

C Medicare A CONNECTION

medicare.fcso.com



A Newsletter for MAC Jurisdiction N Providers

May 2016



In this issue

Clarification of IPF requirements for certification and recertification	3
Prolonged drug and biological infusions using an external pump	10
July 2016 update of the hospital OPPS	31
July 2016 IOCE specifications version 17.2	35

JW modifier: Drug amount discarded/not administered to any patient

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) issued change request (CR) 9603 to alert MACs and providers of the change in policy regarding the use of the JW modifier for discarded Part B drugs and biologicals.

Effective July 1, 2016, providers are required to:

- Use the JW modifier for claims with unused drugs or biologicals from single use vials or single use packages that are appropriately discarded (except those provided under the competitive acquisition program (CAP) for Part B drugs and biologicals) and
- Document the discarded drug or biological in the patient's medical record when submitting claims with

unused Part B drugs or biologicals from single use vials or single use packages that are appropriately discarded

Make sure that your billing staffs are aware of these changes. Remember that the JW modifier is not used on claims for CAP drugs and biologicals.

Background

The *Medicare Claims Processing Manual*, Chapter 17, Section 40 provides policy detailing the use of the JW modifier for discarded Part B drugs and biologicals. The current policy allows MACs the discretion to determine whether to require the JW modifier for any claims with discarded drugs or biologicals, and the specific details regarding how the discarded drug or biological information should be documented.

Be aware in order to more effectively identify and monitor billing and payment for discarded drugs and biologicals, CMS is revising this policy to require the uniform use of the JW modifier for all claims with discarded Part B drugs and biologicals.

See **DISCARDED**, page 9



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

General Information

Clarification of IPF requirements for certification and recertification	3
Reporting place of service codes	4
Move PAP smear risk indicator and technical/professional dates to screening auxiliary file	5
Update to Internet-Only-Manual Publication 100-04, Chapter 18, Section 30.6	6
Limiting the scope of review on redeterminations and reconsiderations of certain claims	6
Billing requirements for rural health clinics	7

Processing Issues

Correction to end-stage renal prospective payment system	8
Reprocessing of selected dialysis claims	8
Coinsurance correction for certain rural health clinic claims	8

General Coverage

July update of the HCPCS drug/biological code changes	9
Policy for prolonged drug and biological infusions using an external pump	10
Billing external pump for prolonged drug and biological infusions	11
Billing and coverage for drug wastage	12
Medicare coverage of substance abuse services	12
Screening for cervical cancer with human papillomavirus testing	15
Eighth coding revisions to national coverage determinations	17
Seventh Coding revisions to national coverage determinations	18

Local Coverage Determinations

Advance beneficiary notice	19
----------------------------------	----

Revisions to LCDs

Amniotic membrane - sutureless placement on the ocular surface	20
Quarterly provider update	20

Hospital

System changes to implement temporary exception for certain severe wound discharges	21
Allogeneic hematopoietic stem cell transplantation	23
Percutaneous left atrial appendage closure	25
Shared savings program accountable care organization qualifying stay edits	28

Rural Health Clinics

RHCs HCPCS reporting requirement and billing updates	29
--	----

Electronic Data Interchange

Correction to remittance advice messages part of update to manual	30
---	----

Reimbursement

July 2016 update of the hospital OPPS	31
July 2016 IOCE specifications version 17.2	35
Payment of drugs and biologicals services for OPPS providers	37

Educational Resources

Upcoming provider outreach and educational event - June 2016	39
--	----

CMS MLN Connects™ Provider eNews

eNews for April 28, 2016	40
eNews for May 5, 2016	41
eNews for May 12, 2016	41
eNews for May 19, 2016	42

First Coast Contact Information

Phone numbers/addresses	43
-------------------------------	----

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

Publication staff:

Terri Drury
Sofia Lennie
Mark Willett
Robert Petty

Fax comments about this publication to:

Medicare Publications
904-361-0723

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

CPT® five-digit codes, descriptions, and other data only are copyright 2014 by American Medical Association (or such other date of publication of CPT®). All Rights Reserved. Applicable FARS/DFARS apply. No fee schedules, basic units, relative values or related listings are included in CPT®. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for data contained or not contained herein.

ICD-10-CM codes and its descriptions used in this publication are copyright 2015 Optum360, LLC. All rights reserved.

This document contains references to sites operated by third parties. Such references are provided for your convenience only. Florida Blue and/or First Coast Service Options Inc. do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

All stock photos used are obtained courtesy of a contract with www.shutterstock.com.

General Information

Clarification of IPF requirements for certification

Provider types affected

This *MLN Matters*® article is intended for physicians and other specified providers submitting claims to Medicare administrative contractors (MACs) to certify and recertify the medical necessity of inpatient psychiatric services provided to Medicare beneficiaries.

What you need to know

A physician or other specified providers need to certify the medical necessity of inpatient services. This is required at admission, and if the service is needed for an extended period of time, a recertification is necessary. CR 9522 clarifies that your MAC will cease denials of inpatient psychiatric facility (IPF) providers that do not use “the statement” that “the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel” for recertification when documentation is present that validates (without using any particular words) that the patient continues to need care.



Background

Currently, the IPF prospective payment system (PPS) requires facilities to provide “the statement” for recertification. As a result, payments to providers whose documentation validates all the necessary requirements to continue care were being denied because they did not use “the statement.”

CR 9522 clarifies physician certification, recertification and delayed/lapsed certification and recertification with respect to IPF services in the *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 4, Section 10.9 and in the *Medicare Benefit Policy Manual*, Chapter 2, Section 30.2.1.

There is also a difference in the content of the certification and recertification. In certification the physician is required to document that the IPF admission was medically necessary for either: (1) treatment which could reasonably be expected to improve the patient’s condition, or (2) diagnostic study.

Key points of CR 9522

- Your MAC will use the beneficiary’s IPF medical record, if the statement “that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel” is not present in the physician’s recertification documentation, to determine if all the required elements for recertification were met.

- Your MAC will allow providers to adopt any method that permits verification of all the elements IPFs require to continue treatment. No specific procedures or forms are required for certification and recertification. The recertification may be entered on provider generated forms, in progress notes, or in the records (relating to the stay in question) and must be signed by a physician.
- Your MAC will deny IPF claims that do not have timely certifications and recertifications. However, delayed certifications and recertifications will be honored where, for instance, there has been an oversight or lapse, and there is a legitimate reason for the delay. Denial of payment for lack of the required certification and recertification is considered a technical denial, which means a statutory requirement has not been met.
 - MACs will allow the reopening of technical denial decisions (initiated by the provider or contractor).
 - MACs will reverse any delayed/lapsed certification or recertification denials where the provider later produced a legitimate reason for the delay.
- MACs will review provider explanations/reasons for delayed certification and recertification. The submission of documents must include an explanation for the delay and any medical or other evidence the IPF considers relevant for purposes of explaining the delay.
- MACs will allow the IPF to determine the format of delayed certification and recertification statements, and the method by which they are obtained. A delayed certification may be included with one or more recertifications on a single signed statement. Separate signed statements for each delayed certification and recertification are not required, as they would be if timely certification and recertification had been completed. For all IPF services, a delayed certification may not extend past discharge. An IPF certification or recertification statement may only be signed by a physician.

Additional information

The official instruction, CR 9522, was issued to your MAC regarding this change via two transmittals. The first updates the *Medicare General Information, Eligibility and Entitlement Manual* and it is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R98GI.pdf>. The second updates the *Medicare*

See IPF, next page

Reporting place of service codes

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

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

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

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

Important facts when filing a claim to Medicare

- The POS is a required field, entered in the 2400 Place of Service Code loop (segment SV105) of the 837P electronic claim or Item 24B on the CMS-1500 paper claim
- The name, address and zip code of where the service(s) were actually performed is required for all POS codes, and is entered in Item 32 on the CMS 1500 claim form or in the corresponding loop on its electronic equivalent

- Must specify the correct location where the service(s) is performed and billed on the claim, since both the POS and the locality address are components of the MPFS
- If the POS is missing, invalid or inconsistent with procedure code on claim form it will be returned as unprocessable (RUC)
 - For example, POS 21 (inpatient hospital) is not compatible with procedure code 99211 (Establish patient office or other outpatient visit)

Helpful hints for POS codes for professional claims

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

IPF

From previous page

Benefit Policy Manual and it is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R223BP.pdf>. The revised manual section is attached to each transmittal.

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

MLN Matters® Number: MM9522

Related Change Request (CR) #: CR 9522
 Related CR Release Date: May 13, 2016
 Effective Date: August 15, 2016
 Related CR Transmittal #: R223BP and R98GI
 Implementation Date: August 15, 2016

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.

PAP smear risk indicator and technical/professional dates move to screening auxiliary file

Provider types affected

This *MLN Matters*[®] article is intended for institutional providers and home health agencies (HHAs) submitting inquiries to Medicare administrative contractors (MACs) for information on Pap smear services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 9188 announces changes to Medicare systems regarding the placement of Pap smear data on Medicare's internal files. The Pap smear data is displayed on the following provider inquiry screens:

- **HIQA:** Healthcare inquiry for Part A for online transactions
- **HIQH:** Healthcare inquiry for home health for online transactions
- **ELGA:** Eligibility for Part A
- **ELGH:** Eligibility for home health
- **HUQA:** Healthcare update inquiry for Part A

The Healthcare Common Procedure Coding System (HCPCS) codes for PAP screening displayed on these screens are P3000, G0123, G0143, G0144, G0145, G0147 and G0148, and the screens can show up to three occurrences per HCPCS.

The other significant change for providers is that on the unformatted provider inquiry, HUQA, PAP information will now be carried in screening data location 4053-4612, instead of 780-784.

Additional information

The official instruction, CR 9188, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1551OTN.pdf>.

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



MLN Matters[®] Number: MM9188
Related CR Release Date: November 5, 2015
Related CR Transmittal #: R1551OTN
Related Change Request (CR) #: CR 9188
Effective Date: April 4, 2016
Implementation Date: April 4, 2016

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT[®] only copyright 2015 American Medical Association.

Correct your claims on the 'SPOT'

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



Update to Internet-Only Manual Publication 100-04, Chapter 18, Section 30.6

Provider types affected

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

Provider action needed

CR 9606 advises the MACs of an update to the *Medicare Claims Processing Manual*, Chapter 18, Section 30.6. CR 9606 updates the manual by replacing an incorrect diagnosis code for screening of cervical cancer with HPV testing. The manual shows an incorrect ICD-10 code of Z12.92 and the correct ICD-10 code is Z12.72 (encounter for screening for malignant neoplasm of the vagina). Make sure that your billing staffs are aware of this change.

Additional information

The official instruction, CR 9606, issued to your MAC

Limiting the scope of review on redeterminations and reconsiderations of certain claims

Note: This article was revised May 9, 2016, to provide updated information regarding redetermination requests received by Medicare administrative contractors (MACs) or qualified independent contractors (QICs) on or after April 18, 2016. This information was previously published in the *August 2015 Medicare A Connection*, page 7.

Provider types affected

This *MLN Matters*[®] special edition article is intended for physicians, providers, and suppliers who submit claims to MACs for services provided to Medicare beneficiaries.

What you need to know

This special edition article is being published by the Centers for Medicare & Medicaid Services (CMS) to inform providers of the clarification CMS has given to the MACs and QICs regarding the scope of review for redeterminations (technical direction letter 160305, which rescinds and replaces technical direction letter 150407). This updated instruction applies to redetermination requests received by a MAC or QIC on or after April 18, 2016, and will not be applied retroactively.

Background

CMS recently provided direction to MACs and QICs regarding the applicable scope of review for redeterminations and reconsiderations for certain claims. Generally, MACs and QICs have discretion while

regarding this change, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3522CP.pdf>. The updated manual section is attached to the CR.



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

MLN Matters[®] Number: MM9606
Related Change Request (CR) #: CR 9606
Related CR Release Date: May 13, 2016
Effective Date: June 14, 2016

Related CR Transmittal #: R3522CP
Implementation Date: June 14, 2016

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT[®] only copyright 2015 American Medical Association.

conducting appeals to develop new issues and review all aspects of coverage and payment related to a claim or line item. As a result, in some cases where the original denial reason is cured, this expanded review of additional evidence or issues results in an unfavorable appeal decision for a different reason.

For redeterminations and reconsiderations of claims denied following a complex prepayment review, a complex post-payment review, or an automated post-payment review by a contractor, CMS has instructed MACs and QICs to limit their review to the reason(s) the claim or line item at issue was initially denied. Prepayment reviews occur prior to Medicare payment, when a contractor conducts a review of the claim and/or supporting documentation to make an initial determination.

Post-payment review or audit refers to claims that were initially paid by Medicare and subsequently reopened and reviewed by, for example, a zone program integrity contractor (ZPIC), recovery auditor, MAC, or comprehensive error rate testing (CERT) contractor, and revised to deny coverage, change coding, or reduce payment.

Complex reviews require a manual review of the supporting medical records to determine whether there is an improper payment. Automated reviews use claims data analysis to identify improper payments. If an appeal involves a claim or line item denied on an automated pre-

See **SCOPE**, next page

SCOPE

From previous page

payment basis, MACs and QICs may continue to develop new issues and evidence at their discretion and may issue unfavorable decisions for reasons other than those specified in the initial determination.

Please note that contractors will continue to follow existing procedures regarding claim adjustments resulting from favorable appeal decisions. These adjustments will process through CMS systems and may suspend due to system edits. Claim adjustments that do not process to payment because of additional system imposed payment limitations, conditions or restrictions (for example, frequency limits or correct coding initiative edits) may result in new denials with full appeal rights.

