as an optional element of the AWV. ACP services furnished on the same day and by the same provider as an AWV are considered a preventive service. Therefore, the deductible and coinsurance are not applied to the codes used to report ACP services when performed as part of an AWV.

Voluntary ACP means the face-to-face service between a physician (or other qualified health care professional) and the patient discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time.

Voluntary ACP, upon agreement with the patient, would be an optional element of the AWV. Effective January 1, 2016, when ACP services are provided as a part of an AWV, practitioners would report CPT[®] code 99497 (plus add-on code 99498 for each additional 30 minutes, if applicable) for the ACP services in addition to either of the AWV codes G0438 and G0439. CPT[®] codes 99497 and 99498 used to describe ACP are separately payable under the Medicare physician fee schedule (MPFS). When voluntary ACP services are furnished as a part of an AWV, the coinsurance and deductible would not be applied for

ACP. Under that circumstance, both the ACP and AWV must also be billed together on the same claim. In order to have the deductible and coinsurance waived for ACP when performed with an AWV, the ACP code(s) must be billed with modifier 33 (Preventive services). Since payment for an AWV is limited to only once a year, the deductible and coinsurance for ACP billed with an AWV can only be waived once a year.

Critical access hospitals (CAHs) may also bill for these professional services provided on or after January 1, 2016, using type of bill 85x with revenue codes 96x, 97x, and 98x. The CAH Method II payment will be based on the lesser of the actual charge or the facility-specific MPFS.

However, the deductible and coinsurance does apply when ACP is not furnished as part of a covered AWV.

Additional information

The official instruction, CR 9271, was issued to your MAC regarding this change via two transmittals. The first updates the *Medicare Benefit Policy Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R216BP.pdf>. The second transmittal updates the *Medicare Claims Processing Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3428CP.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: MM9271

Related Change Request (CR) #: CR 9271

Related CR Release Date: December 22, 2015

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Related CR Transmittal #: R216BP and R3428CP

Implementation Date: January 4, 2016

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Documentation requirements for home health prospective payment

Note: This article was rescinded January 15, 2016, to reflect changes regarding the documentation requirements for HH face-to-face encounters, which were updated in the 2015 home health prospective payment system (HH PPS) final rule. Those changes eliminated the narrative requirement for face-to-face encounter as part of the certification of eligibility, for episodes on or after January 1, 2015. For information regarding certifying patients for the Medicare home health benefit, please review SE1436. This was previously published in the January 2014 Medicare B Connection, Pages 28-29.

Document history

Date of change	Description
January 15, 2016	The article was rescinded due to changes regarding the documentation changes to HH face-to-face encounters, which were updated in the 2015 HH PPS final rule. Those changes eliminated the narrative requirement for face-to-face encounter as part of the certification of eligibility for episodes on or after January 1, 2015.



Related CR Release Date: N/A
 Effective Date: N/A
 Related CR Transmittal #: N/A
 Implementation Date: N/A

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MLN Matters® Number: SE1405 *Rescinded*
 Related Change Request (CR) #: N/A

NCD for screening for colorectal cancer using Cologuard™

Note: This article was revised January 5, 2016, to reflect the revised change request (CR) 9115 issued December 30, 2015. The CR was revised to show that HCPCS code G0464 expired December 31, 2015, and is replaced in the 2016 clinical laboratory fee schedule with CPT® code 81528. The article is revised to reflect this change. Also, the CR release date, transmittal number, and the Web address for accessing the CR are changed. All other information remains the same. This information was previously published in the September 2015 Medicare A Connection, Pages 11-13.

Provider types affected

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

Provider action needed

Stop – impact to you

This article is based on CR 9115 which announces effective October 9, 2014, the Centers for Medicare & Medicaid Services (CMS) has determined that the

evidence is sufficient to cover Cologuard™ - a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, aged 50 to 85 years.

Caution – what you need to know

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

Go – what you need to do

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

Background

The Social Security Act (the Act) (Sections 1861(s)(2)(R) and 1861(pp) - see http://www.ssa.gov/OP_Home/ssact/title18/1861.htm) and regulations at 42 CFR 410.37 (see

See NCD, next page

NCD

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<http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-37.pdf> authorize coverage for screening colorectal cancer (CRC) tests under Medicare Part B. The statute and regulations authorize the Secretary to add other tests and procedures (and modifications to such tests and procedures for colorectal cancer screening) as the Secretary determines appropriate in consultation with appropriate experts and organizations.

As part of the CMS – Food and Drug Administration (FDA) Parallel Review Pilot Program, CMS finalized a NCD for Screening for CRC Using Cologuard™ - A Multitarget Stool DNA Test. After considering public comments and consulting with appropriate organizations, effective October 9, 2014, CMS has determined that the evidence is sufficient to cover Cologuard™ - a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, who are ages 50 to 85 years.

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

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

Note: HCPCS code G0464 is in the January 1, 2015, CLFS and integrated outpatient code editor (IOCE) updates with an effective date of October 9, 2014. Therefore, MACs shall apply contractor pricing to claims containing HCPCS G0464 with dates of service October 9, 2014, through December 31, 2014. However, in the 2016 CLFS, G0464 expires effective December 31, 2015, and effective January 1, 2016, CPT® code 81528 replaces G0464.

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

Effective for dates of service on or after October 9, 2014, Medicare Part B will cover the Cologuard™ test once

every three years for Medicare beneficiaries that meet all of the following criteria:

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

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

Medicare will pay for this service for eligible beneficiaries only once every 3 years. Next eligible dates will be displayed on all common working file (CWF) provider query screens. Subsequent claim lines for HCPCS code G0464 received in the same three-year period will be denied using the following:

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

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

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

See NCD, next page

NCD

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

- CARC 167 – “This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N386 - “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

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

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

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

Additional information

The official instruction, CR 9115, was issued to your MAC regarding this change via two transmittals. The first updates the *Medicare National Coverage Determinations Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R188NCD.pdf>. The second transmittal updates the *Medicare Claims Processing Manual* and it is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3319CP.pdf>.

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

MLN Matters® Number: MM9115 *Revised*
Related Change Request (CR) #: CR 9115
Related CR Release Date: December 30, 2015
Effective Date: October 9, 2014
Related CR Transmittal #: R188NCD and R3319CP
Implementation Date: September 8, 2015 for non-shared MAC edits; January 4, 2016 for shared systems changes

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. CPT® only copyright 2015 American Medical Association.

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

New influenza virus vaccine code

Note: This article was revised December 24, 2015, to reflect the revised change request (CR) 9357 issued December 22. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same. This information was previously published in the [December 2015 Medicare A Connection, Page 8](#).

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 system 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.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3429CP.pdf>.

MLN Matters[®] Number: MM9357
 Related Change Request (CR) #: CR 9357
 Related CR Release Date: December 22, 2015
 Effective Date: August 1, 2015
 Related CR Transmittal #: R3429CP
 Implementation Date: April 4, 2016

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Take action to combat the flu

Now is the perfect time for providers to vaccinate Medicare beneficiaries, as it can take two weeks after vaccination to develop antibodies that protect against seasonal influenza. As a health care provider, you play an important role in setting an example by getting yourself vaccinated and recommending and promoting influenza vaccination.

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*



Corrected LCDs

2016 HCPCS local coverage determination – correction to the changes

The 2016 HCPCS local coverage determination changes based on the 2016 Healthcare Common Procedure Coding System (HCPCS) annual update was previously published in the *December 2015 Connection*. Below are corrections to the previously published article. The corrections are listed in bold type.



LCD Title	Changes
<i>Noncovered Services</i>	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 CPT® code 94799)

LCD Title	Changes
<i>Noncovered Services</i> (continued)	Delete CPT® code 0311T (replaced with CPT® code 93050), and HCPCS codes G6027 and G6028 (replaced with CPT® codes 46601 and 46607)
<i>Spinal Cord Stimulation for Chronic Pain</i>	Descriptor change for CPT® code 95972 Deleted CPT® code 95973

Revised LCDs

Computed tomographic angiography of the chest, heart, and coronary arteries – revision to the LCD

LCD ID number: L33282 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for computed tomographic angiography of the chest, heart, and coronary arteries was revised to change ICD-10-CM diagnosis code range R07.1-R07.89 to R07.1-R07.9 in the “ICD-10 Codes that Support Medical Necessity” section of the LCD for *Current Procedural Terminology (CPT®) code 71275*. The updated LCD will be available on the Medicare coverage database (MCD) on or after January 1, 2016.

Effective date

This LCD revision is effective for claims processed **on or after December 28, 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](#).

Noncovered services and gene expression profiling panel for use in the management of breast cancer treatment – revision to the LCD

LCD ID number: L33777 and L33586 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered services (L33777) was revised based on a reconsideration request to remove CPT® code 0008M [Oncology (breast), mRNA analysis of 58 genes using hybrid capture, on formalin-fixed paraffin-embedded (FFPE) tissue, prognostic algorithm reported as a risk score] and was added to the gene expression profiling panel for use in the management of breast cancer treatment LCD (L33586) with limited indications. The “Indications and Limitations of Coverage and/or Medical Necessity,” “CPT®/HCPCS Codes,” and “Sources of Information and Basis for

Decision” sections of LCD L33586 were updated.

Effective date

This LCD revision is effective for services rendered **on or after January 21, 2016**. 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](#).

Pemetrexed – revision to the LCD

LCD ID number: L33978 (Florida/Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for Pemetrexed was revised based on a reconsideration request to include National Comprehensive Cancer Network (NCCN) 2A indications for the treatment of non-small cell lung cancer (NSCLC): (a) for the initial treatment as definitive concurrent chemoradiation in combination with carboplatin or cisplatin and (b) for preoperative concurrent chemoradiation in combination with cisplatin or carboplatin. The “Indications and Limitations of Coverage and/or Medical Necessity” and “Sources of Information and Basis

for Decision” sections of the LCD were updated.

Effective date

This LCD revision is effective for claims processed **on or after December 8, 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](#).

Radiation therapy for T1 basal cell and squamous cell carcinomas of the skin – revision to the LCD

LCD ID number: L33538 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for radiation therapy for T1 basal cell and squamous cell carcinomas of the skin was revised to add ICD-10-CM diagnosis codes C44.41 and C44.42 to the “ICD-10 Codes that Support Medical Necessity” section of the LCD for the following HCPCS/CPT® codes.

Part A

Healthcare Common Procedure Coding System (HCPCS) codes G6003, G6004, G6005, and G6006 and *Current Procedural Terminology* (CPT®) codes 77401, 77402, 77767, 77768, and 77789

Part B

Healthcare Common Procedure Coding System (HCPCS)

codes G6003, G6004, G6005, and G6006 and CPT® codes 77401, 77767, 77768, and 77789

The updated LCD will be available on the Medicare coverage database (MCD) on or after January 21, 2016.

Effective date

This LCD revision is effective for claims processed **on or after January 14, 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, [click here](#).

Screening and diagnostic mammography – revision to LCD

LCD ID number: L36342 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for screening and diagnostic mammography was revised to add the following additional national ICD-10-CM diagnosis codes to the “ICD-10 Codes that Support Medical Necessity” section of the LCD for *Current Procedural Terminology (CPT®)* codes 77055 and 77056 and Healthcare Common Procedure Coding System (HCPCS) codes G0204 and G0206, based on national coverage determination (NCD) 220.4:

C43.52, C43.59, C44.501, C44.509, C44.511, C44.519, C44.521, C44.529, C44.591, C44.599, C45.9, C56.1-C56.9, C78.00-C78.02, C78.1, C78.2, C78.7, C79.31-C79.32, C79.40-C79.49, C79.51-C79.52, C79.60-C79.62, C80.0, C80.1, D03.52, D03.59, D04.5, D22.5, D23.5, D48.5, D49.1, D49.2, D49.6, D49.7, M70.80, M70.88, M70.89, M70.90, M70.98, M70.99, M79.5, M79.81-M79.89, M79.9, N64.81, N64.9, N65.0, N65.1, R59.0-R59.9, R92.0, R93.9, S20.00xA, S20.01xA, S20.02xA, S21.001A, S21.002A, S21.009A, S21.011A, S21.012A, S21.019A, S21.021A, S21.022A, S21.029A,

S21.031A, S21.032A, S21.039A, S21.041A, S21.042A, S21.049A, S21.051A, S21.052A, S21.059A, S28.211A, S28.212A, S28.219A, S28.221A, S28.222A, S28.229A, S29.001A, S29.009A, S29.091A, S29.099A, S29.8xxA, S29.9xxA, S39.001A, S39.091A, S39.81xA, S39.91xA, T85.41xA, T85.42xA, T85.43xA, T85.44xA, T85.49xA, T85.79xA, Z03.89, Z08, Z77.123, Z77.128, Z77.9, Z85.831, Z85.89, Z91.89, Z92.89, Z98.82, and Z98.86

Effective date

This LCD revision is effective for claims processed **on or after February 1, 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, [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 code range H35.51-H35.54 to the “ICD-10 Codes that Support Medical Necessity” section of the LCD for *Current Procedural Terminology (CPT®)* codes 92081, 92082, and 92083.