In addition, if a MAC or QIC conducts an appeal of a claim or line item that was denied on pre- or post-payment review because a provider, supplier, or beneficiary failed to submit requested documentation, the contractor will review all applicable coverage and payment requirements for the item or service at issue, including whether the item or service was medically reasonable and necessary. As a result, claims initially denied for insufficient documentation may be denied on appeal if additional documentation is submitted and it does not support medical necessity.

This clarification and instruction applies to redetermination and reconsideration requests received by a MAC or QIC on or after April 18, 2016. It will not be applied retroactively. Appellants will not be entitled to request a reopening of a previously issued redetermination or reconsideration for the purpose of applying this clarification on the scope of review. CMS encourages providers and

suppliers to include any audit or review results letters with their appeal request. This will help alert contractors to appeals where this instruction applies.

Additional information

You can find out more about appealing claims decisions in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 29 (Appeals of Claims Decisions), Section 310.4.C.1. (Conducting the Redetermination (Overview)) at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf>.

You can also find out more about 1) conducting a redeterminations in 42 CFR 405.948, at [http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405_1948](http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1948); and 2) conducting a reconsideration in 42 CFR 405.968 at [http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405_1968](http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1968).

MLN Matters® Number: SE1521

Revised Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

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.

Billing requirements for rural health clinics

The Centers for Medicare & Medicaid Services (CMS) understands that some rural health clinics (RHCs) are unable to implement the billing requirements described in *MLN Matters*® article MM9269 due to internal systems constraints. Contact your Medicare administrative contractor (<http://go.usa.gov/cuX3x>) to find out if a temporary option is available while your system is updated.

Check the status of claim redeterminations online

Don't wait up learn the status of your appeal. You may *check on its status at your convenience -- online*, which enables providers to check the status on active redeterminations to confirm if the appeal has been received by First Coast Service Options.

Processing Issues

Correction to certain end-stage renal prospective payment system claims

Issue

Effective January 1, 2016, with the implementation of change request (CR) 9367 end-stage renal prospective payment system claims may not have been calculated correctly. The Centers for Medicare and Medicaid Services (CMS) has identified that the claims were processed January 1, 2016, through February 21, 2016, billed with a valid national drug code(s) (NDC), on a type of bill (TOB) 72x.

Resolution

A system fix was implemented on February 22, 2016, to

correct this issue. Your Medicare administrative contractor (MAC) will adjust any claim processed incorrectly.

Status/date resolved

Open.

Provider action

No provider action is required.

Current processing issues

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

Reprocessing of selected dialysis claims

Issue

Dialysis claims with dates of service prior to October 1, 2015, which include screening for sexually transmitted infections, are being denied in full instead of at the line level. Medicare administrative contractors are updating their systems to correct this problem and will reprocess denied claims (72x type of bill; CPT® code 86631, 86632, 87110, 87270, 87320, 87490, 87491, 87800, 87810, 87590, 87591, 87850, 86592, 86593, 86780, 87340, or 87341; diagnosis code V74.5 or V73.89).

Resolution

Medicare administrative contractors will update its systems to correct this problem and will reprocess denied claims.

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.

Coinsurance correction for certain rural health clinic claims

Issue

Effective April 1, 2016, rural health clinics (RHC) began reporting Healthcare Common Procedure Coding System (HCPCS codes) for all services furnished during the visit. The Centers for Medicare & Medicaid Services (CMS) is aware that coinsurance may not be calculated correctly when RHC claims are submitted with multiple revenue lines for medical services.

Resolution

A system fix was implemented on May 9, 2016, to correct

this issue. Your Medicare administrative contractor (MAC) will adjust any claim processed incorrectly.

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.

DISCARDED

From front page

Additional information

The official instruction, CR 9603, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3530CP.pdf>.

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

Document history

Document history	Description
May 25, 2016	The article was revised to reflect an updated CR. That CR updated the X-Ref Requirement number in the CR's 'Supporting Information' section. In the article, the CR release date, transmittal number and link to the CR was changed. All other information remains the same.



MLN Matters® Number: MM9603
 Related Change Request (CR) #: CR 9603
 Related CR Release Date: May 24, 2016
 Effective Date: July 1, 2016
 Related CR Transmittal #: R3530CP
 Implementation Date: July 5, 2016

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.

July update of the HCPCS drug/biological code changes

Provider types affected

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

Provider action needed

Change request (CR) 9636 informs Medicare providers and suppliers that effective for claims with dates of service on or after July 1, 2016, new healthcare common procedure coding system (HCPCS) codes Q9981 (rolapitant, oral, 1mg); Q9982 (flutemetamol f18 diagnostic); and Q9983 (florbetaben f18 diagnostic) will be payable for Medicare. In addition, the HCPCS code set will contain code Q5102 (Inj., infliximab biosimilar), which is effective for dates of service on or after April 5, 2016. Claims for Q5102 must also have the modifier ZB (Pfizer/hospira). Make sure that your billing staffs are aware of these changes.

Background

The HCPCS code set is updated on a quarterly basis and CR9636 provides that effective July 1, 2016, the HCPCS codes contained in the following table will be established:

HCPCS code	Short description	Long description	Type of service
Q9981	rolapitant, oral, 1mg	Rolapitant, oral, 1 mg	1

HCPCS code	Short description	Long description	Type of service
Q9982	flutemetamol f18 diagnostic	Flutemetamol F18, diagnostic, per study dose, up o 5 millicuries	4
Q9983	florbetaben f18 diagnostic	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	4

Also, as of July 1, the HCPCS code set will contain code Q5102 (short descriptor – Inj., infliximab biosimilar – and long descriptor – Injection, Infliximab, 10 mg). Code Q5102 will be effective for dates of service on or after April 5, 2016, and will have TOS codes of 1 and P. In addition, claims for Q5102 must also have the modifier ZB (Pfizer/hospira).

Additional information

The official instruction, CR 9636, issued to your MAC regarding this change, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3518CP.pdf>.

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

See JULY, next page

Policy for prolonged drug and biological infusions using an external pump

Provider types affected

This *MLN Matters*[®] special edition article is intended for all physicians and hospital outpatient departments submitting claims to Medicare administrative contractors (MACs) for prolonged drug and biological infusions started incident to a physician's service using an external pump. **Note that this article does not apply to suppliers' claims submitted to durable medical equipment MACs (DME MACs).**

What you need to know

Medicare pays for drugs and biologicals which are not usually self-administered by the patient and furnished incident to physicians' services rendered to patients while in the physician's office or the hospital outpatient department. In some situations, a hospital outpatient department or physician office may:

- Purchase a drug for a medically reasonable and necessary prolonged drug infusion,
- Begin the drug infusion in the care setting using an external pump,
- Send the patient home for a portion of the infusion, and
- Have the patient return at the end of the infusion period.

In this case, the drug or biological, the administration, and the external infusion pump is billed to your MAC. **However, because prolonged drug and biological infusions started incident to a physician's service using an external pump should be treated as an incident to service, it cannot be billed on suppliers' claims to DME MACs.**

Background

Under Section 1861(s)(2)(A) of the Social Security Act (the Act), Medicare will pay for drugs and biologicals which are furnished incident to a physician's professional service. Under Section 1861(s)(2)(B) of the Act, Medicare will pay for drugs and biologicals which are not usually self-administered by the patient furnished as incident to physicians' services rendered to outpatients. In order for Medicare to pay for a drug or biological under Section 1861(s)(2)(A) or (B) of the Act, the physician or hospital (respectively) must incur a cost for the drug or biological.

Generally, the administration of drugs or biologicals covered by Medicare under the incident to benefit (1861(s)(2)(A) and (B)) will start and end while the patient is in the physician's office or the hospital outpatient department under the supervision of a physician.

However, in some situations a hospital or office may purchase a drug for a medically reasonable and necessary prolonged drug infusion, then begin the drug infusion in the care setting using an external pump, send the patient home for a portion of the infusion duration, and have the patient return at the end of the infusion period. In this case, the drug or biological continues to be covered under Section 1861(s)(2)(A) and (B) of the Act and is billable to the MAC even though the entire administration of the drug or biological did not occur in the physician's office or the hospital outpatient department.

Also, the drug or biological continues to meet the requirements for the incident to benefit as the physician or hospital incurred a cost for the drug or biological and the administration of the drug began in a physician's office or hospital incident to a physician's service. For the administration of the drug, the physician supervision rules under [42 CFR §410.26\(b\)\(5\)](#) and [42 CFR §410.27\(a\)\(1\)\(iv\)](#) and [CMS Publication 100-02, Chapter 15, Section 50.3](#), apply only while the patient is present in the physician's office or hospital outpatient department.

CMS does not provide specific coding guidance; however, appropriate drug administration codes for this situation would describe the services that are provided by the physician or hospital (for example, intravenous infusion, patient monitoring) while the patient is in the office or the outpatient setting.

Medicare's payment for the administration of the drug or biological billed to the MAC will also include payment for equipment used in furnishing the service. Equipment, such as an external infusion pump used to begin administration of the drug or biological that the patient takes home to complete the infusion, is not separately billable as durable medical equipment for a drug or biological paid under the Section 1861(s)(2)(A) and (B) incident to benefit. The MAC may direct use of a code described by CPT[®] or an otherwise applicable HCPCS code for the drug administration service. If necessary, the MAC may direct

See **POLICY**, next page

JULY

From previous page

MLN Matters[®] Number: MM9636
 Related Change Request (CR) #: CR 9636
 Related CR Release Date: May 6, 2016
 Effective Date: July 1, 2016
 Related CR Transmittal #: R3518CP
 Implementation Date: July 5, 2016

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT[®] only copyright 2015 American Medical Association.

Billing external pump for prolonged drug and biological infusions

The Centers for Medicare & Medicaid Services (CMS) recently provided additional clarification to Medicare administrative contractors (MAC) and providers regarding reimbursement for prolonged drug and biological infusions that are started in the office or outpatient hospital and are associated with care that is billed incident to a physician service using an external pump. The complete information can be found in *MLN Matters*® SE1609.

In order for Medicare to pay for a drug or biological under Section 1861(s)(2)(A) or (B) of the Act, the physician or hospital (respectively) must incur a cost for the drug or biological. Generally, the administration of drugs or biologicals covered by Medicare under the “incident to” benefit (1861(s)(2)(A) and (B)) will start and end while the patient is in the physician’s office or the hospital outpatient department under the supervision of a physician.

However, in some situations a hospital or office may purchase a drug for a medically reasonable and necessary prolonged drug infusion, then begin the drug infusion in the care setting using an external pump, send the patient home for a portion of the infusion duration, and have the patient return at the end of the infusion period. In this case, the drug or biological continues to be covered under Section 1861(s)(2)(A) and (B) of the Act and is billable to the A/B MAC even though the entire administration of the drug or biological did not occur in the physician’s office or the hospital outpatient department.

In order for physicians and hospital outpatient departments to receive reimbursement for cost incurred for the services above First Coast ask that the instructions listed below be followed.

Part B physician services

- Please continue to bill any applicable Current Procedural Terminology (CPT®) or HCPCS codes for the drug or biological, and its administration.
- To bill for the use of the external pump, please submit using unlisted CPT® code 96379 for a daily reimbursement of the service.



- CPT® code 96379 should be billed on a single line with a ‘FROM’ and ‘TO’ date and the corresponding number of units (days) indicated in the appropriate field.
- The word “pump” must be notated in block 19 on the CMS-1500 claim form or the equivalent segment for electronic claims submissions.
- If you have previously billed the drug and administration and are now needing to bill for the pump, bill only the pump as a new claim. You do not need to rebill the administration and drug codes

Part A hospital outpatient department

- Please continue to bill any applicable CPT® or HCPCS codes for the drug or biological, and its administration.
- To bill for the use of the external pump, please submit using unlisted CPT® code 96379 for a daily reimbursement of the service.
- CPT® code 96379 should be billed according to the date of receipt of the pump with the corresponding number of days indicated in the “Units” field.
- The word “pump” must be notated on page 07 and page 33 as the remark.
- If adjusting a processed claim within timely filing period follow the normal adjustment process.

POLICY

From previous page

use of a miscellaneous code for the drug administration if there is no specified code that describes the drug administration service that also accounts for the cost of equipment that the patient takes home to complete the infusion that they later return to the physician or hospital.

Additional information

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

MLN Matters® Number: SE1609
 Related Change Request (CR) #: N/A
 Related CR Release Date: N/A
 Effective Date: N/A
 Related CR Transmittal #: N/A
 Implementation Date: N/A

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.

Billing and coverage for drug wastage

First Coast Service Options Inc. (First Coast) will consider payment for the unused and discarded portion of a single-use drug/biological product after administration of the appropriate (reasonable and necessary) dosage for the patient's condition. This applies to drugs priced through the average sales price (ASP) drug/biological program. The Centers for Medicare & Medicaid Services (CMS) encourages physicians, hospitals, and other providers to provide injectable drug therapy incident to a physician's services in a fashion that maximizes efficiency of therapy in a clinically appropriate manner.

If a physician, hospital, or other provider must discard the unused portion of a single-use vial or other single-use package after administering a dose/quantity appropriate to the clinical context for a Medicare beneficiary, the program provides payment for the entire portion of drug or biological indicated on the vial or package label.

If less than a complete vial is administered at the time of service, and the unused portion is discarded, drug wastage must be documented in the patient's medical record with the date, time, and quantity wasted. Upon review, any discrepancy between amount administered to the patient and the billed amount will be denied, unless wastage is clearly documented. The amount billed as "wastage" must not be administered to another patient or billed again to Medicare. *All procedures for drug storage, reconstitution and administration should conform to applicable Federal*



Drug Administration (FDA) guidelines and provider scope of practice.

Note: For billing purposes, First Coast does not require the use of modifier JW prior to July 1, 2016. Drug wastage is billed by combining on a single line the wastage and administered dosage amount. **Effective July 1, modifier JW is required when billing for drugs discarded or not administered.** Additional information is available in [MLN Matters® article MM9603](#).

Source: *Publication 100-04, Chapter 17, Section 40 CMS IOM, Publication 100-04, Chapter 23, Section 20.3*

Medicare coverage of substance abuse services

Provider types affected

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

What you need to know

While there is no distinct Medicare benefit category for substance abuse treatment, such services are covered by Medicare when reasonable and necessary. The Centers for Medicare & Medicaid Services (CMS) provides a full range of services, including those services provided for substance abuse disorders. This article summarizes the available services and provides reference links to other online Medicare information with further details about these services.

Background

Services for substance abuse disorders are available under Medicare, as long as those services are reasonable and necessary. These services include:

Inpatient treatment

- Inpatient treatment would be covered if reasonable and necessary.
- Professional services provided during that care would be paid either:

- as part of the inpatient stay (for professional services provided by clinicians not recognized for separate billing, for instance peer counselors), or
- separately, to the professional billing for the provided services if they are recognized under Part B and considered separate from the inpatient stay (for instance, physicians, and NPPs within their state scopes of practice).
- Any medication provided as part of inpatient treatment would be bundled into the inpatient payment and not paid separately.

Outpatient treatment

- Similar to inpatient treatment, coverage of outpatient treatment would depend on the provider of the services.
- Pursuant to the Social Security Act, Medicare does not recognize substance abuse treatment facilities as an independent provider type, nor is there an integrated payment for the bundle of services those providers may provide (either directly, or incident to a physician's service).
- Coverage and payment would be on a service by service basis for those services that are recognized by Medicare. For instance, Medicare could pay for counseling by an enrolled licensed clinical social worker, psychologist or psychiatrist.

See **ABUSE**, next page

ABUSE

From previous page

- Some services could be provided by auxiliary personnel incident to a physician's services.
- Medications used in an outpatient setting that are not usually self-administered may be covered under Part B if they meet all Part B requirements.

Partial hospitalization program (PHP)

The PHP is an intensive outpatient psychiatric day treatment program that is furnished as an alternative to inpatient psychiatric hospitalization. This means that without the PHP services, the person would otherwise be receiving inpatient psychiatric treatment. Patients admitted to a PHP must be under the care of a physician who certifies and re-certifies the need for partial hospitalization and require a minimum of 20 hours per week of PHP therapeutic services, as evidenced by their plan of care. PHPs may be available in your local hospital outpatient department and Medicare certified community mental health center (CMHCs). PHP services include:

- Individual or group psychotherapy with physicians, psychologists, or other mental health professionals authorized or licensed by the state in which they practice (for example, licensed clinical social workers, clinical nurse specialists, certified alcohol and drug counselors);
- Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy, if required, must be a component of the physicians treatment plan for the individual;
- Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients;
- Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes (subject to limitations specified in 42 CFR 410.29);
- Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals;
- Family counseling services for which the primary purpose is the treatment of the patient's condition;
- Patient training and education, to the extent the training and educational activities are closely and clearly related to the individuals care and treatment of his/her diagnosed psychiatric condition; and
- Medically necessary diagnostic services related to mental health treatment.

Similar to inpatient and individual outpatient treatment, coverage of PHP services would depend on the provider of the services.

MLN Matters® special edition article [SE1512](#) titled "Partial Hospitalization Program (PHP) Claims Coding & CY2015 per Diem Payment Rates" is intended for hospitals and

Community Mental Health Centers (CMHCs) that submit claims to MACs for PHP services provided to Medicare beneficiaries. In SE1512, CMS reminds hospitals and CMHCs that provide PHP services to follow existing claim coding requirements given in the *Medicare Claims Processing Manual* (Chapter 4, Section 260) at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf>.

Coverage and payment would be for those PHP services that are recognized by Medicare. For instance, Medicare could pay for psychotherapy by an enrolled licensed clinical psychologist or psychiatrist.

Substance abuse treatment by suppliers of services

There are individuals under the Medicare Part B program who are authorized as suppliers of services that are eligible to furnish substance abuse treatment services providing the services are reasonable and necessary and fall under their State scope of practice.

These suppliers of services include:

- Physicians (medical doctor or doctor of osteopathy);
- Clinical psychologists;
- Clinical social workers;
- Nurse practitioners;
- Clinical nurse specialists;
- Physician assistants; and,
- Certified nurse-midwives.

Screening, brief intervention, and referral to treatment (SBIRT) services

SBIRT is an early intervention approach that targets individuals with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. This approach differs from the primary focus of specialized treatment of individuals with more severe substance use, or those who meet the criteria for diagnosis of a substance use disorder.

SBIRT services aim to prevent the unhealthy consequences of alcohol and drug use among those who may not reach the diagnostic level of a substance use disorder, and helping those with the disease of addiction enter and stay with treatment. You may easily use SBIRT services in primary care settings, enabling you to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work, or family issues. For more information on the Medicare's SBIRT services, refer to Medicare's fact sheet, "Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services" at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SBIRT_Factsheet_ICN904084.pdf.

SBIRT consists of three major components:

- Structured assessment (Medicare) or screening (Medicaid): Assessing or screening a patient for risky substance use behaviors using standardized assessment or screening tools;

See **ABUSE**, next page

ABUSE

From previous page

2. Brief intervention: Engaging a patient showing risky substance use behaviors in a short conversation, providing feedback and advice; and
3. Referral to treatment: Providing a referral to brief therapy or additional treatment to patients whose assessment or screening shows a need for additional services.

The first component to the SBIRT process is assessment or screening which uses tools including the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT) Manual and the Drug Abuse Screening Test (DAST). For more information on SBIRT assessment and screening tools, as well as examples of tools, visit <https://www.integration.samhsa.gov/clinical-practice/sbirt/screening>.

Medicare covers only reasonable and necessary SBIRT services that meet the requirements of diagnosis or treatment of illness or injury (that is, when the service is provided to evaluate and/or treat patients with signs/symptoms of illness or injury) per the Social Security Act (Section 1862(a)(1)(A); see https://www.ssa.gov/OP_Home/ssact/title18/1862.htm).

Medicare pays for medically reasonable and necessary SBIRT services furnished in physicians' offices (by physicians and non-physician practitioners) and outpatient hospitals. In these settings, you assess for and identify individuals with, or at-risk for, substance use-related problems and furnish limited interventions/treatment. To bill Medicare, suppliers of SBIRT services must be:

- Licensed or certified to perform mental health services by the State in which they perform the services;
- Qualified to perform the specific mental health services rendered; and
- Working within their state scope of practice act.

Medicare pays for these services under the Medicare physician fee schedule (PFS) and the hospital outpatient prospective payment system (OPPS). For more information on Medicare's payment for SBIRT services, refer to the *Medicare Claims Processing Manual* (Chapter 4, Section 200.6) at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf>.

Drugs used to treat opioid dependence

Medicare Part D sponsors must include coverage for Part D drugs, either by formulary inclusion or via an exception, when medically necessary for the treatment of opioid dependence. Coverage is not limited to single entity products such as Subutex®, but must include combination products when medically necessary (for example, Suboxone®). For any new enrollees, CMS requires sponsors to have a transition policy to prevent any unintended interruptions in pharmacologic treatment with Part D drugs during their transition into the benefit. This transition policy, along with CMS' non-formulary exceptions/appeals requirements, should ensure that all

Medicare enrollees have timely access to their medically necessary Part D drug therapies for opioid dependence.

A Part D drug is defined, in part, as "a drug that may be dispensed only upon a prescription." Consequently, methadone is not a Part D drug when used for treatment of opioid dependence because it cannot be dispensed for this purpose upon a prescription at a retail pharmacy. (NOTE: Methadone is a Part D drug when indicated for pain). State Medicaid Programs may continue to include the costs of methadone in their bundled payment to qualified drug treatment clinics or hospitals that dispense methadone for opioid dependence.

See the *Medicare Prescription Drug Benefit Manual* (Chapter 6, Section 10.8 (Drugs Used to Treat Opioid Dependence)) at <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/chapter6.pdf>.

Note: Medicare covers diagnostic clinical laboratory services that are reasonable and necessary for the diagnosis or treatment of an illness or injury. For beneficiaries being treated for substance abuse, testing for drugs of abuse when reasonable and necessary can help manage their treatment. Information on the clinical laboratory fee schedule is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Clinical-Laboratory-Fee-Schedule-Fact-Sheet-ICN006818.pdf>.

Additional information

Providers may want to review the following resources:

- "Mental Health Services" booklet: see <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Mental-Health-Services-Booklet-ICN903195.pdf>.
- "Summary of Medicare Reporting and Payment of Services for Alcohol and/or Substance (Other than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services;" see <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1013.pdf>.
- National coverage determinations (NCDs): Inpatient Hospital Stays for the Treatment of Alcoholism (130.1); Outpatient Hospital Services for Treatment of Alcoholism (130.2); Chemical & Electrical Aversion Therapy for Treatment of Alcoholism (130.3, 130.4); Treatment of Alcoholism and Drug Abuse in a Freestanding Clinic (130.5); Treatment of Drug Abuse (Chemical Dependency) (130.6); Withdrawal Treatments for Narcotic Addictions (130.7): See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf.
- "Medicaid Program Integrity What Is a Prescriber's Role in Preventing the Diversion of Prescription Drugs?" fact sheet: See <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Drug-Diversion-ICN901010.pdf>.

See **ABUSE**, next page

ABUSE

From previous page

- “Effective Strategies for Addressing Overutilization and Abuse of Prescription Drugs in Medicare Part D”: See https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/AHIP_Overutilization_Strategies_CMS_10192015.pdf.
- “New Medicare Part D Opioid Drug Mapping Tool Available”: See <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-11-03.html>.
- “Prescription Drug Monitoring Programs: A Resource to Help Address Prescription Drug Abuse and Diversion”: See <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1250.pdf>.
- “Calendar Year (CY) 2016 Clinical Laboratory Fee Schedule (CLFS) Final Determinations” (includes 2016 coding and policy information for drugs of abuse): See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/>

[CY2016-CLFS-Codes-Final-Determinations.pdf](#).

- *MLN Matters*® Number: SE1105 (Medicare drug screen testing): See <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1105.pdf>.
- The Prescription Opioid Epidemic (CCSQ grand rounds webinar); see <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/The-Prescription-Opioid-Epidemic.pdf>.

MLN Matters® Number: SE1604
 Related Change Request (CR) #: N/A
 Related CR Release Date: N/A
 Effective Date: N/A
 Related CR Transmittal #: N/A
 Implementation Date: N/A

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.

Screening for cervical cancer with human papillomavirus testing — NCD 210.2.1

Note: This article was revised April 22, 2016, to correct the G code in two places. The correct code is G0476. All other information remains the same. This information was previously published in the [February 2016 Medicare A Connection, page 1](#).

Provider types affected

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

Provider action needed

Change request (CR) 9434 announces that the Centers for Medicare & Medicaid Services (CMS) has determined that, effective for dates of service on or after July 9, 2015, evidence is sufficient to add human papillomavirus (HPV) testing under specified conditions. Make sure that your billing staffs are aware of this change.

Background

Medicare covers a screening pelvic examination and Pap test for all female beneficiaries at 12- or 24-month intervals, based on specific risk factors; however, current Medicare coverage does not include the HPV testing.

Section 1861(ddd) of the Social Security Act (the Act) (see http://www.ssa.gov/OP_Home/ssact/title18/1861.htm) states that CMS may add coverage of “additional preventive services” through the national coverage determination (NCD) process. The preventive services

must meet all of the following criteria:

1. Reasonable and necessary for the prevention or early detection of illness or disability;
2. Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and,
3. Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS has reviewed the USPSTF recommendations and supporting evidence for screening for cervical cancer with HPV co-testing, and has determined that the criteria were met. Therefore, effective for claims with dates of service on or after July 9, 2015, CMS will cover screening for cervical cancer with HPV co-testing under the following conditions:

CMS has determined that the evidence is sufficient to add HPV testing once every 5 years as an additional preventive service benefit under the Medicare program, for asymptomatic beneficiaries aged 30 to 65 years in conjunction with the Pap smear test. CMS will cover screening for cervical cancer with the appropriate U.S. Food and Drug Administration (FDA)-approved/cleared laboratory tests, used consistent with FDA-approved labeling, and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations.

A new Healthcare Common Procedure Coding System (HCPCS) code, G0476 (HPV combo assay, CA screen), type of service (TOS) 5 (diagnostic lab), has been created for this benefit. This code will:

See HPV, next page

HPV

From previous page

- Be effective retroactive back to the effective date of July 9, 2015;
- Be included in the January 2016, integrated outpatient code editor, outpatient prospective payment system, and Medicare physician fee schedule database;
- Be MAC-priced from July 9, 2015, through December 31, 2016, and during this period code G0476 is paid only when it is billed by a laboratory entity; and,
- Beginning January 1, 2017, this will be priced and paid according to the clinical laboratory fee schedule (CLFS).