The updated LCD will be available on the Medicare coverage database (MCD) on or after January, 14 2016.

Effective date

This LCD revision is effective for claims processed **on or after December 28, 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](#).

Vitamin D; 25 hydroxy, includes fraction(s), if performed – revision to the LCD

LCD ID number: L33771 (Florida/Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for vitamin D; 25 hydroxy, includes fraction(s), if performed, was revised to add ICD-10-CM diagnosis codes M89.9 and M94.9 to the “ICD-10 Codes that Support Medical Necessity” section of the LCD for *Current Procedural Terminology (CPT®)* code 82306.

The updated LCD will be available on the Medicare coverage database (MCD) on or after January 14, 2016.

Effective date

This LCD revision is effective for claims processed **on or after December 25, 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](#).

Additional Information

New requirement for CMS approved investigational device exemption (IDE) studies

Change request (CR) 8921 released by the Centers for Medicare and Medicaid Services (CMS) became effective January 1, 2015. The CR updated procedures related to items and services in FDA-approved Category B IDE exemptions. Per the CR, CMS established a centralized approval process for studies approved by the Food and Drug Administration (FDA) on or after January 1, 2015. Recently, First Coast Service Options Inc. (First Coast) has been made aware of denied claims related to studies approved by CMS on or after the January 1 implementation date because the prior process entailed linking provider facility numbers to approved IDEs. In order to avoid inappropriately denied claims for studies

approved by CMS (FDA approved on or after January 1, 2015), the following documents must be submitted to the contractor at clinicaltrials@fco.com prior to claims being submitted for processing:

- Cover letter that includes the IDE G-number and clinical trial (NCT) number and the provider (facility) number
- A copy of the CMS approval letter
- A copy of the Institutional Review Board (IRB) approval letter
- A copy of the signed cost and coding information form

Clarification for coding related to Cologuard®

The Centers for Medicare & Medicaid Services (CMS) recently implemented a national coverage determination to cover Cologuard® – a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, aged 50 to 85 years.

Previously, providers/suppliers used Healthcare Common Procedure Coding System (HCPCS) code G0464 to bill for the Cologuard® test.

Per the 2016 clinical lab fee schedule change request (CR) 9465, effective December 31, 2015, HCPCS code G0464 expires.

Beginning January 1, 2016, providers/suppliers should bill CPT® code 81528 for the Cologuard® test. Continue to use HCPCS code G0464 for claims with prior dates of service through December 31, 2015.



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Clarification on patient's reason for visit necessary to capture HIPAA-compliant fields

Provider types affected

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

What you need to know

In order for Medicare to process Health Insurance Portability and Accountability Act (HIPAA) compliant claim information located on the UB-04, or 837I transactions, the Centers for Medicare & Medicaid Services (CMS) needs to clarify the usage of the patient's reason for visit used for processing claims. Change request (CR) 9450 ensures correct education and editing for institutional claim processing system fields. Make sure that your billing staffs are aware of these instructions.

Background

Institutional providers are required to submit HIPAA compliant claims, and CMS is continuing with their application of the HIPAA, V5010. The National Uniform Billing Committee (NUBC) has provided clarified direction on the patient's reason for visit form locator (FL) in the 2016 *Data Specifications Manual*.

The administrative simplification provisions of HIPAA require the Secretary of HHS to adopt standard electronic transactions and code sets for administrative health care transactions. The Secretary may also modify these standards periodically.

The patient's reason (FL 70a-c) is a "situational" reported field. The requirement for reporting patient's reason for visit is restricted to the outpatient type of bills 013x and 085x. It is required for these TOBs for Medicare institutional claims processing when:

- a) Form locator 14 (priority (type) of admission or visit) codes 1, 2, or 5 are reported; and
- b) Revenue codes 045x, 0516, or 0762 are reported.

If the patient's reason for visit is not required, it may be reported on other 013x and 085x bill types that fail to meet the criteria in a) or b) above at the provider's discretion



when this information substantiates the medical necessity of services.

Additional information

The official instruction, CR 9450, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3435CP.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: MM9450
 Related Change Request (CR) #: CR 9450
 Related CR Release Date: December 31, 2015
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 Related CR Transmittal #: R3435CP
 Implementation Date: March 31, 2016

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January 2016 update of the hospital outpatient prospective payment system

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9486, which implements changes to and billing instructions for various policies implemented in the January 2016 OPPS update. The January 2016 integrated outpatient code editor (I/OCE) and OPPS pricer will reflect the healthcare common procedure coding system (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions identified in CR 9486. CR 9486 also implements several changes related to outpatient observation services, finalized in the 2016 OPPS/ambulatory surgical center (ASC) final rule. In addition, CR 9486 also implements several changes in the manual requirements of the *Medicare Benefit Policy*, Pub. 100-02, Chapter 6, related to outpatient observation services that were finalized in the [2016 OPPS /ASC final rule](#). Make sure that your billing personnel are aware of these changes.

Background

The key changes to and billing instructions for various payment policies implemented in the January 2016 OPPS update are as follows:

1. New device pass-through categories

Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least two, but not more than three years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that the Centers for Medicare & Medicaid Services (CMS) create additional categories for transitional pass-through payment for new medical devices not described by existing or previously existing categories of devices.

For the January 2016 update, HCPCS code C1822 is being added to the OPPS pass-through list as a pass-through device. This HCPCS code will be assigned to OPPS status indicator “H” (Pass-Through Device Categories), effective January 1, 2016.

In the 2016 OPPS/ASC final rule, published in the *Federal Register* November 13, 2015, CMS finalized a payment policy whereby the application process for device pass-through payments will add a rulemaking component to the existing quarterly process and a newness criterion. Refer

to the [2016 OPPS/ASC final rule with comment period](#) for complete details of these policy and process changes for device pass-through. Also, refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html for updated device pass-through application instructions.

Device offset from payment for new device category

Section 1833(t)(6)(D)(ii) of the Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount. CMS has determined that a portion of the APC payment amount associated with the cost of HCPCS code C1822 is reflected in APC 5464. The HCPCS code C1822 device should always be billed with *Current Procedural Terminology (CPT)*[®] code 63685 (*Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling*) which is assigned to APC 5464 for 2016. The device offset from payment represents a deduction from pass-through payments for the device in category C1822.

Table 1 (Page 28) provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

Revised short and long descriptors for HCPCS code C1820

With the establishment of HCPCS code C1822, CMS is modifying the short and long descriptors for existing HCPCS code C1820 to appropriately differentiate between HCPCS code C1822 and C1820. Effective January 1, 2016, the short and long descriptors for HCPCS code C1820 are listed in Table 2 (Page 28).

Table 2 – Revised short and long descriptors for HCPCS code C1820

HCPCS	Short descriptor	Long descriptor	2016 OPPS SI
C1820	Gen, neuro, non-HF rechgbat	Generator, neurostimulator (implantable), non-high-frequency with rechargeable battery and charging system	N

Note that HCPCS code C1820 describes an implantable **non high-frequency** neurostimulator generator device with rechargeable battery and charging system, while HCPCS code C1822 describes an implantable **high-frequency** neurostimulator generator device with

See **OPPS**, next page

OPPS

From previous page

rechargeable battery and charging system.

2. Device edit for procedures assigned to device - intensive APCs

For 2016, CMS will no longer restrict the device code reporting requirement to only those device-intensive APCs (APCs with a device offset of greater than 40 percent) which were formerly device-dependent APCs. Therefore, effective January 1, 2016, procedures requiring the implantation of a device which are assigned to device intensive APCs will require a device code to be present on the claim. CMS is updating the *Medicare Claims Processing Manual*, Chapter 4, Section 61.2 to reflect these changes to the reporting guidelines for procedures assigned to device-intensive APCs.

3. Removal of device portion from procedures that are assigned to a device-intensive APC and that are discontinued prior to the administration of anesthesia

In accordance with the regulations at [42 CFR 419.44\(b\)](#) and the *Medicare Claims Processing Manual*, Chapter 4, Section 20.6.4, when a surgical procedure, for which anesthesia is planned, is terminated **after** the patient is prepared and taken to the room where the procedure is to be performed, but prior to the administration of anesthesia, hospitals are instructed to append modifier 73 to the procedure line item on the claim. Medicare processes these line items by removing one-half of the full program allowance.

In the 2016 OPPS/ASC final rule, CMS revised its payment policy for surgical procedures for which anesthesia is planned and that are discontinued prior to the administration of anesthesia, appended with modifier 73.

Specifically, effective January 1, 2016, for such procedures that are assigned to a device-intensive APC (defined as those APCs with a device offset greater than 40 percent), CMS will remove the full device portion of the device-intensive APC procedure payment prior to applying the additional payment adjustments that apply when the procedure is discontinued.

4. Transitional pass-through payments for designated devices

Certain designated new devices are assigned to APCs and identified by the OCE as eligible for payment based on the reasonable cost of the new device reduced by the amount included in the APC for the procedure that reflects the packaged payment for devices used in the procedures assigned to the APC. OCE will determine the proper payment amount for these APCs as well as the coinsurance and any applicable deductible. All related payment calculations will be returned on the same APC line and identified as a designated new device. Refer to

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.htm for the most current OPPS APC offset file.

5. Services eligible for new technology APC assignment and payments

Under OPPS, services eligible for payment through new technology APCs are those codes that are assigned to the series of new technology APCs published in [Addendum A](#) of the latest OPPS update. OPPS considers any HCPCS code assigned to these APCs to be a “new technology procedure or service.”

Procedures for applying for assignment of new services to new technology APCs are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html.

The list of HCPCS codes indicating the APCs to which each is assigned can be found in Addendum B of the latest OPPS update regulation each year at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>.

6. New brachytherapy source payment

Section 1833(t)(2)(H) of the Act mandates the creation of additional groups of covered outpatient department (OPD) services that classify devices of brachytherapy consisting of a seed or seeds (or radioactive source) (“brachytherapy sources”) separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the brachytherapy sources furnished. CivaSheet is a new brachytherapy source. The HCPCS code assigned to this source and the payment rate under OPPS are listed in Table 3 (Page 28).

7. Modifier “CA”

Effective January 1, 2016, if an “inpatient-only” service is furnished but the patient expires before inpatient admission or transfer to another hospital and the hospital reports the “inpatient only” service with modifier “CA,” then CMS makes a single payment for all services reported on the claim, including the “inpatient only” procedure, through one unit of APC 5881, (Ancillary outpatient services when the patient dies). Hospitals should report modifier “CA” on only one procedure. CMS is updating the *Medicare Claims Processing Manual*, Chapter 4, Section 180.7 to reflect the revised payment policy.

8. Modifier “CT”

In accordance with Section 1834(p) of the Act, CMS has established a new modifier “CT” to identify computed tomography (CT) scans that are furnished on equipment that does not meet the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013, titled

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“Standard Attributes on CT Equipment Related to Dose Optimization and Management.”