In addition, you should be aware of the following:

1. Your MACs will not apply beneficiary coinsurance and deductibles to claim lines containing HCPCS G0476, HPV screening;
2. Part B MACs shall only accept claims with a place of service code equal to '81', independent lab or '11', office; and
3. Effective for claims with dates of service on or after July 9, 2015, your MACs will deny line-items on claims containing HCPCS G0476, HPV screening, when reported more than once in a five-year period [at least four years and 11 months (59 months total) must elapse from the date of the last screening]. The next eligible dates for this service are shown on all common working file (CWF) provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN).

When denying a line-item on a claim for this requirement they will use the following messages:

- Claim adjustment reason code (CARC) 119 – “Benefit maximum for this time period or occurrence has been reached;”
 - Remittance advice remark code (RARC) N386 – “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. 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;”
 - Group code “CO” if the claim contains a GZ modifier to denote a signed advance beneficiary notice (ABN) is not on file or with group code “PR” (patient responsibility) if the claim has a GA modifier to show a signed ABN is on file.
4. HCPCS code G0476 will be paid only for institutional claims submitted on type of bill codes (TOB) 12x, 13x, 14x, 22x, 23x, and 85x. Institutional claims on other TOBs will be returned to the provider.
 5. Effective for claims with dates of service on or after July 9, 2015, your MACs will deny line-items on claims containing HCPCS G0476, HPV screening, when the

beneficiary is less than 30 years of age or older than 65 years of age.

When denying a line-item on claims for this requirement, they will use 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” if the claim contains a GZ modifier to denote a signed advance beneficiary notice (ABN) is not on file or with group code “PR” (patient responsibility) if the claim has a GA modifier to show a signed ABN is on file.
6. Effective for claims with dates of service on or after July 9, 2015, you must report the following diagnosis codes when submitting claims for HCPCS G0476:
 - ICD-9 (for dates of service prior to October 1, 2015): V73.81, special screening exam, HPV (as primary), and V72.31, routine gynecological exam (as secondary)
 - ICD-10: Z11.51, encounter for screening for HPV, and Z01.411, encounter for gynecological exam (general)(routine) with abnormal findings, OR Z01.419, encounter for gynecological exam (general)(routine) without abnormal findings.

Effective on this date, your MACs will deny line-items on claims containing HCPCS Code G0476, HPV screening, when the claim does not contain these codes.

When denying a line-item on claim for this requirement, they will use 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. If you do not have web access, you may contact the contractor to request a copy of the NCD;” and
- Group code CO.
- This NCD does not change current policy as it relates to screening for pap smears and pelvic exams as described in the *Medicare NCD Manual*, Section 210.2, or in the *Medicare Claims Processing Manual*, Chapter 18, Section 30, which you can find at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf.

See **HPV**, next page

Eighth coding revisions to national coverage determinations

Provider types affected

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

Provider action needed

CR 9631 is the 8th maintenance update of International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR 7818, CR 8109, CR 8197, CR 8691, CR 9087, CR 9252, and CR 9540, while others are the result of revisions required to other NCD-related CRs released separately. Review *MLN Matters*® articles [MM7818](#), [MM8109](#), [MM8197](#), [MM8691](#), [MM9087](#), [MM9252](#), and [MM9540](#) for information pertaining to these CR's.

Background

The translations from ICD-9 to ICD-10 are not consistent one-to-one matches, nor are all ICD-10 codes appearing in a complete general equivalence mappings (GEMS) guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.

No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Updated NCD coding spreadsheets related to CR 9631 are available at <https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9631.zip>.

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

To be specific, CR 9631 makes adjustments to the following NCDs:

- NCD 20.4 -Implantable automatic defibrillators
- NCD 20.7 -Percutaneous transluminal angioplasty (PTA)
- NCD 20.9 - Artificial hearts
- NCD 20.29 - Hyperbaric oxygen therapy
- NCD 50.3 - Cochlear implants
- NCD 110.18 - Aprepitant
- NCD 210.3 - Colorectal cancer screening
- NCD 220.4 - Mammography
- NCD 230.9 - Cryosurgery of prostate
- NCD 260.9 - Heart transplants
- NCD 210.4 - Smoking/tobacco-use cessation counseling
- NCD 210.4.1 - Counseling to prevent tobacco use

See **NCD**, next page

HPV

From previous page

Additional information

The official instruction, CR 9434, was issued to your MAC via two transmittals. The first updates the *NCD Manual* and is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R189NCD.pdf> and the second transmittal updates the *Medicare Claims Processing Manual* and it is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3460CP.pdf>.

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

Document history

- This article was revised April 22, 2016, to correct the reference to G0476 in two places. The original article

mentioned G4076, which is incorrect. All references should have shown G0476.

MLN Matters® Number: MM9434 *Revised*
 Related Change Request (CR) #: CR 9434
 Related CR Release Date: February 5, 2016
 Effective Date: July 9, 2015
 Implementation Date: July 5, 2016 (CWF analysis and design), October 3, 2016 (CWF coding, testing and Implementation, MCS and FISS implementation; January 3, R3460CP 2017 (requirement 9434-04.8.2), March 7, 2016 (non-shared MAC edits)
 Related CR Transmittal #: R189NCD and R3460CP

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.

Seventh coding revisions to national coverage determinations

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) 9540 is the 7th maintenance update of the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

Background

The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically, CR 7818, CR 8109, CR 8197, CR 8691, CR 9087, and CR 9252. You may review the corresponding *MLN Matters*[®] articles MM7818, MM8109, MM8197, MM8691, MM9087, and MM9252 for these CRs on the Centers for Medicare & Medicaid Services (CMS) website. Some are the result of revisions required to other NCD-related CRs released separately.

Updated NCD coding spreadsheets related to CR 9540 are available at <https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9540.zip>. CR 9540 updates the following 14 NCDs:

1. NCD 20.29 - Hyperbaric oxygen therapy
2. NCD 90.1 - Pharmacogenomic testing for warfarin response
3. NCD 110.18 - Aprepitant for chemotherapy-induced emesis
4. NCD 150.3 - Bone mineral density studies
5. NCD 160.18 - Vagus nerve stimulation for treatment of seizures
6. NCD 160.24 - Deep brain stimulation for essential tremor

7. NCD 210.3 - Colorectal cancer screening tests
8. NCD 210.14 - Screening for lung cancer with low-dose CT (CR 9246)
9. NCD 230.18 - Sacral nerve stimulation for urinary incontinence
10. NCD 260.1 - Adult liver transplantation (CR 9252, CR 8109)
11. NCD 110.4 - Extracorporeal photopheresis
12. NCD 20.33 - Transcatheter mitral valve repair (CR 9002, TDL 150341, policy effective August 7, 2014)
13. NCD 220.13 - Percutaneous image-guided breast biopsy
14. NCD 220.4 - Mammograms

MACs will adjust any claims already processed, if erroneously impacted by the above changes, if you bring such claims to their attention.

Additional information

The official instruction, CR 9540, issued to your MAC regarding this change is available for download at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1658OTN.pdf>.

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

MLN Matters[®] Number: MM9540
 Related Change Request (CR) #: CR 9540
 Related CR Release Date: April 29, 2016
 Effective Date: July 1, 2016
 Related CR Transmittal #: R1658OTN
 Implementation Date: July 5, 2016, unless otherwise noted

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.

NCD

From previous page

Additional information

The official instruction, CR 9631, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1665OTN.pdf>.

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

MLN Matters[®] Number: MM9631

Related Change Request (CR) #: CR 9631
 Effective Date: October 1, 2016 - unless noted differently in CR 9631
 Related CR Release Date: May 13, 2016
 Related CR Transmittal #: R1665OTN
 Implementation Date: October 3, 2016

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT[®] only copyright 2015 American Medical Association.

This section of *Medicare B 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 (MAC) jurisdiction N (JN) 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.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the First Coast eNews mailing list. Simply go to <http://medicare.fcso.com/Header/137525.asp>, enter your email address and select the subscription option that best meets your needs.

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



Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? First Coast's LCD lookup, available at http://medicare.fcso.com/coverage_find_lcds_and_ncds/lcd_search.asp, helps you find the coverage information you need quickly and easily. Just enter a procedure code, keyword, or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your Internet connection, the LCD search process can be completed in less than 10 seconds.

Advance beneficiary notice

Modifier GZ must be used when 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 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 must append the billed service with modifier GA or GZ.

“ We are aware of the changes in medical policies via First Coast eNews we receive every week. We are continuously monitoring to identify changes and thus prevent claims to be denied. ”

Sign up for eNews by clicking [here](#).



*– Luis Rodríguez Félix,
Billing manager, Ashford Presbyterian
Community Hospital*

Revisions to LCDs

Amniotic membrane - sutureless placement on the ocular surface – revision to the Part A and Part B LCD

LCD ID number: L36237 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for amniotic membrane – sutureless placement on the ocular surface was revised to add ICD-10-CM diagnosis code ranges H16.121–H16.129 (Filamentary keratitis) and H16.231–H16.239 (Neurotrophic keratoconjunctivitis) for CPT® code 65778 to the “ICD-10 Codes that Support Medical Necessity” section of the LCD.

Effective date

This LCD revision is effective for services rendered **on or after April 6, 2016**. First Coast Service Options Inc.

LCDs are available through the CMS Medicare coverage database at <https://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](#).



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 <https://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.

System changes to implement temporary exception for certain severe wound discharges

Provider types affected

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

Provider action needed

Change request (CR) 9599 implements a temporary exception for certain wound care discharges from the site neutral payment rate for certain LTCHs. Make sure your billing staffs are aware of this exception.

Background

Under the LTCH prospective payment system (PPS), for LTCH discharges in cost reporting periods beginning on or after October 1, 2015, Medicare established two separate payment categories for LTCH patients upon discharge. LTCH cases meeting specific clinical criteria are paid the LTCH PPS standard federal rate payment and those cases not meeting specific clinical criteria are paid the site neutral rate payment (that is, the lesser of an “inpatient prospective payment system (IPPS)-comparable” payment amount or 100 percent of the estimated cost of the case).

In general, in order to be paid at the LTCH PPS standard Federal rate payment amount, an LTCH discharge must either:

1. Have been admitted directly from an IPPS hospital during which at least three days were spent in an intensive care unit (ICU) or coronary care unit (CCU), but the discharge must not have a principal diagnosis in the LTCH of a psychiatric or rehabilitation diagnosis; or
2. Have been admitted directly from an IPPS hospital and the LTCH discharge is assigned to an MS-LTC-DRG based on the receipt of ventilator services of at least 96 hours, but must not have a principal diagnosis in the LTCH of a psychiatric or rehabilitation diagnosis.

Section 231 of the Consolidated Appropriations Act, 2016, establishes a temporary exception from the site neutral payment rate for certain patients discharged from certain LTCHs before January 1, 2017.

As implemented, this exception applies to discharges occurring on or after April 21, 2016, and prior to January 1, 2017, from LTCHs “identified by the amendment made by Section 4417(a) of the Balanced Budget Act of 1997” and “located in a rural area” or “treated as being so located” pursuant to Section 1886(d)(8)(E) of the Social Security Act when the individual discharged had a “severe wound.” The final payment for discharges that meet the statutory provider-level and discharge-level criteria as implemented by the Centers for Medicare & Medicaid Services (CMS) is based on the LTCH PPS standard federal payment rate. This temporary statutory exception from the site neutral

payment rate was implemented in an interim final rule with comment period (IFC) (published in the *Federal Register* on April 21, 2016).

Provider-level criteria

The statute specifies that the temporary exclusion for certain discharges from the site neutral payment rate is applicable to an LTCH that is “identified by the amendment made by Section 4417(a) of the Balanced Budget Act of 1997.” As discussed in the IFC, CMS has interpreted the phrase to mean hospitals which are described in 42 CFR Section 412.23(e)(2)(i) that meet the criteria of Section 412.22(f), which are a group of LTCHs commonly referred to as “grandfathered hospitals-within-hospitals” (or grandfathered HwHs). **Note:** An HwH is defined in the regulations at 42 CFR 412.22(e) as a hospital which occupies space in a building also used by another hospital or on the campus of another hospital). Therefore, in order to be eligible for this temporary exception, an LTCH must have participated in Medicare as an LTCH and have been co-located with another hospital as of September 30, 1995, and must currently meet the requirements of Section 412.22(f).

Section 412.22(f) requires that, in order to maintain grandfathered status, an HwH must continue to operate under the same terms and conditions including but not limited to the number of beds.

There are several reasons for which an LTCH described in Section 412.23(e)(2)(i) may not currently meet the criteria in Section 412.22(f). For example, the LTCH may have more than one location, or the HwH may have increased beds after September 30, 2003 (CMS notes these examples are not intended to be an exhaustive list of the reasons an LTCH may not meet the criteria in Section 412.22(f)). MACs must verify that an LTCH described in Section 412.23(e)(2)(i) currently meets the criteria in Section 412.22(f) in order for the LTCH to be eligible for this temporary exception from the site neutral payment rate for certain wound care discharges. This process will likely involve direct outreach to LTCHs in order to verify the required information. Additional information on the requirement that grandfathered HwHs meet the criteria in § 412.22(f) can be found in the following IPPS rules: FY 1997 IPPS final rule (62 FR 46012); FY 2004 IPPS final rule (68 FR 45463); May 22, 2008 LTCH PPS interim final rule with comment period (73 FR 29703); and FY 2010 IPPS/RV 2010 LTCH PPS final rule (74 FR 43980).