Effective January 1, 2016, Medicare requires that hospitals and suppliers use this modifier on claims for CT scans described by applicable HCPCS codes that are furnished on non-NEMA Standard XR-29-2013-compliant equipment. The applicable CT services are identified by HCPCS codes 70450-70498; 71250-71275; 72125-72133; 72191-72194; 73200-73206; 73700-73706; 74150-74178; 74261-74263; and 75571-75574 (and any succeeding codes).

The use of this modifier will result in a payment reduction of five percent in 2016 for the applicable CT services when the service is paid separately. The five percent payment reduction will also be applied to the APC payment for the HCPCS codes listed above that are subject to the multiple imaging composite policy. This includes procedures assigned to the two APCs (8005 and 8006) in the CT and computed tomographic angiography (CTA) imaging family. CR 9486 updates the *Medicare Claims Processing Manual*, Chapter 4, Section 20.6.12, to include this new modifier.

9. Comprehensive observation services C-APC (APC 8011)

Effective January 1, 2016, CMS will provide payment for all qualifying extended assessment and management encounters through newly created C-APC 8011 (comprehensive observation services). Any clinic visit, Type A emergency department (ED) visit, Type B ED visit, critical care visit, or direct referral for observation services furnished in a non-surgical encounter by a hospital in conjunction with observation services of eight or more hours, will qualify for comprehensive payment through C-APC 8011. Effective January 1, 2016, CMS will no longer provide payment for extended assessment and management encounters through APC 8009 (Extended Assessment and Management Composite) and APC 8009 is deleted, effective January 1, 2016.

Also effective January 1, 2016, CMS has created new status indicator (SI) J2 to designate specific combinations of services that, when performed in combination with each other and reported on a hospital Medicare Part B outpatient claim, would allow for all other OPPS payable services and items reported on the claim (excluding all preventive services and certain Medicare Part B inpatient services) to be deemed adjunctive services representing components of a comprehensive service and resulting in a single prospective payment through C-APC 8011 for the comprehensive service based on the costs of all reported services on the claim. CMS is updating the *Medicare Claims Processing Manual*, Chapter 4, Sections 10.2.1, 10.2.3, 10.4, 290.5.1 and 290.5.2 and adding a new Section 290.5.3 to reflect the new billing guidelines for this new comprehensive APC.

10. Billing for lung cancer screening counseling and shared decision making visit, and annual screening for lung cancer with LDCT

Effective February 5, 2015, a CMS national coverage determination (NCD) added lung cancer screening counseling and shared decision making visit, and for certain beneficiaries, annual screening for lung cancer with low-dose computed tomography (LDCT), as an additional screening service benefit under the Medicare program if all eligibility criteria described in the NCD are met.

For purposes of Medicare coverage of lung cancer screening with LDCT, beneficiaries must meet all of the following eligibility criteria:

- Age 55 – 77 years;
- Asymptomatic (no signs or symptoms of lung cancer);
- Tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; one pack = 20 cigarettes);
- Current smoker or one who has quit smoking within the last 15 years; and
- Receives a written order for lung cancer screening with LDCT that meets the requirements described in the NCD. Written orders for lung cancer LDCT screenings must be appropriately documented in the beneficiary’s medical records.

To implement this recent coverage determination, CMS created two new G-codes to report lung cancer screening counseling and shared decision making visit, and annual screening for lung cancer with LDCT. The long descriptors for both G-codes appear in Table 4.

Table 4 – Lung cancer screening counseling and shared decision making visit, and annual screening for lung cancer with LDCT

HCPCS	Long descriptor	Status indicator	2015 APC	2016 APC
G0296	Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)	S	0432	5822

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CPT® code	2016 short descriptor	2016 status indicator		
G0297	Low dose CT scan (LDCT) for lung cancer screening	S	0332	5570

For 2016, HCPCS codes G0296 and G0297 are assigned to APC 5822 (Level 2 health and behavior services) and APC 5570 (Computed tomography without contrast), respectively, and both given a status indicator assignment of “S.” Further reporting guidelines on lung cancer screening counseling and shared decision making visit and annual screening for lung cancer with LDCT can be found in the *Medicare Claims Processing Manual*, Chapter 18, Section 220, as well as in *MLN Matters®* article [MM9246](#) which was published on October 15, 2015.

11. Billing instructions for IMRT planning

Payment for the services identified by CPT® codes 77014, 77280-77295, 77305-77321, 77331, and 77370 is included in the APC payment for CPT® code 77301 (Intensity modulated radiation therapy (IMRT) planning). These codes should not be reported in addition to CPT® code 77301 (on either the same or a different date of service) unless these services are being performed in support of a separate and distinct non-IMRT radiation therapy for a different tumor.

12. Billing for stereotactic radiosurgery (SRS) planning and delivery

Effective for cranial single session stereotactic radiosurgery (SRS) procedures (CPT® code 77371 or 77372) furnished on or after January 1, 2016, until December 31, 2017, costs for certain planning and preparation CPT® codes are not factored into the APC payment rate for APC 5627 (Level 7 Radiation Therapy). Rather, the ten planning and preparation codes listed in Table 5 will be paid according to their assigned status indicator when furnished 30 days prior or 30 days post SRS treatment delivery.

Table 5 – Excluded planning and preparation CPT® codes

CPT® code	2016 short descriptor	2016 status indicator
70551	MRI brain stem w/o dye	Q3
70552	MRI brain stem w/dye	Q3
70553	MRI brain stem w/o & w/ dye	Q3
77011	CT scan for localization	N

CPT® code	2016 short descriptor	2016 status indicator
77014	CT scan for therapy guide	N
77280	Set radiation therapy field	S
77285	Set radiation therapy field	S
77290	Set radiation therapy field	S
77295	3-D radiotherapy plan	S
77336	Radiation physics consult	S

In addition, hospitals must report modifier “CP” (Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification [C-APC] procedure) on TOB 13x claims for any other services (aside from the ten codes in Table 5) that are adjunctive or related to SRS treatment but billed on a different date of service and within 30 days prior or 30 days after the date of service for either CPT® codes 77371 (Radiation treatment delivery, stereotactic radiosurgery, complete course of treatment cranial lesion(s) consisting of 1 session; multi-source Cobalt 60-based) or 77372 (Linear accelerator based). The “CP” modifier should be reported under all circumstances in which a service adjunctive or related to SRS treatment is provided within one month of SRS treatment. This means that if multiple physicians within the same health system furnish an adjunctive SRS service, then all claims from these physicians would need to report the “CP” modifier with the HCPCS code for the related SRS adjunctive service(s).

13. Billing instructions for corneal tissue

In the 2016 OPPS/ASC final rule with comment period (80 FR 70472), procurement /acquisition of corneal tissue will be paid separately only when it is used in corneal transplant procedures. Specifically, corneal tissue will be separately paid when used in procedures performed in the hospital outpatient department (HOPD) only when the corneal tissue is used in a corneal transplant procedure described by one of the following CPT® codes:

- 65710 (Keratoplasty (corneal transplant); anterior lamellar);
- 65730 (Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia));
- 65750 (Keratoplasty (corneal transplant); penetrating (in aphakia));
- 65755 (Keratoplasty (corneal transplant); penetrating (in pseudophakia));
- 65756 (Keratoplasty (corneal transplant); endothelial);
- 65765 (Keratophakia);
- 65767 (Epikeratoplasty); and
- Any successor code or new code describing a new

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type of corneal transplant procedure that uses eye banked corneal tissue.

HCPCS code V2785 (Processing, preserving and transporting corneal tissue) should only be reported when corneal tissue is used in a corneal transplant procedure; V2785 should not be reported in any other circumstances.

14. Revisions to laboratory test packaging

For 2016, CMS is implementing a conditional packaging status indicator “Q4” for packaged laboratory services. Status indicator “Q4” designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3.” The “Q4” status indicator was created to identify 13x bill type claims where there are only laboratory HCPCS codes that appear on the clinical laboratory fee schedule (CLFS), automatically change their status indicator to “A,” and pay them separately at the CLFS payment rates. With the assignment of the “Q4” status indicator, the “L1” modifier would only be used to identify unrelated laboratory tests that are ordered for a different diagnosis and by a different practitioner than the other OPPS services on the claim.

15. New 2016 HCPCS codes for pathogen-reduced blood products

For 2016, three new HCPCS P-codes have been created for new pathogen-reduced blood products. The term “pathogen reduction” describes various techniques (including treatment with Amotosalen and UVA light) used on blood products to eliminate certain pathogens and reduce the risk of transfusion-associated infections. Because these three HCPCS P-codes are new for 2016, there are currently no claims data on the charges and costs for these blood products upon which to apply our blood-specific cost to charge ratio (CCR) methodology. Therefore, CMS is establishing interim payment rates for these three HCPCS P-codes based on a crosswalk to existing blood product HCPCS codes that CMS believes provides the best proxy for the costs of the three new blood products described by the new HCPCS P-codes. These new codes are listed in Table 6 (Page 29).

16. Drugs, biologicals, and radiopharmaceuticals

a. New 2016 HCPCS codes and dosage descriptors for certain drugs, biologicals, and radiopharmaceuticals

For 2016, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 7.

Table 7 – New 2016 HCPCS codes effective for certain drugs, biologicals, and radiopharmaceuticals

2016 code	2016 long descriptor	2016 SI	2016 APC
C9458	Florbetaben F18, diagnostic, per study dose, up to 8.1 millicuries	G	9458
C9459	Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries	G	9459
C9460	Injection, cangrelor, 1 mg	G	9460
Q9980	‘Hyaluronan or derivative, GenVisc 850, for intra-articular injection, 1 mg	E	
J0714	‘Injection, ceftazidime and avibactam, 0.5g/0.125g	K	1825
J1575	Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immunoglobulin	K	1826
J7188	Injection, factor viii (antihemophilic factor, recombinant), (obizur), per i.u.	K	1827
J7328	Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg	E	
J7340	Carbidopa 5 mg/levodopa 20 mg enteral suspension	K	1828
J7503	Tacrolimus, extended release, (envarsus xr), oral, 0.25 mg	E	
Q4161	Bio-connekt wound matrix, per square centimeter	N	
Q4162	Amniopro flow, bioskin flow, biorenew flow, woundex flow, amniogen-a, amniogen-c, 0.5 cc	N	

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2016 code	2016 long descriptor	2016 SI	2016 APC
Q4163	Amniopro, bioskin, biorenew, woundex, amniogen-45, amniogen-200, per square centimeter	N	
Q4164	Helicoll, per square centimeter	N	
Q4165	Keramatrix, per square centimeter	N	

b. Other changes to 2016 HCPCS and CPT® codes for certain drugs, biologicals, and radiopharmaceuticals

Many HCPCS and CPT® codes for drugs, biologicals, and radiopharmaceuticals have undergone changes in their HCPCS and CPT® code descriptors that will be effective in 2016. In addition, several temporary HCPCS C-codes have been deleted, effective December 31, 2015, and replaced with permanent HCPCS codes in 2016. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active 2015 HCPCS and CPT® codes.

Table 8 (Page 29) notes those drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS/CPT® code, their long descriptor, or both. Each product's 2015 HCPCS/CPT® code and long descriptor are noted in the two left hand columns and the 2016 HCPCS/CPT® code and long descriptor are noted in the adjacent right hand columns.

c. Drugs and biologicals with payments based on average sales price (ASP) effective January 1, 2016

For 2016, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In 2016, a single payment of ASP + six percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available.

Effective January 1, 2016, payment rates for many drugs and biologicals have changed from the values published in the 2016 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of 2015. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January

2016 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this CR implementing the January 2016 update of the OPPS. However, the updated payment rates, effective January 1, 2016, can be found in the January 2016 update of the OPPS Addendum A and Addendum B, available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html>.

d. Correction to effective dates for certain vaccines

CR 9486 revises the effective dates for vaccine CPT® codes 90620 and 90621 as shown in Table 9 (Page 30).

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

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html>. Providers may resubmit claims that were impacted by adjustments to previous quarter's payment files.

f. Payment correction for diagnostic radiopharmaceutical C9458

The payment rate listed in Addendum B of the 2016 OPPS/ASC final rule with comment period for HCPCS code C9458 (Florbetaben F18) is incorrect. The corrected payment rate of \$2,968 per study dose for HCPCS code C9458 is listed in Addendum B of this January update and has been installed in the January 2016 OPPS Pricer, effective for services furnished on or after January 1, 2016.

g. Biosimilar payment policy

Effective January 1, 2016, the payment rate for biosimilars in the OPPS will be the same as the payment rate in the physician office setting, calculated as the ASP of the biosimilar(s) described by the HCPCS code + six percent of the ASP of the reference product. Biosimilars will also be eligible for transitional pass-through payment; however, pass-through payment will be made to the first eligible biosimilar biological product to a reference product. Subsequent biosimilar biological products to a reference product will not meet the newness criterion, and, therefore, will be ineligible for pass-through payment.

h. Updated guidance: Billing and payment for new drugs, biologicals, or radiopharmaceuticals approved by the Food and Drug Administration (FDA) but before assignment of a product-specific HCPCS code

Hospital outpatient departments are allowed to bill for new drugs, biologicals, and therapeutic radiopharmaceuticals that are approved by the FDA on or after January 1, 2004,

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for which pass-through status has not been approved and a C-code and APC payment have not been assigned using the “unclassified” drug/biological HCPCS code C9399 (Unclassified drugs or biological). Drugs, biologicals, and therapeutic radiopharmaceuticals that are assigned to HCPCS code C9399 are contractor priced at 95 percent of AWP.

Diagnostic radiopharmaceuticals and contrast agents are policy packaged under the OPPS unless they have been granted pass-through status. Therefore, new diagnostic radiopharmaceuticals and contrast agents are an exception to the above policy and should not be billed with C9399 prior to the approval of pass-through status but, instead, should be billed with the appropriate “A” NOC code as follows:

- 1. Diagnostic radiopharmaceuticals** – All new diagnostic radiopharmaceuticals are assigned to either HCPCS code A4641 (Radiopharmaceutical, diagnostic, not otherwise classified), HCPCS code A9599 (Radiopharmaceutical, diagnostic, for beta-amyloid positron emission tomography (PET) imaging, per study dose), or HCPCS code J3490 (Unclassified drugs) (applicable to all new diagnostic radiopharmaceuticals used in non-beta-amyloid PET imaging). HCPCS code A4641, A9599, or J3490, whichever is applicable, should be used to bill a new diagnostic radiopharmaceutical until the new diagnostic radiopharmaceutical has been granted pass-through status and a C-code has been assigned. HCPCS codes A4641, A9599, and J3490 are assigned status indicator “N” and, therefore, the payment for a diagnostic radiopharmaceutical assigned to any of these HCPCS codes is packaged into the payment for the associated service.
- 2. Contrast agents** – All new contrast agents are assigned HCPCS code A9698 (Non-radioactive contrast imaging material, not otherwise classified, per study) or A9700 (Supply of injectable contrast material for use in echocardiography, per study). HCPCS code A9698 or A9700 should be used to bill a new contrast agent until the new contrast agent has been granted pass-through status and a C-code has been assigned. HCPCS code A9698 is assigned status indicator “N” and, therefore, the payment for a drug assigned to HCPCS code A9698 is packaged into the payment for the associated service. The status indicator for A9700 will change from SI=B (Not paid under OPPS) to SI=N (Payment is packaged into payment for other services) and, therefore, the payment for a drug assigned to HCPCS code A9700 is packaged into the payment for the associated service.



i. Skin substitute procedure edits

The payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. The skin substitute products are divided into two groups: 1) high cost skin substitute products, and 2) low cost skin substitute products for packaging purposes. Table 10 lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. CMS will implement an OPPS edit that requires hospitals to report all high-cost skin substitute products in combination with one of the skin application procedures described by *CPT*[®] codes 15271-15278 and to report all low-cost skin substitute products in combination with one of the skin application procedures described by HCPCS code C5271-C5278. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by *CPT*[®] code 15271-15278.

Table 10 – Skin substitute product assignment to high cost/low cost status for 2016

2016 code	2016 Short descriptor	2016 SI	Low/high cost skin substitute
C9349	PuraPly, PuraPly antimic	G	High
C9363	Integra Meshed Bil Wound Mat	N	High
Q4101	Apligraf	N	High
Q4102	Oasis Wound Matrix	N	Low
Q4103	Oasis Burn Matrix	N	High
Q4104	Integra BMWD	N	High
Q4105	Integra DRT	N	High
Q4106	Dermagraft	N	High
Q4107	GraftJacket	N	High

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2016 code	2016 Short descriptor	2016 SI	Low/high cost skin substitute
Q4108	Integra Matrix	N	High
Q4110	Primatrix	N	High
Q4111	Gammagraft	N	Low
Q4115	Alloskin	N	Low
Q4116	Alloderm	N	High
Q4117	Hyalomatrix	N	Low
Q4119	Matristem Wound Matrix	N	Low
Q4120	Matristem Burn Matrix	N	High
Q4121	Theraskin	G	High
Q4122	Dermacell	N	High
Q4123	Alloskin	N	High
Q4124	Oasis Tri-layer Wound Matrix	N	Low
Q4126	Memoderm/derma/ tranz/integup	N	High
Q4127	Talymed	N	High
Q4128	Flexhd/Allopatchhd/ Matrixhd	N	High
Q4129	Unite Biomatrix	N	Low
Q4131	Epifix	N	High
Q4132	Grafix Core	N	High
Q4133	Grafix Prime	N	High
Q4134	hMatrix	N	Low
Q4135	Mediskin	N	Low
Q4136	Ezderm	N	Low
Q4137	Amnioexcel or Biodexcel, 1cm	N	High
Q4138	Biodfence DryFlex, 1cm	N	High
Q4140	Biodfence 1cm	N	High
Q4141	Alloskin ac, 1cm	N	High
Q4143	Repriza, 1cm	N	Low
Q4146	Tensix, 1CM	N	Low
Q4147	Architect ecm, 1cm	N	High
Q4148	Neox 1k, 1cm	N	High
Q4150	Allowrap DS or Dry 1 sq cm	N	High
Q4151*	AmnioBand, Guardian 1 sq cm	N	High
Q4152*	Dermapure 1 square cm	N	High
Q4153	Dermavest 1 square cm	N	High
Q4154*	Biovance 1 square cm	N	High

2016 code	2016 Short descriptor	2016 SI	Low/high cost skin substitute
Q4156*	Neox 100 1 square cm	N	High
Q4157	Revitalon 1 square cm	N	Low
Q4158	MariGen 1 square cm	N	Low
Q4159	Affinity 1 square cm	N	High
Q4160	NuShield 1 square cm	N	High
Q4161	Bio-Connekt per square cm	N	Low
Q4162	Amnio bio and woundex flow	N	Low
Q4163	Amnion bio and woundex sq cm	N	Low
Q4164	Helicoll, per square cm	N	Low
Q4165	Keramatrix, per square cm	N	Low

*HCPCS codes Q4151, Q4152, Q4154, and Q4156 were assigned to the low cost group in the 2016 OPPS/ASC final rule with comment period. Upon submission of updated pricing information, Q4151, Q4152, Q4154, and Q4156 are assigned to the high cost group for 2016.

17. Changes to OPPS pricer logic

- a) Rural sole community hospitals (SCHs) and essential access community hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in 2016. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with Section 1833(t)(13)(B) of the Act, as added by Section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).
- b) New OPPS payment rates and copayment amounts will be effective January 1, 2016. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the 2016 inpatient deductible.
- c) For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2016. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is (cost- (APC payment x 1.75))/2.

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- d) The fixed-dollar threshold increases in 2016 relative to 2015. The estimated cost of a service must be greater than the APC payment amount plus \$3,250 in order to qualify for outlier payments.
- e) For outliers for community mental health centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2016. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is (cost for nuclear medicine procedures – [APC 0173 payment x 3.4])/2.
- f) Effective October 1, 2013, and expiring December 31, 2015, one device (C1841 - Retinal prosthesis, includes all internal and external components) was eligible for pass-through payment in the OPPS pricer logic. After pass-through status expires for a medical device, the payment for the device is packaged into the payment for the associated procedure.
- g) Effective January 1, 2016, CMS is packaging C1841 and assigning CPT® code 0100T (which includes the retinal prosthesis device) to new technology APC 1599, which has a final payment of \$95,000 for 2016.
- h) Effective January 1, 2015, and continuing for 2016, the OPPS pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.
- i) Effective January 1, 2016, there will be three diagnostic radiopharmaceuticals and one contrast agent receiving pass-through payment in the OPPS pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical or contrast agent payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical or contrast agent with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical or contrast agent expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the “policy-packaged” portions of the 2016 APC payments for nuclear medicine procedures and may be found on the CMS website.
- j) Effective January 1, 2016, there will be two skin substitute products receiving pass-through payment in the OPPS Pricer logic. For skin substitute application procedure codes that are assigned to APC 5054 (Level 4 Skin Procedures) or APC 5055 (Level 5 skin procedures), Pricer will reduce the payment amount for the pass-through skin substitute product by the wage-adjusted offset for the APC when the pass-through skin substitute product appears on a claim with a skin substitute application procedure that maps to APC 5054 or APC 5055. The offset amounts for skin substitute products are the “policy-packaged” portions of the 2016 payments for APC 5054 and APC 5055.
- k) Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals with pass-through status when those payment rates are based on ASP on a quarterly basis.
- l) Effective January 1, 2016, CMS is adopting the 2016 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals.
- m) Effective January 1, 2014, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40 percent), a device offset cap will be applied based on the credit amount listed in the “FD” (Credit received from the manufacturer for a replaced medical device) value code. The credit amount in value code “FD,” which reduces the APC payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs are available at <https://www.cms.gov/Medicare/Medicare-Fee->



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[for-Service-Payment/HospitalOutpatientPPS/passthrough_payment.html](http://www.cms.gov/Service-Payment/HospitalOutpatientPPS/passthrough_payment.html).

Coverage determinations

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

Additional information

The official instruction, CR 9486, issued to your MAC regarding this change, is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3425CP.pdf>. The portions of Medicare

manuals updated by CR 9486 are attached to the CR.

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: MM9486
 Related Change Request (CR) #: CR 9486
 Related CR Release Date: December 18, 2015
 Effective Date: January 1, 2016
 Related CR Transmittal #: R3425CP
 Implementation Date: January 4, 2016

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Note: The follow is a continuation of MM9486. These tables are referenced in the Background section of the article. "

Table 1 – New device pass-through code

HCPCS		SI	APC	Short descriptor	Long descriptor	Device offset from payment
C1822	01-01-2015	H	1661	Gen, neuro, HF, rechg bat	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	22,478.58

Table 3 – New brachytherapy source code, effective January 1, 2016

HCPCS	Effective date	SI	APC	Short descriptor	Long descriptor	Payment	Minimum un-adjusted copayment
C2645	1/1/2016	U	2648	Brachytx	Brachytherapy planar, planar source, palladium-103,per square millimeter	\$4.69	\$0.94

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Table 6 – New pathogen-reduced blood products HCPCS P-codes and interim payment rates and crosswalk for 2016

HCPCS	Effective date	Long descriptor	Cross walked HCPCS P-code	Cross walked HCPCS P-code long descriptor	Payment
P9070	1/1/2016	Plasma, pooled multiple donor, pathogen reduced, frozen, each unit	P9059	Fresh frozen plasma between 8-24 hours of collection, each unit	\$73.08
P9071	1/1/2016	Plasma (single donor), pathogen reduced, frozen, each unit	P9017	Fresh frozen plasma (single donor), frozen within 8 hours of collection, each unit	\$72.56
P9072	1/1/2016	Platelets, pheresis, pathogen reduced, each unit	P9037	Platelets, pheresis, leukocytes reduced, irradiated, each unit	\$641.85

Table 8 – Other 2016 HCPCS and CPT® code changes for certain drugs, biologicals, and radiopharmaceuticals