The temporary statutory exclusion for certain discharges from the site neutral payment rate is further limited to grandfathered HwH LTCHs that are “located in a rural area” or “treated as being so located” pursuant to Section 1886(d)(8)(E) of the Act. For purposes of this provision, “located in a rural area” refers to LTCHs that are currently located in a rural area as defined under § 412.503 (that is, located in any area outside an urban area, which is an

See **WOUND**, next page

WOUND

From previous page

area within a metropolitan statistical area (as defined by the Office of Management and Budget)). (Information on the current labor market area geographic classifications used under the LTCH PPS is available in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50180 through 50185)).

Section 1886(d)(8)(E) of the Act provides for an urban IPPS hospital that is located in an urban area to be reclassified as a rural hospital if it submits an application in accordance with CMS' established criteria and meets certain conditions (see Section 412.103). (Additional information on CMS' policies for IPPS hospitals located in urban areas and that apply for reclassification as rural under § 412.103 can be found in the FY 2012 IPPS/ LTCH PPS final rule (76 FR 51595).)

For the purpose of implementing the phrase “treated as being so located” pursuant to Section 1886(d)(8)(E) of the Act for the temporary statutory exclusion for certain LTCH discharges from the site neutral payment rate, CMS revised its regulations to “borrow” the existing rural reclassification process for urban IPPS hospitals under § 412.103 and to allow grandfathered HwH LTCHs (defined above) to apply to their CMS regional office for treatment as being located in a rural area for the sole purpose of qualifying for this temporary exclusion from the application of the site neutral payment rate.

For grandfathered HwH LTCHs that qualify for this temporary exception for certain wound care discharges from the site neutral payment rate by applying for and satisfying the criteria to reclassify as rural under the provisions of § 412.103, the exception from the site neutral payment rate for qualifying discharges is effective beginning the effective date of the rural reclassification (that is, as of the filing date of the application as specified in § 412.103).

Note: This policy only allows grandfathered HwH LTCHs to apply for this reclassification, and the rural treatment only extends to this statutory temporary exception for certain wound care discharges from the site neutral payment rate, and reclassifying grandfathered HwH LTCH will not be treated as rural under the LTCH PPS for any other reason including, but not limited to, the 25 percent policy and wage index). Any rural treatment under the provisions of § 412.103 for a grandfathered HwH LTCH will expire at the same time as this temporary provision (that is, December 31, 2016).

Discharge-level criteria

As implemented, the statutory temporary exclusion for certain discharges from the site neutral payment rate for certain LTCHs is applicable to discharges occurring on or after April 21, 2016, and on or before December 31, 2016, that had a “severe wound.” The statute defines a “severe wound” as, “a stage three wound, stage four wound, unstageable wound, non-healing surgical wound, infected wound, fistula, osteomyelitis, or wound with morbid obesity as identified in the claim from the long-term care hospital.”

To implement this statutory definition, CMS has defined wound as “an injury, usually involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment.” To implement this definition, CMS is using ICD-10 diagnosis codes on the claim where ICD-10 diagnosis codes contain sufficient specificity for this purpose or through the use of a payer-specific condition code where the ICD-10 diagnosis codes lack sufficient specificity for this purpose.

For six of the eight statutory categories included in the definition of “severe wound” (stage three wound, stage four wound, unstageable wound, non-healing surgical wound, fistula, and osteomyelitis), CMS is using the list of ICD-10 diagnosis codes found on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html>.

Note: Under the CMS definition of wound, the ICD-10 diagnosis codes used to identify severe wounds in the osteomyelitis category are also part of the ICD-10 diagnosis codes used to identify severe wounds in the fistula category so no separate identification of ICD-10 codes for osteomyelitis is necessary.

The remaining two statutory categories included in the definition of “severe wound” (infected wound and wound with morbid obesity) lack ICD-10 diagnosis codes with sufficient specificity to identify the presence of a “severe” wound, so claims containing such wounds will be identified by using specified “payer-only” condition codes.

For the purposes of this provision, CMS has defined a “wound with morbid obesity” as “a wound in those with morbid obesity that require complex, continuing care including local wound care occurring multiple times a day” and an “infected wound” as “a wound with infection requiring complex, continuing care including local wound care occurring multiple times a day.” If an LTCH has a discharge meeting this definition of “wound with morbid obesity” or “infected wound” the LTCH will inform its MAC, and the MAC will then place the payer-only condition code “M4” on the claim for processing.

The presence of that designated payer-only condition code on the claim for qualifying rural (or reclassified rural) grandfathered HwH LTCHs will generate a standard Federal payment rate payment for the claim (that is, exclusion from the site neutral payment rate) consistent with this statutory provision in the LTCH PPS Pricer and claim processing system.

MACs will reprocess claims with a through date (for interim claims) or a discharge date (for final claims) on or after April 21, 2016, through December 31, 2016, when the temporary relief indicator for an LTCH on the provider specific file (PSF) equals ‘Y’ and one of the ICD-10 diagnosis codes listed on the CMS website mentioned above is present. The claims shall be reprocessed within 60 days from the implementation date of this change request. MACs will adjust impacted LTCH inpatient claims with a through date (for interim claims) or a discharge date (for final claims) on or after April 21, 2016, through

See **WOUND**, next page

Allogeneic hematopoietic stem cell transplantation

Provider types affected

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

Provider action needed

Change request (CR) 9620, from which this article was developed, notifies providers that effective for claims with dates of service on and after January 27, 2016, for the use of allogeneic hematopoietic stem cell transplantation (HSCT) for treatment of multiple myeloma, myelofibrosis, and sickle cell disease is covered by Medicare, but only if provided in the context of a Medicare-approved clinical study meeting specific criteria under the coverage with evidence development (CED) paradigm.

CR 9620 also clarifies the ICD-9 and ICD-10 diagnosis codes for allogeneic HSCT for treatment of myelodysplastic syndromes (MDS) in the context of a Medicare-approved, prospective clinical study under CED. Specifically, for dates of service on or after August 4, 2010, through September 30, 2015, the ICD-9-CM diagnosis codes are 238.72, 238.73, 238.74, or 238.75, and clinical trial ICD-9-CM diagnosis code V70.7. For dates of service on or after October 1, 2015, the ICD-10-CM diagnosis codes are D46.A, D46.B, D46.C, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, or D46.Z AND clinical trial ICD-10-CM diagnosis code Z00.6. Make sure your billing staff is aware of these determinations.

Background

HSCT is a process that includes mobilization, harvesting, and transplant of stem cells and the administration of high-dose chemotherapy and/or radiotherapy prior to the actual transplant. During the process stem cells are harvested from either the patient (autologous) or a donor (allogeneic) and subsequently administered by intravenous infusion to the patient.

Multiple myeloma is a neoplastic plasma-cell disorder. Myelofibrosis is a stem cell-derived hematologic disorder. Sickle cell disease is a group of inherited red blood cell disorders created by the presence of abnormal hemoglobin genes. On April 30, 2015, the Centers for Medicare & Medicaid Services (CMS) accepted a formal request from the American Society for Blood and Marrow Transplantation (ASBMT) to reconsider its policy and expand coverage of allogeneic HSCT for sickle cell disease, myelofibrosis, multiple myeloma and rare diseases.

Myelodysplastic syndrome (MDS) refers to a group of diverse blood disorders in which the bone marrow does not produce enough healthy, functioning blood cells. On August 4, 2010, CMS issued a final decision stating that allogeneic HSCT for MDS is covered by Medicare only if provided pursuant to a Medicare-approved clinical study under CED. CR 7137 (see the article, MM7137 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7137.pdf>) provides specific ICD-9 related coding and claim processing requirements regarding this particular coverage decision, and CRs 8197 and 8691 (see MM8197 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8197.pdf> and MM8691 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8691.pdf>) provide ICD-10 related coding requirements. On November 30, 2015, CMS accepted a formal request from the National Marrow Donor Program (NMDP) to clarify the list of ICD-9-CM and ICD-10-CM diagnosis codes covered for allogeneic HSCT for the treatment of MDS in the context of a Medicare-approved clinical study under CED.

On January 27, 2016, CMS issued a final decision to expand national coverage of items and services necessary for research in an approved clinical study via coverage with evidence development (CED) under Section 1862(a)(1)(E) of the Social Security Act (the Act) for allogeneic

See **HSCT**, next page

WOUND

From previous page

December 31, 2016, processed prior to implementation of CR 9599 or after when brought to the attention of the MAC by a qualifying LTCH.

Note: Claims for LTCHs which are treated as rural for the purposes of this provision will be reprocessed with a through date (for interim claims) or a discharge date (for final claims) on or after the effective date of the rural reclassification.

Additional information

The official instruction, CR 9599, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1654OTN.pdf>.

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

MLN Matters® Number: MM9599
 Related Change Request (CR) #: CR 9599
 Related CR Release Date: April 29, 2016
 Effective Date: April 21, 2016
 Related CR Transmittal #: R1654OTN
 Implementation Date: October 3, 2016

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.

HSCT

From previous page

HSCT for the following indications:

- Multiple myeloma
- Myelofibrosis
- Sickle cell disease

Refer to the following Medicare manual sections for more information regarding this NCD and further billing instructions specific to this NCD and the business requirements specific to CR 9620:

- Chapter 1, Section 110.23, of the *Medicare NCD Manual*, which is attached to the CR 9620 NCD transmittal at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R191NCD.pdf>.
- Chapter 1, Section 310.1, of the *Medicare NCD Manual*, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf, and
- Chapter 32, Sections 69 and 90, of the *Medicare Claims Processing Manual*, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf>.

In addition to the diagnosis codes detailed at the beginning of this article, providers need to be aware of the other billing requirements, as follows:

Inpatient claims

For claims submitted on type of bill 11x for discharges on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- An ICD-10-PCS procedure code of 30230G1, 30230Y1, 30233G1, 30233Y1, 30240G1, 30240Y1, 30243G1, 30243Y1, 30250G1, 30250Y1, 30253G1, 30253Y1, 30260G1, 30260Y1, 30263G1, or 30263Y1; **and**
- The clinical trial ICD-10-CM code of Z00.6; **and**
- Condition code 30, denoting qualifying clinical trial; **and**
- Value code D4 showing the clinical trial number (assigned by NLM/NIH with an 8-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
 - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 OR
 - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 OR
 - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Outpatient claims

For claims submitted on type of bill 13x or 85x for dates

of service on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- An HSCT CPT® code of 38240; **and**
- The clinical trial ICD-10-CM code of Z00.6; **and**
- Condition code 30, denoting qualifying clinical trial; **and**
- Value code D4 showing the clinical trial number (assigned by NLM/NIH with an eight-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
 - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02; **or**
 - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81; **or**
 - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Method II critical access hospital (CAH) claims

For claims submitted on type of bill 85x with revenue codes 96x, 97x, or 98x for dates of service on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- An HSCT CPT® code of 38240; **and**
- The clinical trial ICD-10-CM code of Z00.6; **and**
- Condition code 30, denoting qualifying clinical trial; **and**
- Value code D4 showing the clinical trial number (assigned by NLM/NIH with an eight-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
 - Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02; **or**
 - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81; **or**
 - Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Professional claims

For professional claims submitted on type of bill 85x with revenue codes 96x, 97x, or 9x for dates of service on or after January 27, 2016, for HSCT for the treatment of multiple myeloma, myelofibrosis, or sickle cell disease, the claim must show:

- An HSCT CPT® code of 38240; **and**
- The clinical trial ICD-10-CM code of Z00.6; **and**
- The Q0 modifier; **and**
- A place of service code of 19, 21, or 22 along with the appropriate ICD-10-CM diagnosis code of:

See **HSCT**, next page

HSCT

From previous page

- Multiple myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02; **or**
- Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81; **or**
- Sickle cell disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

For all of the above claims types submitted without the requisite coding, MACs will deny the claims using the following messages:

- **Claim adjustment reason code (CARC) 50** - These are non-covered services because this is not deemed a 'medical necessity' by the payer. **Note:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Remittance advice remarks code (RARC) N386** - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <https://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.
- **Group code** - patient responsibility (PR) if an advance beneficiary notice (ABN)/hospital notice on non-coverage (HINN), otherwise contractual obligation (CO)

For claims with dates of service prior to the implementation date of CR 9620, MACs shall perform necessary adjustments only when the provider brings such claims to the attention of their MAC.

Additional information

The official instruction, CR 9620, consists of two transmittals. The first updates the *Medicare Claims Processing Manual* at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3509CP.pdf>. The second transmittal updates the *Medicare NCD Manual* at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R191NCD.pdf>.

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

MLN Matters® Number: MM9620

Related Change Request (CR) #: CR 9620

Related CR Release Date: April 29, 2016

Effective Date: January 27, 2016

Related CR Transmittal #: R191NCD and R3509CP

Implementation Date: October 3, 2016

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.

Percutaneous left atrial appendage closure

Provider types affected

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

Provider action needed

Change request (CR) 9638 informs MACs that the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) covering percutaneous left atrial appendage closure (LAAC) through coverage with evidence development (CED) when LAAC is furnished in patients with non-valvular atrial fibrillation (NVAF) and the device has received Food and Drug Administration (FDA) premarket approval (PMA) for that device's FDA-approved indication and meets all the specified conditions. Make sure that your billing staffs are aware of these changes.

Background

LAAC is a strategy to reduce the risk of stroke by closing the left atrial appendage (LAA) in patients with NVAF. Patients with NVAF, an abnormally rapid, irregular heartbeat, are at an increased risk of stroke. Some evidence suggests that many of the strokes attributed to NVAF originate from the LAA. The LAA is a tubular

structure that opens into the left atrium of the heart. LAAC with a percutaneously implanted device could be used in patients with NVAF to reduce cardioembolic stroke risk as a potential alternative to oral anticoagulation.

On February 8, 2016, CMS issued an NCD covering percutaneous LAAC through CED when LAAC is furnished in patients with NVAF and the device has received FDA PMA for that device's FDA-approved indication and meets all the specified conditions. Coverage requires that patients must have:

- A CHADS2 score ≥ 2 (congestive heart failure, hypertension, Age >75 , diabetes, stroke/transient ischemia attack/thromboembolism) or CHA2DS2-VASc score ≥ 3 (congestive heart failure, hypertension, Age ≥ 65 , diabetes, stroke/transient ischemia attack/thromboembolism, vascular disease, sex category)
- A formal shared decision making interaction with an independent non-interventional physician using an evidence-based decision tool on oral anticoagulation in patients with NVAF prior to LAAC. Additionally, the shared decision making interaction must be documented in the medical record
- A suitability for short-term warfarin but deemed unable to take long term oral anticoagulation following the

See **LAAC**, next page

LAAC

From previous page

conclusion of shared decision making, as LAAC is only covered as a second line therapy to oral anticoagulants

The NCD lists the criteria for the physician and facility criteria and includes a requirement for a multidisciplinary team to be engaged in patient care.

The patient must be enrolled in, and the multidisciplinary team (MDT) and hospital must participate in a prospective, national, audited registry that: 1) consecutively enrolls LAAC patients and 2) tracks the specified annual outcomes for each patient for a period of at least four years from the time of the LAAC. The registry must address pre-specified research questions, adhere to standards of scientific integrity, and be approved by CMS. Approved registries will be posted at <https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/LAAC.html>. The process for submitting a registry to Medicare is outlined in the NCD.

For devices and indications that are not approved by FDA, patients must be enrolled in a qualifying FDA-approved randomized controlled trial (RCT). The clinical study must address pre-specified research questions, adhere to standards of scientific integrity, and be approved by CMS-approved studies will be posted at <https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/LAAC.html>. The process for submitting a clinical research study to Medicare is outlined in the NCD.

LAAC claims with dates of service on or after February 8, 2016, will be billed with temporary level III CPT® code 0281T (percutaneous transcatheter closure of the left atrial appendage with implant, including fluoroscopy, transeptal puncture, catheter placement(s) left atrial angiography, left atrial appendage angiography, radiological supervision and interpretation) and will be MAC-priced. CMS will issue further instructions, once a permanent CPT® level 1 replaces the temporary code.

LAAC is non-covered for the treatment of NVAf when not furnished under CED according to the criteria outlined in the NCD, which is at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R192NCD.pdf>.

Additional billing instructions

On institutional claims (type of bill 11x), hospitals should show:

- ICD-10 procedure code of 02L73DK (occlusion of left atrial appendage with intraluminal device, percutaneous approach)
- A primary diagnosis code of one of the following:
 - I48.0 – Paroxysmal atrial fibrillation
 - I48.1 – Persistent atrial fibrillation
 - I48.2 – Chronic atrial fibrillation
 - I48.91 – Unspecified atrial fibrillation

- A secondary ICD-10 diagnosis code of Z00.6 – Encounter for examination for normal comparison and control in clinical research program
- Condition code 30 (Qualifying clinical trial), and
- Value code D4 – Clinical trial number (assigned by NLM/NIH with an eight-digit clinicaltrials.gov identifier number listed on the CMS website)

MACs will fully reject inpatient claims for LAAC with discharges on or after February 8, 2016, when billed without the appropriate procedure, diagnosis, or clinical trial codes, with the following messages:

- **Claim adjustment reason code (CARC) 50** – These are non-covered services because this is not deemed a “medical necessity” by the payer.
- **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 <https://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.
- **Group code** – contractual obligation (CO)

Professional claims with dates of service on or after February 8, 2016, for LAAC under CED will be paid only when billed with the following codes:

- CPT® 0281T
- Primary ICD-10 diagnosis code (one of the following):
 - I48.0 – Paroxysmal atrial fibrillation,
 - I48.1 – Persistent atrial fibrillation,
 - I48.2 – Chronic atrial fibrillation,
 - I48.91 – Unspecified atrial fibrillation
- Place of service code of 21 (inpatient hospital)
- Secondary diagnosis code Z00.6
- Modifier Q0
- Clinical trial number in item 23 of the CMS-1500 form or electronic equivalent

MACs will deny LAAC claims when billed without the appropriate diagnosis codes, with the following messages:

- **CARC 50** – These are non-covered services because this is not deemed a “medical necessity” by the payer. **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 <https://www.cms.hhs.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code** – contractual obligation (CO).

See **LAAC**, next page

LAAC

From previous page

MACs will deny claims for LAAC with 0281T with a POS code other than 21 using the following messages:

- **CARC 58** – “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- **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 <https://www.cms.hhs.gov/mcd/search.asp>. If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- **Group code** – contractual obligation (CO).

MACs will return claim lines on professional claims for 0281T as unprocessable when the Q0 modifier is not present using messages:

- **CARC 4**: “The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- **Group code** – contractual obligation (CO)

MACs will return claim lines with 0281T as unprocessable when billed without secondary diagnosis code Z00.6 using the following messages:

- **CARC 16**: “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)”
- **RARC M76**: “Missing/incomplete/invalid diagnosis or condition.”
- **Group code** – contractual obligation (CO)

Finally, failure to include the clinical trial number will result in MACs returning claim lines as unprocessable using the following messages:

- **CARC 16**: “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)”
- **RARC MA50**: Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number.
- **Group code** – contractual obligation (CO)

Note that MACs will not search their files for claims for LAAC with dates of service on or after February 8, 2016, that were processed prior to implementation of CR 9638. However, they will adjust such claims that you bring to their attention.

Additional information

The official instruction, CR 9638, consists of two transmittals. The first contains the actual NCD and is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R192NCD.pdf>. The second provides the claim processing instructions and it is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3515CP.pdf>.

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

MLN Matters® Number: MM9638
 Related Change Request (CR) #: CR 9638
 Related CR Release Date: May 6, 2016
 Effective Date: February 8, 2016
 Related CR Transmittal #: R192NCD and R3515CP
 Implementation Date: October 3, 2016

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.

Shared savings program accountable care organization qualifying stay edits

Provider types affected

This *MLN Matters*® article is intended for hospitals and skilled nursing facilities (SNFs) working with accountable care organizations (ACOs) participating in the Medicare shared savings program (SSP) and submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9568 allows the processing of SNF claims without having to meet the three-day hospital stay requirement for certain designated SNFs that have a relationship with an ACO participating in the SSP. Make sure that your SNF is clear on whether or not it is eligible to participate in this initiative and that your billing staffs are aware of these changes.

Background

The Medicare SNF benefit is for beneficiaries who require a short-term intensive stay in a SNF, requiring skilled nursing and/or rehabilitation care. Pursuant to Section 1861(i) of the Social Security Act (the Act), beneficiaries must have a prior inpatient hospital stay of no fewer than three consecutive days in order to be eligible for Medicare coverage of inpatient SNF care. This has become known as the SNF three-day rule.

The Centers for Medicare & Medicaid Services (CMS) understands that, in certain circumstances, it could be medically appropriate for some patients to receive skilled nursing care and/or rehabilitation services provided in a SNF without prior hospitalization or with an inpatient hospital length of stay of less than three days.

Section 3022 of the Affordable Care Act amended Title XVIII of the Act by adding a new Section 1899 to establish the Medicare SSP. Under Section 1899(f), the Secretary of Health and Human Services is permitted to waive “such requirements of . . . title XVIII of this Act as may be necessary to carry out the provisions of this section.” As a result, CMS proposed and finalized through rulemaking (80 FR 32692 at <https://www.gpo.gov/fdsys/pkg/FR-2015-06-09/pdf/2015-14005.pdf>) a waiver of the prior three-day inpatient hospitalization requirement in order to provide Medicare SNF coverage when certain beneficiaries assigned to SSP ACOs in track three are admitted to designated SNF affiliates either directly from an inpatient hospital stay or after fewer than three inpatient hospital days, starting in January 2017. The waiver will be available for SSP ACOs in Track three that demonstrate the capacity and infrastructure to identify and manage patients who

would be either directly admitted to a SNF or admitted to a SNF after an inpatient hospital stay of fewer than three days, for services otherwise covered under the Medicare SNF benefit.

To identify the beneficiaries eligible to receive the SNF three-day waiver, CMS provides ACOs with a prospective beneficiary assignment list for the performance year. ACOs will receive the prospective assignment list close to the start of each performance year.

To identify the SNFs eligible to use the SNF three-day waiver, ACOs designate SNFs (as SNF affiliates) eligible to participate in the SNF three-day waiver with the ACO.

CMS will reimburse designated SNFs (specifically, SNF affiliates participating in track three SSP ACOs), for the Medicare SNF benefit without the required three-day in-patient hospitalization for beneficiaries that are prospectively assigned to the track three ACO.

Additional information

The official instruction, CR 9568, issued to your MAC regarding this change, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1660OTN.pdf>.

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

You can learn more about the SSP by visiting our website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/index.html>. To learn more about the SNF three-day waiver, visit the SSP web page and click on Statutes/Regulations/Guidance.

MLN Matters® Number: MM9568

Related Change Request (CR) #: CR 9568

Related CR Release Date: May 6, 2016

Effective Date: January 1, 2017

Related CR Transmittal #: R166OTN

Implementation Date: January 3, 2017

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.

Rural health clinics HCPCS reporting requirement and billing updates

Provider types affected

This *MLN Matters*® special edition article is intended for rural health clinics (RHCs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

This article provides information to assist RHCs in meeting the requirements to report the HCPCS code for each service furnished along with the revenue code on claims to Medicare effective for dates of service on or after April 1, 2016. Make sure your billing staff is aware of these instructions.

Background

From April 1, 2016, through September 30, 2016, all charges for a visit will continue to be reported on the service line with the qualifying visit HCPCS code, minus any charges for preventive services, using revenue code 052x for medical services and/or revenue code 0900 for mental health services. This guidance is available in *MLN Matters*® article MM9269 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9269.pdf>. The RHC qualifying visit list (QVL) can be accessed on the RHC center page located at <https://www.cms.gov/center/provider-type/rural-health-clinics-center.html>.

In April 2016, CMS instructed RHCs to hold claims only for a billable visit shown in red on the RHC QVL until October 1, 2016. Upon billing these claims and/or for claim adjustments beginning on October 1, 2016, RHCs shall add modifier CG (policy criteria applied) to the line with all the charges subject to coinsurance and deductible. The subsequent paragraph explains modifier CG further.

Beginning October 1, 2016, the MACs will accept modifier CG on RHC claims and claim adjustments. RHCs shall report modifier CG on one revenue code 052x and/or 0900 service line per day, which includes all charges subject to coinsurance and deductible for the visit. For RHCs, the coinsurance is 20 percent of the charges. Therefore, coinsurance and deductible will be based on the charges reported on the revenue code 052x and/or 0900 service line with modifier CG. RHCs will continue to be paid an all-inclusive rate (AIR) per visit.

Coinsurance and deductible are waived for the approved preventive health services in Table 1. When a preventive health service is the primary service for the visit, RHCs should report modifier CG on the revenue code 052x service line with the preventive health service. Medicare will pay 100 percent of the AIR for the preventive health service.

Table 1: Approved preventive health services with coinsurance and deductible waived

HCPCS code	Short descriptor
G0101	Ca screen; pelvic/breast exam
G0296	Visit to determ LDCT elig

HCPCS code	Short descriptor
G0402	Initial preventive exam
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel >10
G0438	Ppps, initial visit
G0439	Ppps, subseq visit
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High inten beh couns std 30 min
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15 min
Q0091	Obtaining screen pap smear

Each additional service furnished during the visit should be reported with the most appropriate revenue code and charges greater to or equal to \$0.01. The additional service lines are for informational purposes only. MACs will continue to package/bundle the additional service lines, which do not receive the AIR.

When the patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, the subsequent medical service should be billed using revenue code 052x and modifier 59. Beginning on October 1, 2016, RHCs can also report modifier 25 to indicate the subsequent visit was distinct or independent from an earlier visit furnished on the same day. When modifier 59 or modifier 25 is reported, RHCs will receive the AIR for an additional visit. This is the only circumstance in which modifier 59 or modifier 25 should be used.

Finally, note that the HCPCS reporting requirements have no impact in the way that telehealth or chronic care management services are reimbursed.

Additional information

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

MLN Matters® Number: SE1611
 Related Change Request (CR) #: N/A
 Related CR Release Date: N/A
 Effective Date: October 1, 2016
 Related CR Transmittal #: N/A
 Implementation Date: October 3, 2016

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.

Updates to Pub. 100-04, Chapters 1 and 16 to correct remittance advice messages

Provider types affected

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

Provider action needed

If change request (CR) 9578 updates Chapter 1 and Chapter 16 of the *Medicare Claims Processing Manual* to reflect the standard format and to correct any non-compliant remittance advice code combinations. Make sure that your billing staffs are aware of the corrected code combinations.

Background

Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry's use of electronic data interchange (EDI) transactions. Operating rule 360: Uniform use of CARCs and RARCs, regulates the way in which group codes, claims adjustment reason codes (CARCs), and remittance advice remark codes (RARCs) may be used. The rule requires specific codes which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages.