2015 code	2015 long descriptor	2016 code	2016 long descriptor
C9025	Injection, ramucirumab, 5 mg	J9308	Injection, ramucirumab, 5 mg
C9026	Injection, vedolizumab, 1 mg	J3380	Injection, vedolizumab, 1 mg
C9027	Injection, pembrolizumab, 1 mg	J9271	Injection, pembrolizumab, 1 mg
Q9975	Injection, Factor VIII, FC Fusion Protein (Recombinant), per iu	J7205	Injection, factor viii fc fusion protein (recombinant), per iu
C9442	Injection, belinostat, 10 mg	J9032	Injection, belinostat, 10 mg
C9443	Injection, dalbavancin, 10 mg	J0875	Injection, dalbavancin, 5 mg
C9444	Injection, oritavancin, 10 mg	J2407	Injection, oritavancin, 10 mg
C9445	Injection, c-1 esterase inhibitor (recombinant), Ruconest, 10 units	J0596	Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units
C9446	Injection, tedizolid phosphate, 1 mg	J3090	Injection, tedizolid phosphate, 1 mg
Q9978	Netupitant 300 mg and Palonosetron 0.5 mg, oral	J8655	Netupitant 300 mg and palonosetron 0.5 mg
C9449	Injection, blinatumomab, 1 mcg	J9039	Injection, blinatumomab, 1 microgram
C9450	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg	J7313	Injection, fluocinolone acetonide, intravitreal implant, 0.01 mg
C9451	Injection, peramivir, 1 mg	J2547	Injection, peramivir, 1 mg
C9452	Injection, ceftolozane 50 mg and tazobactam 25 mg	J0695	Injection, ceftolozane 50 mg and tazobactam 25 mg
C9453	Injection, nivolumab, 1 mg	J9299	Injection, nivolumab, 1 mg
C9454	Injection, pasireotide long acting, 1 mg	J2502	Injection, pasireotide long acting, 1 mg
C9455	Injection, siltuximab, 10 mg	J2860	Injection, siltuximab, 10 mg
C9456	Injection, isavuconazonium sulfate, 1 mg	J1833	Injection, isavuconazonium, 1 mg
C9457	Injection, sulfur hexafluoride lipid microsphere, per ml	Q9950	Injection, sulfur hexafluoride lipid microspheres, per ml

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2015 code	2015 long descriptor	2016 code	2016 long descriptor
J0571	Buprenorphine, oral, 1 mg	J0571	Buprenorphine, oral, 1 mg
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg	J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg	J0573	Buprenorphine/naloxone, greater than 3 mg, but less than or equal to 3.1 to 6 mg buprenorphine
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg	J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg
J0575	Buprenorphine/naloxone, oral, greater than 10 mg	J0575	Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine
J1446	Injection, tbo-filgrastim, 5 micrograms	J1447	Injection, tbo-filgrastim, 1 microgram
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg	J7297	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration
J7302	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg	J7298	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration
J7506	Prednisone, oral, per 5mg	J7512	Prednisone, immediate release or delayed release, oral, 1 mg
J7508	Tacrolimus, extended release, oral, 0.1 mg	J7508	Tacrolimus, extended release, (astagraf xl), oral, 0.1 mg
Q9979	Injection, alemtuzumab, 1 mg	J0202	Injection, alemtuzumab, 1 mg
Q4153	Dermavest, per square centimeter	Q4153	Dermavest and plurivest, per square centimeter
Q9976	Injection, ferric pyrophosphate citrate solution, 0.1 mg of iron	J1443	Injection, ferric pyrophosphate citrate solution, 0.1 mg of iron
Q9977	Compounded Drug, Not Otherwise Classified	J7999	Compounded Drug, Not Otherwise Classified
S5011	5% dextrose in lactated ringer's, 1000 ml	J7121	5% dextrose in lactated ringers infusion, up to 1000 cc

Table 9 – Corrected effective dates for certain vaccine codes

CPT®	SI	APC	Short descriptor	Long descriptor	Corrected effective date
90620	K	1807	Menb rp w/ omv vaccine im	<i>Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use</i>	1/23/2015
90621	K	1808	Menb rlp vaccine im	<i>Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use</i>	10/29/2014

January 2016 integrated outpatient code editor specifications version 17.0

Provider types affected

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

Provider action needed

Change request (CR) 9459 provides the instructions and specifications for the I/OCE to be used under the outpatient prospective payment system (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the home health prospective payment system (PPS) or to a hospice patient for the treatment of a non-terminal illness. This notification applies to [Chapter 4](#), Section 40.1 of the *Medicare Claims Processing Manual*. Make sure that your billing staffs are aware of these changes.

Background

CR 9459 informs the MACs and the fiscal intermediary shared system (FISS) maintainer that the I/OCE is being updated for January 1, 2016. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. The I/OCE specifications are available at <http://www.cms.gov/OutpatientCodeEdit/>. The modifications of the I/OCE for the January 2016 version 17.0 release are summarized in the table. Some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the “Effective date” column.

You should also read through the entire CR 9459 document and note the highlighted sections, which also indicate changes from the prior release of the software. A full summary of data changes in I/OCE V17, including diagnosis, Healthcare Common Procedure Coding System (HCPCS), *Current Procedural Terminology (CPT®)* codes, status indicators (SIs), and ambulatory payment classification (APC) codes, is attached to CR 9459.

Effective date	Edits affected	Modification
1/1/2016		Implement new program logic for pass-through device offset amount passed to Pricer by way of payer value code with payer value code amount field in the claim return buffer (Table 5 of I/OCE specifications). Assign new payment adjustment flag values to identify pass-through devices (see OPPS special processing logic, Table 5, 7 and Appendix G).
1/1/2016		Update comprehensive APC program logic to add new Comprehensive Observation C-APC 8011, and SI = J2 (see OPPS special processing logic and Appendix L); add new flowchart for Comprehensive Observation APC logic.
1/1/2016		Update the program logic for processing inpatient procedures when the patient expires to be assigned under comprehensive APCs (see OPPS special processing logic and Appendix L).
1/1/2016		Add new program logic to exclude SRS (stereotactic radiosurgery) planning and preparation services from packaging under C-APCs if present on the same claim as the SRS C-APC (see OPPS special processing logic and Appendix L).
1/1/2016		Update the critical care ancillary packaging to remove the exception when ancillary services are reported with modifier 59 as not applicable under C-APCs (see OPPS special processing logic).

Effective date	Edits affected	Modification
1/1/2016		Move the former Appendix O (summary of modifications) to the beginning of the specification document and rename to “Summary of Quarterly Release Modifications”; rename Appendix P (code lists) to Appendix O.

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Effective date	Edits affected	Modification
1/1/2016		Add program logic for processing advanced care planning services for payment by either the Medicare physician fee schedule (SI = A) or by APC through conditional packaging (SI = Q1) (see OPPS special processing logic).
1/1/2016		Add program logic for conditionally packaged laboratory services with new SI = Q4 (see OPPS special processing logic).
1/1/2016		Add program logic for certain CT scan codes reported with modifier CT that do not meet National Electrical Manufacturers Association (NEMA) equipment standards; pass new payment adjustment flag 14 (see OPPS special processing logic, Appendix G and Appendix K).
1/1/2016		Update Appendix K to note the deactivation of composite APC 8009; add reference to Comprehensive Observation APC for direct referral logic.
1/1/2016		Implement new status indicators (see Table 7): J2: Hospital Part B services that may be paid through a comprehensive APC Q4: Conditionally packaged laboratory services
1/1/2016		Implement new Payment Adjustment Flag values (see Table 7 and Appendix G): 12: Offset for device pass-through 13: Offset for additional device pass-through 14: Protecting Access to Medicare Act of 2014 (PAMA) Section 218 reduction on CT scan

Effective date	Edits affected	Modification
1/1/2016		Implement new payment indicator values (see Table 7): 14: Grandfathered tribal Federally Qualified Health Center (FQHC) encounter payment
1/1/2016	93	Implement new edit 93 (Corneal tissue processing reported without cornea transplant procedure) (see Table 4). Edit criteria: Corneal tissue processing HCPCS (V2785) is reported and there is no corneal transplant procedure present for the same service date (LIR).
1/1/2016	94	Implement new edit 94 (Biosimilar HCPCS reported without biosimilar modifier) (see Table 4). Edit criteria: A biosimilar HCPCS code is reported on the claim without its corresponding biosimilar manufacturing modifier (RTP).
	2	Remove the age edit restriction for ICD-10 diagnosis codes F930, F938, F939, F941-F949, F9821, F9829, F983, F988, and F989.
1/1/2016	8	Updates to the male and female sex restriction edit for new procedure codes.

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Effective date	Edits affected	Modification
1/1/2016	22	New modifiers: CP: C-APC adjunctive service CT: CT does not meet NEMA standards ZA: Novartis/Sandoz
1/1/2016		Update program logic and documentation for any references to APC values that now reflect new APC values due to restructure of APC groups (for example, partial hospitalization program (PHP) logic, mental health composite).
1/1/2016		Update FQHC program logic for grandfathered tribal FQHC encounters (see special processing conditions for FQHC claims and Appendix M).
1/1/2016		Update FQHC program logic for separate payment of chronic care management services (see special processing conditions for FQHC claims and Appendix M).
1/1/2016		Update FQHC program logic for advanced care planning services; treat as qualifying visit code or packaged preventive service (see special processing conditions for FQHC claims and Appendix M).
1/1/2016	67	Update mid-quarter FDA effective dates for the following codes: - 90621: 10/29/2014 - 90620: 01/23/2015
6/2/2014	68	Update the SI assignment for HCPCS G0472 to SI = A, effective with the mid-quarter NCD edit already in place.

Effective date	Edits affected	Modification
1/1/2016	68	Implement mid-quarter NCD effective dates for the following codes: - G0296: 02/05/2015 - G0297: 02/05/2015 - G0476: 07/09/2015 - 90630: 08/01/2015
1/1/2016		Update the following lists for the release (see quarterly data files): - Comprehensive APCs (C-APC list, ranking, exclusions, complexity-adjusted code pairs) - Skin substitute products (edit 87, Appendix O) - Conditionally STV-packaged and T-packaged - Deductible/coinsurance N/A - Inpatient only procedures (edit 18) - Device and device-procedures (edit 92) - Lab services (conditional packaging) - FQHC (preventive services, flu/PPV vaccine, non-covered and qualifying visit pairs) - Cornea transplant procedures (new edit 93) - CT scan not meeting NEMA standard (new, payment adjustment flag 14) - Device offset (new, payment adjustment flag 12, 13) - SRS planning and preparation codes (new C-APC logic) - ICD-10 diagnosis age edit restrictions (edit 2) - Procedure and sex conflict edit restrictions (edit 8)
1/1/2016	57	Update the edit description to remove the reference to 'Composite'.
1/1/2016		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).

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Effective date	Edits affected	Modification
1/1/2016	20, 40	Implement version 22.0 of the NCCI (as modified for applicable institutional providers).

Additional Information

The official instruction, [CR 9459](#), issued to your MAC regarding this change, is available on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning->

Fiscal year (FY) 2016 inpatient prospective payment system (IPPS) and long-term care hospital (LTCH) PPS changes

Note: This article was on December 30, 2015, to reflect a revised change request (CR). That CR added CardioMEMS™ HF Monitoring System to the list of items approved for a New Technology Add-On Payment (page 5 below) and to renumber the list. In the article the transmittal number, CR release date and link to the transmittal was also changed. All other information remains the same. This information was previously published in the [October 2015 Medicare A Connection, Page 1](#).

Provider types affected

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

Provider action needed

Stop – impact to you

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

Caution – what you need to know

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

[Network-MLN/MLNMattersArticles/index.html](#), under - How Does It Work.

MLN Matters® Number: MM9459
 Related Change Request (CR) #: CR 9459
 Related CR Release Date: January 6, 2016
 Effective Date: January 1, 2016
 Related CR Transmittal #: R3437CP
 Implementation Date: January 4, 2016

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Go – What you need to do

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

Background

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a PPS for Medicare payment of inpatient hospital services. In addition, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002.

The Centers for Medicare & Medicaid Services (CMS) is required to make updates to these prospective payment systems annually.

Change request (CR) 9253 outlines those changes for FY 2016.

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

A. FY 2016 IPPS rates and factors

The FY 2016 IPPS rates and factors and operating rates are in the following tables:

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Factor	Rate
Standardized amount applicable percentage increase	<ul style="list-style-type: none"> ▪ 1.017 if Quality = '1' and EHR = 'blank' in PSF; or ▪ 1.011 if Quality = '0' and EHR = 'blank' in PSF; or ▪ 1.005 if Quality = '1' and EHR = 'Y' in PSF; or ▪ 0.999 if Quality = '0' and EHR = 'Y' in PSF
Common fixed loss cost outlier threshold	\$22,539
Federal capital rate	\$438.75
Puerto Rico capital rate	\$212.55

Operating rates for wage index > 1

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

Operating rates for wage index < 1

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

B. Pricer logic changes

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

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

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

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

CMS created the following new MS-DRGs:

- MS-DRG 268 (Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC)
- MS-DRG 269 (Aortic and Heart Assist Procedures Except Pulsation Balloon without MCC)
- MS-DRG 270 (Other Major Cardiovascular Procedures with MCC)
- MS-DRG 271 (Other Major Cardiovascular Procedures with CC)
- MS-DRG 272 (Other Major Cardiovascular Procedures without CC/MCC)
- MS-DRG 273 (Percutaneous Intracardiac Procedures with MCC) and
- MS-DRG 274 (Percutaneous Intracardiac Procedures without MCC).

CMS deleted the following MS-DRGs:

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

D. Post-acute transfer and special payment policy

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

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

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

E. New technology add-on

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

1. Name of approved new technology: Argus

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

2. Name of approved new technology: Kcentra

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

3. Name of approved new technology: CardioMEMS™ HF monitoring system

- Maximum add-on payment: \$8,875;
- Identify and make new technology add-on payments with ICD-10-PCS procedure code 02HQ30Z or 02HR30Z

4. Name of approved new technology: MitraClip® system

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

5. Name of approved new technology: RNS® system

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

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

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

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

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

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

F. Cost of living adjustment (COLA) update for IPPS PPS

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

G. FY 2016 wage index changes and issues

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

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

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

In addition, for the few hospitals that were located in an urban county prior to October 1, 2014, that became rural effective October 1, 2014, under the new OMB

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

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

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

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

3. Section 505 hospital (out-commuting adjustment)

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

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

An urban hospital that reclassifies as a rural hospital under Section 412.103 is considered rural for all IPPS purposes.

Note: hospitals reclassified as rural under Section 412.103 are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see Section 412.320(a)(1)).

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

Beginning with the FY 2008 wage index, CMS instituted a policy that allocates the wages and hours to the CBSA in which a hospital campus is located when a multi-campus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility at

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which the discharge occurred. Also note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA. In general, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers.

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

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

K. Medicare-dependent, small rural hospital (MDH) program

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

L. Hospital specific (HSP) rate factors for sole community hospitals (SCHs) and MDHs

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

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

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Section 204 of the Medicare Access and CHIP Reauthorization Act of 2015 extended the temporary changes to the low-volume hospital payment adjustment through September 30, 2017.

In order to qualify as a low-volume hospital in FY 2016, a hospital must be located more than 15 road miles from another “subsection (d) hospital” and have less than 1600 Medicare discharges (which includes Medicare Part C discharges and is based on the latest available MedPAR data). The applicable low-volume percentage increase is determined using a continuous linear sliding scale

equation that results in a low-volume hospital payment adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more Medicare discharges.

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

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

To receive a low-volume hospital payment adjustment under Section 412.101 for FY 2016, a hospital must have made a written request for low-volume hospital status that is received by its MAC no later than September 1, 2015, in order for the applicable low-volume hospital payment adjustment to be applied to payments for discharges occurring on or after October 1, 2015. Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment in FY 2015 may continue to receive a low-volume hospital payment adjustment for FY 2016 without reapplying if it continues to meet the Medicare discharge criterion established for FY 2016 (as

shown in corrected Table 14 of the FY 2016 IPPS/LTCH PPS Final Rule and subsequent correction notice) and the mileage criterion.

However, the hospital must have sent a written verification that was received by its MAC no later than September 1, 2015, stating that it continues to be more than 15 miles

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from any other “subsection (d)” hospital. This written verification could be a brief letter to the MAC stating that the hospital continues to meet the low-volume hospital distance criterion as documented in a prior low-volume hospital status request. If a hospital’s written request for low-volume hospital status for FY 2016 was received after September 1, 2015, and if the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital’s FY 2016 discharges, effective prospectively within 30 days of the date of its low-volume hospital status determination.

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

N. Hospital quality initiative

The hospitals that will receive the quality initiative bonus are listed at <http://www.qualitynet.org>. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website, and MACs will update their file as needed. A list of hospitals that will receive the statutory reduction to the annual payment update for FY 2016 under the hospital inpatient quality reporting (IQR) program was provided to the MACs.

O. Hospital-acquired condition reduction program (HAC)

Section 3008 of the Affordable Care Act establishes a program, beginning in FY 2015, for IPPS hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain hospital-acquired conditions (HACs). HACs are conditions that patients did not have when they were admitted to the hospital, but which developed during the hospital stay. Under the HAC reduction program, a 1-percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital’s discharges for the specified fiscal year.

The HAC reduction program adjustment amount (that is, the 1-percent payment reduction) is calculated after all other IPPS per discharge payments, which includes adjustments for DSH (including the uncompensated care payment), IME, outliers, new technology, readmissions,

VBP, low-volume hospital payments, and capital payments. This amount will be displayed in the HAC ‘PAYMENT AMT’ field in the IPPS pricer output record. For SCHs and MDHs, the HAC reduction program adjustment amount applies to either the federal rate payment amount or the hospital-specific rate payment amount, whichever results in a greater operating IPPS payment.

A list of providers subject to the HAC reduction program for FY 2016 was not publicly available in the final rule because the review and correction process was not yet completed. CMS provided the MACS with a preliminary list of hospitals subject to the HAC reduction program. Updated hospital level data for the HAC reduction program will be made publicly available following the review and corrections process.

P. Hospital value based purchasing

Section 3001 of the Affordable Care Act added Section 1886(o) to the Social Security Act, establishing the hospital value-based purchasing (VBP) program. This program began adjusting base operating DRG payment amounts for discharges from subsection (d) hospitals, beginning in FY 2013. Under its current agreement with CMS, Maryland hospitals are not subject to the hospital VBP program for the FY 2016 program year. The regulations that implement this provision are in Subpart I of 42 CFR Part 412 (Section 412.160 through Section 412.162).

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

These payment reductions fund value-based incentive payment to hospitals that meet or exceed performance standards on the measures selected for the program. By law, CMS must base value-based incentive payments on hospitals’ performance under the hospital VBP program, and the total amount available for value-based incentive payments must be equal to the amount of payment reductions, as estimated by the Secretary of Health and Human Services. CMS calculates a total performance score (TPS) for each hospital eligible for the hospital VBP program. CMS then uses a linear exchange function to convert each hospital’s TPS into a value-based incentive payment.

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

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

Q. Hospital readmissions reduction program

For FY 2016, the readmissions adjustment factor is the higher of a ratio or 0.97 (-3 percent). The readmissions adjustment factor is applied to a hospital's "base operating DRG payment amount" that is, the wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable), to determine the reduction amount under the hospital readmissions reduction program. Add-on payments for IME, DSH (including the uncompensated care payment), outliers, and low-volume hospitals are not adjusted by the readmissions adjustment factor. In addition, for SCHs, the difference between the SCH's operating IPPS payment under the hospital-specific rate and the Federal rate is not adjusted by the readmissions adjustment factor.

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

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

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

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



R. Medicare disproportionate share hospitals (DSH) program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Starting in FY 2014, hospitals received 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured.

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

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

The total uncompensated care payment amount to be paid to the Medicare DSH hospitals was finalized in the FY 2016 IPPS Final Rule. The uncompensated care payment will be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2016. The estimated per claim amount is determined by dividing the total uncompensated care payment by the average number of claims from the most recent three years of claims data (FY 2012-2014). CMS is issued a correction notice to the FY 2016 IPPS final rule, which changed each provider's uncompensated care payment per claim amounts.

Attachment 3 of CR 9253 includes the updated estimated

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

The estimated per discharge uncompensated care payment amount will be included in the outlier payment determinations. In addition the estimated per discharge uncompensated care payment amount will be included as a federal payment for SCHs to determine if a claim is paid under the hospital-specific rate or federal rate and for Medicare dependent hospitals to determine if the claim is paid 75 percent of the difference between payment under the hospital-specific rate and payment under the federal rate. The total uncompensated care payment amount finalized in the correction notice to the FY 2016 IPPS Final Rule will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis.

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

Under the transition, per the regulations at Section 412.102, for the second year after a hospital loses urban status, the hospital will receive an additional payment that equals one-third of the difference between DSH payment before its re-designation from urban to rural and the DSH payment otherwise applicable to the hospital subsequent to its re-designation from urban to rural. In the second year after a hospital loses urban status, the hospital will receive an additional payment that equals one third of the difference between the DSH payments applicable to the hospital before its re-designation from urban to rural and the DSH payments otherwise applicable to the hospital subsequent to its re-designation from urban to rural. This adjustment will be determined at cost report settlement. In determining the claim payment, the pricer will only apply the DSH payment adjustment based on its urban/rural status according to the re-designation.

S. Recalled devices

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

New MS-DRGs are added to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they are formed from



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

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

- MS-DRG 268 (Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC)
- MS-DRG 269 (Aortic and Heart Assist Procedures Except Pulsation Balloon without MCC)
- MS-DRG 270 (Other Major Cardiovascular Procedures with MCC)
- MS-DRG 271 (Other Major Cardiovascular Procedures with CC)
- MS-DRG 272 (Other Major Cardiovascular Procedures without CC/MCC)
- MS-DRG 273 (Percutaneous Intracardiac Procedures with MCC)
- MS-DRG 274 (Percutaneous Intracardiac Procedures without MCC)

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

LTCH PPS FY 2016 update

A. FY 2016 LTCH PPS rates and factors

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

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Table - FY 2016 LTCH PPS rates and factors

Rate	Factor
LTCH PPS standard federal rates	Rates based on successful reporting of quality data. <ul style="list-style-type: none"> ▪ Full update (quality indicator on PSF = 1): \$41,762.85 ▪ Reduced update (quality indicator on PSF = 0 or blank): \$40,941.55
Labor share	62.0 percent
Non-labor share	38.0 percent
High-cost outlier fixed-loss amount for standard federal rate discharges	\$16,423
High-cost outlier fixed-loss amount for site-neutral rate discharges	\$22,539

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

1. Application of the site neutral payment rate

Section 1206(a) of Public Law 113–67 amended Section 1886(m) of the Act to establish patient-level criteria for payments under the LTCH PPS for implementation for cost reporting periods beginning on or after October 1, 2015. This revision to payments under the LTCH PPS established a dual-rate payment structure, under which discharges are paid based on either of the following:

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

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

- The discharge must not have a principal diagnosis in the LTCH of a psychiatric diagnosis or rehabilitation as indicated by the grouping of the discharge into one of 15 “psychiatric and rehabilitation” MS-LTC-DRGs (that is, MS-LTC-DRGs 876, 880, 881, 882, 883, 884, 885, 886, 887, 894, 895, 896, 897, 945, and 946).
- The discharge must have been immediately preceded by an IPPS hospital discharge (“immediately preceded” is defined as the LTCH admission occurring within one day of the IPPS hospital discharge based on the admission date on the LTCH discharge claim and the discharge date on the IPPS hospital claim).
- The patient discharged from the LTCH must have spent 3 days in the ICU during the immediately preceding IPPS hospital stay (discharges meeting this criteria will be identified by the use of revenue center codes 020x and 021x on the IPPS hospital discharge claim) or have received at least 96 hours of respiratory ventilation services during the LTCH stay (which will generally be identified by the use of ICD-10-PCS procedure code 5A1955Z on the LTCH claim).