CR 9578 makes the following code revisions:

- When a MAC rejects an out of jurisdiction professional claim as unprocessable, the following codes are used:
 - Group code of CO
 - CARC 109, and
 - RARC N104
- When a MAC rejects misdirected Railroad Retirement Board claims as unprocessable, the following codes are used:
 - Group code of CO
 - CARC 109, and
 - RARC N105
- When a MAC rejects misdirected United Mine Workers Association claims as unprocessable, the following codes are used:



Patient: 01608034780	
Claim Number: 06/09/10	
Date Claim Received: 06/09/10	
DATES OF SERVICE	PROCEDURE CODE
05/21/10-05/21/10	82272
05/21/10-05/21/10	94010
05/21/10-05/21/10	94375
05/21/10-05/21/10	93000
05/21/10-05/21/10	36410
	PULMO
	CARDIOVASCULAR SERV
	VENIPUNCTURE
	Total:

- Group code CO
 - CARC 109, and
 - RARC N127
- In the above three situations, RARC MA130 was used previously, but will no longer be used in these situations.

Additional information

The official instruction, CR 9578 issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3510CP.pdf>. The revised manual Chapters 1 and 16 are attached to CR 9578.

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

MLN Matters[®] Number: MM9578
 Related Change Request (CR) #: CR 9578
 Related CR Release Date: April 29, 2016
 Effective Date: October 1, 2016
 Related CR Transmittal #: R3510CP
 Implementation Date: October 3, 2016

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT[®] only copyright 2015 American Medical Association.

July 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 (HH&H) MACs, for services provided to Medicare beneficiaries and which are paid under the outpatient prospective payment system (OPPS).

Provider action needed

Change request (CR) 9658 describes changes to, and billing instructions for, various payment policies implemented in the July 2016 OPPS update. It identifies the healthcare common procedure coding system (HCPCS), ambulatory payment classification (APC), HCPCS modifier, and revenue code additions, changes, and deletions that are reflected in the July 2016 integrated outpatient code editor (I/OCE) and OPPS Pricer. Make sure that your billing staffs are aware of these changes.

Key points of CR 9658

Key changes to and billing instructions for various payment policies implemented in the July 2016 OPPS updates are as follows:

Billing instructions for IMRT planning

The revised intensity modulated radiation therapy (IMRT) planning billing instructions (in the paragraph, below), that were also included in the April 2016 Update of the hospital OPPS (CR 9549), replace the instructions discussed in the 2016 OPPS final rule at 80 FR 70401-70402 and in the January 2016 update of the hospital outpatient prospective payment system (OPPS) (CR 9486). The effective date of these instructions is January 1, 2016.

These instructions state that payment for the services identified by CPT[®] codes 77014, 77280, 77285, 77290, 77295, 77306 through 77321, 77331, and 77370 are included in the APC payment for CPT[®] code 77301 (IMRT planning). You should not report these codes in addition to CPT[®] code 77301, when provided prior to, or as part of, the development of the IMRT plan.

The *MLN Matters*[®] articles related to CRs 9549 and 9486 are available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9549.pdf>, and <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9486.pdf>, respectively.

Upper eyelid blepharoplasty and blepharoptosis repair

The Centers for Medicare & Medicaid Services (CMS) payment policy does not allow separate payment for a blepharoplasty procedure (CPT[®] codes 15822, 15823) in addition to a blepharoptosis procedure (CPT[®] codes 67901-67908) on the ipsilateral upper eyelid. Any removal of upper eyelid skin in the context of an upper eyelid blepharoptosis surgery is considered a part of the blepharoptosis surgery.

A blepharoplasty cannot be billed to Medicare and the beneficiary cannot be separately charged for a cosmetic procedure regardless of the amount of upper eyelid skin that is removed on a patient receiving a blepharoptosis repair because removal of (any amount) of upper eyelid skin is part of the blepharoptosis repair. In addition, the following are not permitted:

- Operating on the left and right eyes on different days when the standard of care is bilateral eyelid surgery
- Charging the beneficiary an additional amount for a cosmetic blepharoplasty when a blepharoptosis repair is performed
- Charging the beneficiary an additional amount for removing orbital fat when a blepharoplasty or a blepharoptosis repairs performed
- Performing a blepharoplasty on a different date of service than the blepharoptosis procedure for the purpose of unbundling the blepharoplasty or charging the beneficiary for a cosmetic surgery
- Performing blepharoplasty as a staged procedure, either by one or more surgeons (note that under certain circumstances a blepharoptosis procedure could be a staged procedure)
- Billing for two procedures when two surgeons divide the work of a blepharoplasty performed with a blepharoptosis repair
- Using modifier 59 to unbundle the blepharoplasty from the ptosis repair on the claim form; this applies to both physicians and facilities
- Treating medically necessary surgery as cosmetic for the purpose of charging the beneficiary for a cosmetic surgery
- Using an advance beneficiary notice of noncoverage for a service that would be bundled into another service if billed to Medicare
- In the rare event that a blepharoplasty is performed on one eye and a blepharoptosis repair is performed on the other eye, the services must each be billed with the appropriate RT or LT modifier.

Revised status indicators (SIs) for pathology (CPT[®] codes)

The SI for CPT[®] code 85396 (Clotting assay whole blood) will change from SI=Q4 (Conditionally packaged laboratory tests) to SI=N (Paid under OPPS; payment is packaged into payment for other services) in the July 2016 update.

The SI for CPT[®] code 88141 (Cytopath c/v interpret) will change from SI=Q4 to SI=N in the July 2016 update.

The SI for CPT[®] code 88174 (Cytopath c/v auto in fluid) will change from SI=N to SI=Q4 in the July 2016 update.

The SI for CPT[®] code 88175 (Cytopath c/v auto fluid redo) will change from SI=N to SI=Q4 in the July 2016 update.

See **HOPPS**, next page

HOPPS

From previous page

These codes, their descriptors, and status indicators are listed in table 1.

Table 1 – Pathology CPT® codes with revised SIs

HCPCS code	Long descriptor	SI
85396	Coagulation/fibrinolysis assay, whole blood (eg, viscoelastic clot assessment), including use of any pharmacologic additive(s), as indicated, including interpretation and written report, per day	N
88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician	N
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	Q4
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision	Q4

Reporting for certain outpatient department services (that are similar to therapy services) (“non-Therapy outpatient department services”) that are adjunctive to comprehensive APC procedures

Effective for claims received on or after July 1, 2016, with dates of service on or after January 1, 2015, non-therapy outpatient department services (that are similar to therapy services) that are adjunctive to a comprehensive APC procedure (status indicator (SI) = J1 procedure) (see 80 FR 70326 at <https://www.federalregister.gov/articles/2015/11/13/2015-27943/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment>) or the specific combination of services assigned to the observation comprehensive APC 8011 (SI=J2), should not be reported with therapy CPT® codes. This includes services described at 1833(a)(8), namely outpatient physical therapy, outpatient speech-language pathology and outpatient occupational therapy furnished either by therapists or non-therapists and included on the same claim as a comprehensive APC procedure. Non-therapy outpatient department services that are adjunctive to J1 or J2 procedures should be reported without a CPT® code and instead should be reported with revenue code 0940 (Other Therapeutic Services). The SI for this revenue code will be changed from SI=B to SI=N, indicating that the payment for these services will be packaged into the C-APC payment.

Category III CPT® codes effective July 1, 2016

The American Medical Association (AMA) releases Category III Current Procedural Terminology (CPT®) codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January. For the July 2016 update, CMS is implementing in the OPSS nine Category III CPT® codes that the AMA released in January 2016 for implementation on July 1, 2016. The SIs and APCs for these codes are shown in Table 2 (See page 33). Payment rates for these services are available in Addendum B of the July 2016 OPSS Update that is posted at <https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/HospitalOutpatientpps/Addendum-A-and-Addendum-B-Updates.html>.

Please note that HCPCS code C9743 (Also listed in Table 2 on page 33) will be deleted June 30, 2016, since it will be replaced with Category III CPT® code 0438T effective July 1, 2016. CPT® code 0438T will be assigned to the same SI and APC assignment as its predecessor HCPCS code C9743 effective July 1, 2016.

Drugs, biologicals, and radiopharmaceuticals

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

For 2016, payment for both nonpass-through, and 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 of these items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis, as later quarter ASP submissions become available. Updated payment rates effective July 1, 2016, and drug price restatements are available in the July 2016 update of the OPSS Addendum A and Addendum B at <https://www.cms.gov/HospitalOutpatientPPS/>.

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

Some drugs and biologicals paid based on the 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/index.html>.

You may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

c. Drugs and biologicals with OPSS pass-through status effective July 1, 2016

Five drugs and biologicals have been granted OPSS pass-through status, effective July 1, 2016. These items, along with their descriptors and APC assignments, are identified in Table 3.

See HOPPS, next page

HOPPS

From previous page

Table 3: Drugs and biologicals with OPSS pass-through status effective July 1, 2016

HCPCS code	Long descriptor	SI	APC
C9476	Injection, daratumumab, 10 mg	G	9476
C9477	Injection, elotuzumab, 1 mg	G	9477
C9478	Injection, sebelipase alfa, 1 mg	G	9478
C9479*	Instillation, ciprofloxacin otic suspension, 6 mg	G	9479
C9480	Injection, trabectedin, 0.1 mg	G	9480

*Note on reporting C9479: Each vial of C9479 contains 60 mg, or 10 doses. If one single use vial is used for both patient's ears with the remainder of the drug in the vial unused, then two units of C9479 should be reported as administered to the patient; any discarded amount should be reported with the JW modifier according to the *Medicare Claims Processing Manual*, Chapter 17 - Drugs and Biologicals, Section 40 - Discarded Drugs and Biologicals.

d. New drug HCPCS code

Effective July 1, 2016, one new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. This new code is listed in Table 4.

Table 4: New drug HCPCS codes effective July 1, 2016

HCPCS code	Short desc	Long desc	SI	APC
Q9981	rolapitant, oral, 1mg	Rolapitant, oral, 1 mg	K	1761

e. Biosimilar biological product payment and required modifiers

As a reminder, OPSS claims for separately paid biosimilar biological products are required to include a modifier that identifies the manufacturer of the specific product. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code but are made by different manufacturers.

On April 5, 2016, the second biosimilar biological product, Inflectra®, was approved by the FDA.

Table 5 lists the biosimilar HCPCS codes and required modifiers. (See page 34)

f. Reassignment of skin substitute product from the low cost group to the high cost group

One existing skin substitute product has been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. This product is listed in Table 6.

Table 6: Reassignment of skin substitute product from the low cost group to the high cost group effective July 1, 2016

HCPCS code	Short desc	SI	Low/high cost status
Q4164	Helicoll, per square cm	N	High

g. Other changes to 2016 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals

Effective July 1, 2016, HCPCS code Q9982, flutemetamol f18 diagnostic, will replace HCPCS code C9459, Flutemetamol f18. The SI will remain G, "Pass-Through Drugs and Biologicals."

Effective July 1, 2016, HCPCS code Q9983, florbetaben f18 diagnostic, will replace HCPCS code C9458, Florbetaben f18. The SI will remain G, "Pass-Through Drugs and Biologicals."

Table 7 describes the HCPCS codes changes and effective dates. (See page 34)

h. Changes to OPSS Pricer logic

Effective July 1, 2016, there will be four diagnostic radiopharmaceuticals (two with new Q-codes replacing the previously used C-codes (as described above in the immediately preceding section g.)) and one contrast agent receiving pass-through payment in the OPSS 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 and contrast agents are the "policy-packaged" portions of the 2016 APC payments for nuclear medicine procedures and are on the CMS website.

Addition of C1713 and C1817 to the List of Devices Allowed for the Device Intensive Procedure Edit

CMS will be adding C1713 (Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)) and C1817 (Septal defect implant system, intracardiac) to the list of devices allowed for the device intensive procedure edit in the July 2016 release, and will make it retroactive to January 2016.

Coverage determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPSS 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,

See HOPPS, next page

HOPPS

From previous page

MACs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Please note that your MACs will adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of July 2016 OPSS Pricer.

Additional information

The official instruction, CR 9658, issued to your MAC regarding this change, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3523CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

MLN Matters® Number: MM9658
 Related Change Request (CR) #: CR 9658
 Related CR Release Date: May 13, 2016
 Effective Date: July 1, 2016
 Related CR Transmittal #: R3523CP
 Implementation Date: July 5, 2016

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.