The site neutral payment rate amount will be paid for patients discharged from the LTCH that do not meet the above criteria. The application of the site neutral payment rate is codified in the regulations at Section 412.522. Additional information on the final policies implementing the application of the site neutral payment rate are in the FY 2016 Final Rule (80 FR 49601-49623). Information on the requirements implementing the application of the site neutral payment rate are in CR 9015. A related *MLN Matters*[®] article, [MM9015](#).

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

2. Transition blended payment rate for FY 2016 and 2017

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

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Under new Section 412.522(c)(1), the site neutral payment rate is the lower of the IPPS comparable per diem amount determined under Section 412.529(d)(4), including any applicable outlier payments under Section 412.525(a), or 100 percent of the estimated cost of the case determined under Section 412.529(d)(2). For purposes of the blended payment rate, the payment rate that would otherwise be applicable had the provisions of Public Law 113-67 not been enacted, is the LTCH PPS standard federal payment determined under section 412.523 (that is, the LTCH PPS standard Federal payment rate that is applicable to discharges that meet the criteria for exclusion from the site neutral payment rate under new Section 412.522(a)(2)).

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

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

3. Subclause (II) LTCHs

In the FY 2015 IPPS Final Rule, CMS established a payment adjustment under the LTCH PPS at Section 412.526 for hospitals “classified under subclause (II) of subsection (d)(1)(B)(iv)” of the Act (referred to as “subclause (II) LTCHs), effective for cost reporting periods beginning on or after October 1, 2014 (that is, federal FY 2015 and beyond). Under this payment adjustment, payments to subclause (II)

LTCHs are adjusted so that their LTCH PPS payments are generally equivalent to an amount determined under the reasonable cost-based reimbursement rules for both operating and capital-related costs. Consequently, the application of the site neutral payment rate at Section 412.522 is not applicable to subclause (II) LTCHs. Currently there is only one hospital meeting the statutory definition of a subclause (II) LTCH, which is located in New York. The FY 2016 LTCH PPS pricer includes logic

to determine the claim payment amount for discharges from the subclause (II) LTCH that does not include the application of the site neutral payment rate in accordance with these policies.

B. Average length of stay calculation

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

C. Discharge payment percentage

For all LTCHs' FY 2016 or later cost reporting periods, the statute requires LTCHs to be notified of their “discharge payment percentage” (DPP). The DPP is the ratio (expressed as a percentage) of the LTCHs' FFS discharges which received LTCH PPS standard federal rate payment to the LTCHs' total number of LTCH PPS discharges. The LTCH's total number of LTCH PPS discharges for a cost reporting period and discharges which were paid at the LTCH PPS standard federal payment rate are to be determined at cost report settlement using data from the define?(PS&R). (Additional information regarding the identification of the discharge counts used in this calculation is forthcoming.)

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

D. LTCH quality reporting (LTCHQR) program

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

E. Provider specific file (PSF)

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

F. Cost of living adjustment (COLA) under the LTCH PPS

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

Additional information

The official instruction, [CR 9253 \(R3431CP\)](#) issued to your MAC regarding this change is available on the CMS website.

If you have any questions, please contact your MAC

2016 eligibility changes to the ESRD PPS low-volume payment adjustment

Provider types affected

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

Provider action needed

This article is based on CR 9478 which provides guidance to Medicare administrative contractors (MACs) on the changes made to the ESRD prospective payment system (PPS) low-volume payment adjustment (LVPA) eligibility criteria effective January 1, 2016. Make sure that your billing staff are aware of these changes.

Background

For an ESRD facility to qualify for the ESRD PPS LVPA, certain criteria must be attested to by the ESRD facility and validated by the MAC. These qualifying criteria include:

- The ESRD facility furnished less than 4,000 dialysis treatments in each of the three cost reporting years preceding its payment year;
- The ESRD facility must not have opened, closed, or received a new provider number due to change in

ownership in the three years preceding the payment year; and

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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- Prior to January 1, 2016, the ESRD facility must not be located within 25 road miles of another ESRD facility under common ownership.

In addition, prior to January 1, 2016, the geographic proximity criterion is only applicable to ESRD facilities that are Medicare certified on or after January 1, 2011, to furnish outpatient maintenance dialysis treatments.

CR 9478 instructs that effective January 1, 2016, the Centers for Medicare & Medicaid Services (CMS)

is implementing changes to the eligibility criteria for the LVPA. CMS has:

1. Removed the grandfathering of ESRD facilities that were Medicare certified prior to January 1, 2011, and
2. Changed the geographic proximity criterion.

Specifically (for the purposes of determining the number of treatments under the definition of a low-volume facility) beginning 2016, the number of treatments considered furnished by any ESRD facility (regardless of when it came into existence and was Medicare certified) will be equal to:

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- The aggregate number of treatments actually furnished by the ESRD facility, and
- The number of treatments furnished by other ESRD facilities that are both:
 - Under common ownership with the ESRD facility in question, and
 - Five road miles or less from the ESRD facility in question.

In order to accommodate the timing of the policy changes, CMS extended the attestation deadline for the 2016 LVPA attestations until December 31, 2015, to allow ESRD facilities time to:

- Assess their eligibility based on the policy changes to the LVPA for 2016, and if appropriate, and
- Submit an attestation. MACs will review the attestations and determine eligibility.

Note: CR 9478 specifically updates the *Medicare Benefit Policy Manual* (Chapter 11 (End Stage Renal Disease (ESRD)), Section 60.B.1) which is included as an attachment to CR 9478. As noted in the manual updates, beginning January 1, 2016, the LVPA is 23.9 percent.

Additional information

The official instruction, CR 9478, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R219BP.pdf>.

Clinical laboratory fee schedule – Medicare travel allowance fees for collection of specimens

Provider types affected

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

Provider action needed

Change request (CR) 9485 revises the payment of travel allowances when billed on a per mileage basis using Healthcare Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat-rate basis using HCPCS code P9604 for 2016.

Background

Medicare Part B allows payment for a specimen collection fee and travel allowance, when medically necessary, for a laboratory technician to draw a specimen from either a

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 of change	Description
January 13, 2016	The article was revised to reflect a revised CR that updated the attestation due date from January 22, 2016, to December 31, 2015. The transmittal number, CR release date and link to the transmittal also changed. All other information remains the same.

MLN Matters[®] Number: MM9478
 Related Change Request (CR) #: CR 9478
 Related CR Release Date: January 13, 2016
 Effective Date: January 1, 2016
 Related CR Transmittal #: R219BP
 Implementation Date: January 22, 2016

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nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act. Payment for these services is made based on the clinical laboratory fee schedule.

The travel codes allow for payment either on a per mileage basis (P9603) or on a flat-rate per trip basis (P9604). Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen, including the laboratory technician's salary and travel expenses.

Your MAC has the discretion to choose either a mileage basis or a flat rate, and how to set each type of allowance. Many MACs established local policy to pay based on a flat-rate basis only.

Under either method, when one trip is made for multiple

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specimen collections (for example, at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat-rate is set by the MAC.

Per mile travel allowance

(P9603): The minimum “per mile travel allowance” is \$0.99, which is to be used in situations where the average trip to the patients’ homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip. This allowance per mile was computed using the federal mileage rate of \$0.54 per mile plus an additional \$0.45 per mile to cover the technician’s time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum \$0.99 per mile if local conditions warrant it. The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the clinical laboratory fee schedule (CLFS), as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician. The Internal Revenue Service (IRS) determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating and automobile.



Per flat-rate trip basis travel allowance (P9604): The per flat-rate trip basis travel allowance is \$9.90.

Note: MACs will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, MACs will adjust claims brought to their attention.

Additional information

The official instruction, CR 9485, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3433CP.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: MM9485
 Related Change Request (CR) #: CR 9485
 Related CR Release Date: December 31, 2015
 Effective Date: January 1, 2016
 Related CR Transmittal #: R3433CP
 Implementation Date: February 1, 2016

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Update to the January 2016 ASP drug pricing file

The Centers for Medicare & Medicaid Services (CMS) has made revisions to the January 2016 ASP drug pricing file. Medicare administrative contractors (MACs) are making these changes to their payment files; the public files posted to the Centers for Medicare & Medicaid Services (CMS) website will be updated to reflect the changes noted below.

- Healthcare Common Procedure Coding System (HCPCS) codes J0886 (Epoetin alfa 1000 units ESRD) and J7506 (Prednisone oral) are being removed from the January file. These codes were terminated on

December 31, 2015.

- HCPCS code J7512 (Prednisone, immediate release or delayed release, 1 mg) is being added to the January file.
- The dosage associated with HCPCS code J3090 (Inj tedizolid phosphat) in the ASP drug pricing file is being changed from 10 mg to 1 mg.

First Coast Service Options’ (First Coast) fee lookup tool will reflect these revisions.

Summary of policies in the 2016 MPFS final rule and telehealth originating site facility fee payment amount

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9476 which provides a summary of the policies in the 2016 Medicare physician fee schedule (MPFS) final rule and announces the telehealth originating site facility fee payment amount. Make sure that your billing staff is aware of these updates for 2016.

Background

The Social Security Act (Section 1848(b)(1); see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) requires the Centers for Medicare & Medicaid Services (CMS) to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. CMS issued a final rule with comment period on October 30, 2015, (see <http://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf>), that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) that are paid under the MPFS in 2016.

The final rule also addresses public comments on Medicare payment policies proposed earlier this year. The proposed rule "Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016" was published in the *Federal Register* on July 15, 2015 (see <http://www.gpo.gov/fdsys/pkg/FR-2015-07-15/pdf/2015-16875.pdf>).

The final rule also addresses interim final values established in the 2015 MPFS final rule with comment period. The final rule assigns interim final values for new, revised, and potentially misvalued codes for 2016 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until December 29, 2015.

CR 9476 provides a summary of the payment policies under the MPFS and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in 2016 and they are as follows:

Sustainable growth rate (SGR)

The Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114-10, enacted on April 16, 2015) (MACRA; see <http://www.gpo.gov/fdsys/pkg/BILLS-114hr2enr/pdf/BILLS-114hr2enr.pdf>) repealed the Medicare SGR update formula for payments under the MPFS.

Access to telehealth services

CMS is adding the following services to the list of services that can be furnished to Medicare beneficiaries under the telehealth benefit: Prolonged service inpatient CPT[®] codes 99356 and 99357 and ESRD-related services 90963 through 90966. The prolonged service codes can only be billed in conjunction with subsequent hospital and subsequent nursing facility codes. Limits of one subsequent hospital visit every three days, and one subsequent nursing facility visit every 30 days, would continue to apply when the services are furnished as telehealth services.

For the ESRD-related services, the required clinical examination of the catheter access site must be furnished face-to-face "hands on" (without the use of an interactive telecommunications system) by a physician, clinical nurse specialist (CNS), nurse practitioner (NP), or physician assistant (PA). For the complete list of telehealth services, visit <http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html>.

Certified registered nurse anesthetists (CRNAs) initially were omitted from the list of distant site practitioners for telehealth services in the regulation because CMS did not believe these practitioners would furnish any of the service on the list of Medicare telehealth services. However, CRNAs in some states are licensed to furnish certain services on the telehealth list, including evaluation and management services. Therefore, CMS revised the regulation at [42 CFR 410.78\(b\)\(2\)](#) (Telehealth services) to include a CRNA, as described under [42 CFR 410.69](#), to the list of distant site practitioners who can furnish Medicare telehealth services.

Telehealth origination site facility fee payment amount update

The Social Security Act (Section 1834(m)(2)(B); see https://www.ssa.gov/OP_Home/ssact/title18/1834.htm) establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare economic index (MEI) as defined in the Social Security Act (Section 1842(i)(3); see https://www.ssa.gov/OP_Home/ssact/title18/1842.htm).

The MEI increase for 2016 is 1.1 percent. Therefore, for 2016, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or \$25.10. (The beneficiary

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is responsible for any unmet deductible amount and Medicare coinsurance.)

Incomplete colonoscopies

The method for calculating the payment for incomplete colonoscopies has been revised for 2016. New payment rates will apply when modifier 53 (discontinued procedure) is appended to codes 44388, 45378, G0105, and G0121. (For more information, see the *MLN Matters*[®] article (MM9317) corresponding to CR 9317 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9317.pdf>.

Advance care planning, and with an annual wellness visit

Advance care planning (ACP) services are separately payable under the MPFS in 2016 (deductible and coinsurance apply). When voluntary ACP services are furnished as part of an annual wellness visit (AWV), the deductible and coinsurance would not be applied for ACP.

Portable X-ray transportation fee

The *Medicare Claims Processing Manual*, Chapter 13, Section 90.3 was revised to remove the word “Medicare” before “patient” in Section 90.3. Also, guidance for the billing of the transportation fee of portable X-ray suppliers has been clarified. When more than one patient is X-rayed at the same location, the single transportation payment under the physician fee schedule is to be prorated among all patients (Medicare Parts A and B, and non-Medicare) receiving portable X-ray services during that trip, regardless of their insurance status. For more information, see the *MLN Matters*[®] article (MM9354) corresponding to CR 9354 for more information at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9354.pdf>.

“Incident to” policy

CMS finalized the changes to [42 CFR 410.26\(a\)\(1\)](#) without modification, and the change to the regulation at [42 CFR 410.26\(b\)\(5\)](#) with a clarifying modification. Specifically, CMS is amending the definition of the term, “auxiliary personnel” at [§ 410.26\(a\)\(1\)](#) that are permitted to provide “incident to” services to exclude individuals who have been excluded from the Medicare program or have had their Medicare enrollment revoked. Additionally, CMS is amending [§ 410.26\(b\)\(5\)](#) by revising the final sentence to make clear that the physician (or other practitioner) directly supervising the auxiliary personnel need not be the same physician (or other practitioner) that is treating the patient more broadly, and adding a sentence to specify that only the physician (or other practitioner) that supervises the auxiliary personnel that provide incident to services may bill Medicare Part B for those incident to services.



Establishing values for new, revised, and misvalued codes

The list of codes with changes for 2016 included under this definition of “adjustments to relative value units (RVUs) for misvalued codes” is available under the “downloads” section at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>.

Target for relative value adjustments for misvalued services

The Protecting Access to Medicare Act of 2014 (PAMA; Section 220(d); see <http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf>) added a new subparagraph to the Social Security Act (Section 1848(c)(2)(O)) to establish an annual target for reductions in MPFS expenditures resulting from adjustments to relative values of misvalued codes. Under the Social Security Act (Section 1848(c)(2)(O)(ii)), if the estimated net reduction in expenditures for a year as a result of adjustments to the relative values for misvalued codes is equal to or greater than the target for that year, reduced expenditures attributable to such adjustments will be redistributed in a budget-neutral manner within the MPFS in accordance with the existing budget neutrality requirement under the Social Security Act (Section 1848(c)(2)(B)(ii)(II)). The provision also specifies that the amount by which such reduced expenditures exceeds the target for a given year will be treated as a net reduction in expenditures for the succeeding year, for purposes of determining whether the target has been met for that subsequent year. Section 1848(c)(2)(O)(iv) defines a target recapture amount as the difference between the target for the year and the estimated net reduction in expenditures under the MPFS resulting from adjustments to RVUs for misvalued codes. Section 1848(c)(2)(O)(iii) specifies that, if the estimated net reduction in MPFS expenditures for the year is less than the target for the year, an amount equal to the target recapture amount will not be taken into account when applying the budget neutrality requirements specified in the Social Security Act (Section 1848(c)(2)(B)(ii)(II)). The PAMA (Section 220(d)) applies to 2017 through 2020 and sets the target under the Social Security Act (Section

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1848(c)(2)(O)(v)) at 0.5 percent of the estimated amount of expenditures under the PFS for each of those four years.

The Achieving a Better Life Experience Act of 2014 (ABLE; Section 202) (Division B of Pub. L. 113-295, enacted December 19, 2014) amended the Social Security Act (Section 1848(c)(2)(O)) to accelerate the application of the MPFS expenditure reduction target to 2016, 2017, and 2018, and to set a 1 percent target for 2016 and 0.5 percent for 2017 and 2018. As a result of these provisions, if the estimated net reduction for a given year is less than the target for that year, payments under the MPFS will be reduced.

In the 2016 PFS proposed rule, CMS proposed a methodology to implement this statutory provision in a manner consistent with the broader statutory construct of the MPFS. CMS finalized the policy to calculate the net reduction using the simpler method as proposed. CMS estimates the 2016 net reduction in expenditures resulting from adjustments to relative values of misvalued codes to be 0.23 percent. Since this does not meet the 1 percent target established by the Achieving a Better Life Experience Act of 2014 (ABLE), payments under the MPFS must be reduced by the difference between the target for the year and the estimated net reduction in expenditures (the "Target Recapture Amount"). As a result,



CMS estimates that the 2016 target recapture amount will produce a reduction to the CF of -0.77 percent.

Additional information

The official instruction, CR 9476, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3423CP.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: MM9476
Related Change Request (CR) #: CR 9476
Related CR Release Date: December 18, 2015
Effective Date: January 1, 2016
Related CR Transmittal #:R3423CP
Implementation Date: January 4, 2016

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Inpatient hospital payment rate impacted by the Consolidated Appropriations Act, 2016

On Friday, December 18, 2015, President Obama signed into law the Consolidated Appropriations Act, 2016. Section 601, Modification of Medicare Inpatient Hospital Payment Rate for Puerto Rico Hospitals modifies the payment calculation with respect to operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for discharges on or after January 1, 2016. CMS is currently revising the inpatient prospective payment system (IPPS) FY 2016 pricer to reflect the new payment calculation requirement. The amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges on or after January 1, 2016, will be based on 0 percent of the applicable Puerto Rico percentage and 100 percent of the applicable federal percentage. In addition, the IPPS FY 2016 pricer will include conforming changes to certain FY 2016 IPPS operating rates and factors that result from the application

of the new Puerto Rico hospital payment calculation requirement, which are applicable to all IPPS hospital discharges on or after January 1, 2016. We will also incorporate the revised IPPS rates into the long-term care hospital (LTCH) pricer, as they are used for certain LTCH claims payments.

To allow sufficient time to develop and test, we will implement the IPPS and LTCH pricers on April 4, 2016. Medicare administrative contractors (MACs) will reprocess IPPS inpatient claims from Puerto Rico and all other IPPS hospitals with a discharge date on or after January 1, 2016. The MACs will also reprocess LTCH claims with a discharge date on or after January 1, 2016, due to the impact of this change. Puerto Rico hospitals (as well as all other IPPS and LTCH hospitals) do not need to take any action. We expect to reprocess claims no later than June 30, 2016.

Educational Events

Provider outreach and educational events – March 2016

Medicare Part A changes and regulations

When: Tuesday, March 15

Time: 10:00 a.m. -11:30 a.m. ET – Delivery language: English

Type of Event: Webcast

<http://medicare.fcso.com/Events/0316267.asp>

Two easy ways to register

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

Please note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

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

Never miss a training opportunity

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

Take advantage of 24-hour access to free online training

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



CMS MLN Connects® Provider eNews

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



MLN Connects® Provider eNews for January 7, 2016

MLN Connects® Provider eNews for January 7, 2016
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In this edition:

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call — Register Now
- Collecting Data on Global Surgery as Required by MACRA Listening Session — Register Now
- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Register Now
- New Audio Recordings and Transcripts Available
- Stay Informed about Medicare Program Changes

Other CMS Events

- Comparative Billing Report on Home E/M Services Webinar

Medicare Learning Network® Publications and Multimedia

- FY 2017 and After Payments to Hospice Agencies That Do Not Submit Required Quality Data MLN Matters® Article — Released
- Remittance Advice Resources and FAQs Fact Sheet — New
- Medicare Overpayments Fact Sheet — Revised
- Medicare Vision Services Fact Sheet — Revised
- Screening, Brief Intervention, and Referral to Treatment Services Fact Sheet — Revised
- Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet — Revised
- Certificate of Medical Necessity Web-Based Training Course — Revised
- New Educational Web Guides Fast Fact

Announcements

- Medicare FFS Utilization and Payment Data Available



for HHAs

- CMS Finalizes Rule Creating Prior Authorization Process for Certain DMEPOS Items
- CMS Quality Measure Development Plan
- Improving the Submission of Quality Data to CMS Quality Reporting Programs
- Pilot Project to Test Improving Patients’ Health by Addressing Their Social Needs
- EHR Incentive Programs: 2015 Program Year Attestation Begins January 4
- PQRS: Submission Timeframes for 2015 Data
- PQRS: Self-Nomination for 2016 Qualified Registries and QCDRs Open through January 31
- IRF Data Submission Deadline Extended to February 15
- LTCH Data Submission Deadline Extended to February 15
- LTCH QRP: FAQs and Provider Training Materials Available
- Hospice Item Set Timeliness Compliance Threshold Fact Sheet Available
- Improving the Documentation of Chiropractic Services Video
- Reporting the Diabetes: Hemoglobin A1c Measure for Program Year 2015
- CMS to Release a Comparative Billing Report on

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MLN Connects® Provider eNews for January 14, 2016

MLN Connects® Provider eNews for January 14, 2016

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In this edition:

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call — Last Chance to Register
- Collecting Data on Global Surgery as Required by MACRA Listening Session — Last Chance to Register
- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Register Now

Medicare Learning Network® Publications and Multimedia

- Introduction to the IMPACT Act of 2014 Video — New
- Preventive Services Poster — New
- Drug Diversion: Schemes, Auditing, and Referrals Web-Based Training — New
- Medicare Parts C and D General Compliance Training Web-Based Training — New
- Combatting Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training — New
- Medicare Quarterly Provider Compliance Newsletter Educational Tool — New
- Hospice Payment System Fact Sheet — Revised



- ICD-10 Post-Implementation: Coding Basics Revisited Video — Reminder

Announcements

- Accountable Care Organization Initiatives Announced to Improve Health System Care Delivery
- Home Health Compare: Deadline to have Data Suppressed is January 25
- CMS to Release a Comparative Billing Report on Electrodiagnostic Testing in February
- Revised Two-Midnight Rule Guidelines
- PQRS Web-Based Measure Search Tool
- January is Cervical Health Awareness Month

eNews

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Domiciliary E/M Services in January

- January Quarterly Provider Update Available
- Get Your Patients Off to a Healthy Start in 2016
- Continue Seasonal Influenza Vaccination through January and Beyond

Claims, Pricers, and Codes

- Holding of 2016 Date-of-Service Claims for Services Paid Under the 2016 MPFS

- Provider Enrollment Application Fee Amount for 2016
- Clarification for Coding Relating to Cologuard
- January 2016 OPPS Pricer File Available
- January 2016 FQHC Pricer Files Available
- Transcatheter Mitral Valve Repair Claims Editing Incorrectly
- Pharmacogenomic Testing for Warfarin Responsiveness Claims Editing Incorrectly
- Adjustments to Correct Home Health Claim Payments

MLN Connects® Provider eNews for January 21, 2016

MLN Connects® Provider eNews for January 21, 2016
[View this edition as a PDF](#)

In this edition:

MLN Connects® Events

- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Register Now

Other CMS Events

- Comparative Billing Report on Domiciliary E/M Services Webinar

Medicare Learning Network® Publications and Multimedia

- PECOS FAQs Fact Sheet — Revised
- The Medicare Home Health Benefit Booklet — Revised

Announcements

- CMS Updates Open Payments Data and Improves Website
- Open Payments System Downtime from January 21 through 26
- LTCH Quality Reporting Program Data Submission Deadline: February 15
- IRF Quality Reporting Program Data Submission



Deadline: February 15

- Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
- LTCH and IRF Dry Run Readmission Reports Available
- Update to IRF-PAI Training Manual V1.4
- Read More about What is Next for the EHR Incentive Programs
- Help Protect the Vision of Your Medicare Patients

Claims, Pricers, and Codes

- January 2016 OPPS Pricer File Update

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.



**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

904-791-8123

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