Table 2: Category III CPT® codes effective July 1, 2016

CPT® code	Long desc	Add date	Term date	July 2016 OPSS SI	July 2016 OPSS APC
0437T	Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to primary procedure)	7/1/16		N	N/A
0438T	Transperineal placement of biodegradable material, periprostatic (via needle), single or multiple, includes image guidance	7/1/16		T	5374
0439T	Myocardial contrast perfusion echocardiography; at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to primary procedure)	7/1/16		N	N/A
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve	7/1/16		J1	5361
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve	7/1/16		J1	5361
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)	7/1/16		J1	5361
0443T	Real time spectral analysis of prostate tissue by fluorescence spectroscopy	7/1/16		T	5373
0444T	Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral	7/1/16		N	N/A
0445T	Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral	7/1/16		N	N/A
C9743	Injection/implantation of bulking or spacer material (any type) with or without image guidance (not to be used if a more specific code applies)	10/1/15		T	5374

See HOPPS, next page

HOPPS

From previous page

Table 5: Biosimilar biological product payment and required modifiers

HCPSC code	Short descriptor	Long descriptor	SI	APC	HCPSC code effective date	Modifier	Modifier effective date
Q5101	Inj filgrastim g-csf biosim	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	G	1822	3/6/15	ZA-Novartis/Sandoz	1/1/16
Q5102	Inj., infliximab biosimilar	Injection, Infliximab, Biosimilar, 10 mg	K	1761	4/5/16	ZB – Pfizer/Hospira	4/1/16

Table 7: Other changes to 2016 HCPCS codes for certain drugs, biologicals, and radiopharmaceuticals effective July 1, 2016

HCPSC code	Short descriptor	Long descriptor	SI	APC	Added date	Termination date
C9459	Flutemetamol f18	Flutemetamol f18, diagnostic, per study dose, up to 5 millicuries	G	9459	1/1/16	6/30/16
Q9982	flutemetamol f18 diagnostic	Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries	G	9459	7/1/16	
C9458	Florbetaben f18	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	G	9458	1/1/16	6/30/16
Q9983	florbetaben f18 diagnostic	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	G	9458	7/1/16	

July 2016 integrated outpatient code editor specifications version 17.2

Provider types affected

This *MLN Matters*® article is intended for providers submitting claims to Medicare administrative contractors (MACs) for outpatient services provided to Medicare beneficiaries and paid under the outpatient prospective payment system (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS.

It is also intended for claims for limited services when provided in a home health agency (HHA) not under the home health PPS (HH PPS) or claims for services to a hospice patient for the treatment of a non-terminal illness.

Provider action needed

Change request (CR) 9661 provides the integrated outpatient code editor (I/OCE) instructions and specifications. Please make sure your billing staff is aware of these updates. Make sure that your billing staffs are aware of these changes.

Background

CR 9661 informs the Part A/B MACs, the HHH MACs, and the fiscal intermediary shared system (FISS) that the I/OCE is being updated for July 1, 2016. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE.

The modifications of the I/OCE for the July 2016 v17.2 release are summarized in the table on pages 36-37.

Additional information

The official instruction, CR 9661, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3524CP.pdf>.

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

MLN Matters® Number: MM9661
 Related Change Request (CR) #: CR 9661
 Related CR Release Date: May 13, 2016
 Effective Date: July 1, 2016
 Related CR Transmittal #: R3524CP
 Implementation Date: July 5, 2016

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.

See I/OCE, next page

I/OCE

From previous page

Type	Effective date	Edits affected	Modification
Logic	7/1/16	95, 96, 97	Implement new edits under the partial hospitalization program logic for weekly hours of service requirements: -Edit 95: Partial hospitalization claim span is equal to or more than four days with insufficient number of hours of service (RTP) Criteria: A PHP claim 'From' and 'Through' date spans four or more days, but less than eight days, and there are less than 20 hours of services present. -Edit 96: Partial hospitalization interim claim 'From' and 'Through' dates must span more than 4 days (RTP) Criteria: An interim PHP claim (bill type 763 or 133 with condition code 41) 'From' and 'Through' date spans less than five days. -Edit 97: Partial hospitalization services are required to be billed weekly (RTP) Criteria: A PHP claim 'From' and 'Through' date spans more than seven days. See special processing logic under OPPS, Appendix C of CR 9661-a (Weekly PHP flowchart) and Appendix F(a) (OPPS edits applied by bill type).
Logic	1/1/16	98	Implement new edit 98: Claim with pass-through device, drug or biological lacks required procedure (RTP). Criteria: A pass-through device, drug or biological HCPCS code is present without an associated, required procedure. See special processing logic under OPPS, Appendix P (flowchart) and Appendix F(a).
Logic	1/1/15		Add program logic to exclude certain blood products (packed red cells and whole blood) from packaging if reported on a comprehensive APC claim (see special processing logic under OPPS, and Appendix L).
Logic	4/5/16	67	Apply mid-quarter FDA approval date for HCPCS code Q5102.
Logic	4/1/16d	94	Apply the edit if new biosimilar HCPCS code Q5102 is reported without the associated new modifier ZB.
Logic	7/1/16	87	Updates to the skin substitute list (Appendix O: move Q4164 from low cost to high cost).
Logic	1/1/16	92	Updates to the device and device procedure lists.
Logic and field definition	1/1/16		Change the program logic to provide unique payer value code QU when a condition for device credit is present, reported with condition code 49, 50, or 53 (see special processing logic under OPPS, and Table 5).
Documentation	1/1/16		Update Appendix L (Comprehensive APC processing) under the inpatient procedure where the patient expired logic to note non-covered SI values are returned as excluded from packaging under comprehensive APCs, but any associated edits are not returned (documentation only, no change to program logic).
Documentation	1/1/15	45	Update the reference to indicate the change made for edit 45 to include SI = J1 procedures is retroactive to 1/1/2015 (documentation only, no change to program logic).
Documentation	7/1/16		Update Table 2 with reference information for the reporting of modifiers.
Documentation	1/1/16		Updated special processing logic on page 9 to include reference to the use of the complexity-adjusted comprehensive APC as the look-up for device credit amount when condition code 49, 50, or 53 are present (documentation only, no change to program logic).

See I/OCE, next page

I/OCE

From previous page

Type	Effective date	Edits affected	Modification
Content	4/1/16	22	Add modifier ZB (Pfizer/Hospira) to the list of valid modifiers.
Content	1/1/15		Modify the valid revenue list for revenue code 940 (Other therapeutic services) to have SI value changed to N if reported with a blank HCPCS code.
Content	7/1/16		Update the following lists for the release (see quarterly data files): -Questionable covered service list (edit 12) -Valid revenue code list -Revised files for pass-through offset conditions (edit 98) -Device and device-procedure lists (edit 92) -Skin substitute product lists (edit 87)
Content	7/1/16		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
Content	7/1/16	20, 40	Implement version 22.2 of the NCCI (as modified for applicable outpatient institutional providers).

Payment of drugs and biologicals for OPSS providers

Provider types affected

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

Provider action needed

Change request (CR) 9601 informs MACs about the implementation of phase 2 of system changes necessary to the fiscal intermediary shared system (FISS) and integrated outpatient code editor (IOCE) which are necessary to make payment for drugs and biologicals to OPSS providers. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) pays for all outpatient drugs using the average sales price (ASP) methodology. The schedule for submission of all ASP pricing is statutory per Section 621(a) of the Medicare Modernization Act. Drug manufacturers are required to submit drug ASPs within 30 days of the close of their fiscal quarter.

Given the complexity, volume of data, and the number of drugs affected, approximately six weeks are required to process, validate, and issue final ASPs for a given quarter. As a result, the ASP rates for drugs furnished on or after January 1, 2016, were not available until mid-December 2015. The ASP rates for drugs furnished on or after April 1, 2016, were not available until mid-March 2016. The ASP rates for drugs furnished on or after July 1, 2016, will not be available until mid-June 2016 and the ASP rates for drugs furnished on or after October 1, 2016, will not be available until mid-September 2016 respectively.

CMS supplies MACs with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis and this file is used for payment to most institutional providers by FISS. OPSS claims were an exception to this process. Payment for OPSS claims were based on tables provided to the OPSS Pricer to account for some of the special processing rules that are unique to OPSS providers (such as, pass-through status necessary and drugs provided solely in the hospital setting).

Starting on October 1, 2016, drug HCPCS on OPSS claims will no longer be priced by the outpatient PPS Pricer. The fee schedule amount from the ASP drug file or any future drug fee schedule amount will be used by FISS to price covered outpatient drugs, and drugs and biologicals with pass-through status under the OPSS. Phase 2 includes logic for FISS to cap the coinsurance amounts for procedures (which include blood and drug services) to the inpatient deductible amount for each calendar year and to insure the rural floor is applied.

The following examples are part of CR 9601 to demonstrate the capped inpatient deductible amount:

Example 1 of inpatient deductible capped amount

Drug line A has a fee of \$2,000.00, a payment of \$1,600.00, and coinsurance of \$400.00.

Drug line B has a fee of \$1,000.00, a payment of \$800.00, and coinsurance of \$200.00.

Drug line C has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Drug line D has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Highest wage adjusted national coinsurance amount for a procedure line is \$888.00.

See **DRUGS**, next page

DRUGS

From previous page

The inpatient Part A deductible is \$1,288.00 for 2016

$\$1,288.00 - \$888.00 = \$400.00$ remaining coinsurance to be applied toward inpatient deductible cap.

Drug line A-D coinsurance is \$800.00.

$\$400.00$ cap remaining / $\$800.00$ drug line(s) coinsurance = 50 percent reduction to coinsurance due to inpatient deductible cap

Apply 50 percent reduction of the coinsurance amounts for each line and add the remaining 50 percent back into the payment amount.

Drug line A has a final payment of \$1,800.00, and coinsurance of \$200.00.

Drug line B has a final payment of \$900.00, and coinsurance of \$100.00.

Drug line C has a final payment of \$450.00, and coinsurance of \$50.00.

Drug line D has a final payment of \$450.00, and coinsurance of \$50.00.

Example 2 of inpatient deductible capped amount

Drug line A has a fee of \$2,000.00, a payment of \$1,600.00, and coinsurance of \$400.00.

Drug line B has a fee of \$1,000.00, a payment of \$800.00, and coinsurance of \$200.00.

Drug line C has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Drug line D has a fee of \$500.00, a payment of \$400.00 and coinsurance of \$100.00.

Highest wage adjusted national coinsurance amount for a procedure line is \$1,588.00.

The inpatient Part A deductible is \$1,288.00 for 2016

$\$1,588.00$ is greater than $\$1,288.00$. The OPPS Pricer will cap the coinsurance amount to be applied on the highest wage adjusted national coinsurance procedure line prior to application of the cap on the drug lines.

Drug line A-D coinsurance is \$800.00.

$\$0$ cap remaining / $\$800.00 = 100$ percent reduction to coinsurance due to inpatient deductible cap



Drug line A has a final payment of \$2,000.00, and no coinsurance.

Drug line B has a final payment of \$1,000.00, and no coinsurance.

Drug line C has a final payment of \$500.00, and no coinsurance.

Drug line D has a final payment of \$500.00, and no coinsurance.

Additional information

The official instruction, CR 9601, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1649OTN.pdf>.

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

MLN Matters® Number: MM9601

Related Change Request (CR) #: CR 9601

Related CR Release Date: April 28, 2016

Effective Date: January 1, 2016

Related CR Transmittal #: R1649OTN

Implementation Date: October 3, 2016

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2015 American Medical Association.

Upcoming provider outreach and educational event June 2016

Medicare Part A changes and regulations

Date: Tuesday, June 14
Time: 10:00-11:30
Type of Event: Webcast
<http://medicare.fcso.com/Events/0325460.asp>

Provider enrollment revalidation – cycle 2

Date: Tuesday, June 21
Time: 11:30-12:30
Type of Event: Webcast
<http://medicare.fcso.com/Events/0325460.asp>

Note: Unless otherwise indicated, all First Coast educational offerings are considered to be “ask-the-contractor” events, “webcast” type of event, designated times are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands.

Two easy ways to register

Online – Visit our provider training website at <http://www.fcsouniversity.com>, log on 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 User Account Form](#) online. Providers who do not have yet a national provider identifier may enter “99999” in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without Internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. 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 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 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you or your colleagues 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 the First Coast Medicare training website, 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 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. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.



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 April 28, 2016

MLN Connects® Provider eNews for April 28, 2016
View this edition as a PDF

In this edition:

MLN Connects® Events

- How to Register for the 2016 PQRS Group Practice Reporting Option Call — Last Chance to Register
- 2015 Mid-Year QRURs Webcast — Register Now
- New Audio Recordings and Transcripts Available

Other CMS Events

- Comparative Billing Report on Subsequent Nursing Facility E/M Services Webinar
- Comparative Billing Report on Modifiers 24 and 25: General Surgeons Webinar
- Medicare Learning Network® Publications and Multimedia
- Acute Care Hospital Inpatient Prospective Payment System Booklet — Revised
- New Educational Web Guides Fast Fact

Announcements

- IRFs: Proposed FY 2017 Payment and Policy Changes
- SNFs: Proposed FY 2017 Payment and Policy Changes
- Hospice Benefit: Proposed FY 2017 Updates to the Wage Index and Payment Rates
- Open Payments: Physician and Teaching Hospital Review and Dispute Period Began April 1
- Nursing Homes, IRFs, and LTCHs: Comment on New



Quality Measures by May 6

- Hospitals: Submit Comments on New EHR Measure by May 15
- Next Generation ACO Model Letter of Intent Deadline Extended to May 20
- 2016 PQRS GPRO Registration Open through June 30
- Home Health Quality Reporting Program: Quarterly QAO Interim Reports Available
- 2015 Mid-Year QRURs Available
- Track and Improve Your ICD-10 Progress
- Hand Hygiene Day is May 5

Claims, Pricers, and Codes

- Reprocessing Claims for Audiology Services
- Prolonged Drug and Biological Infusions Using an External Pump

MLN Connects® Provider eNews for May 5, 2016

MLN Connects® Provider eNews for May 5, 2016

[View this edition as a PDF](#)

In this edition:

MLN Connects® Events

- MACRA Listening Session: Quality Payment Program Proposed Rule — Register Now
- 2015 Mid-Year QRURs Webcast — Register Now
- New Audio Recordings and Transcripts Available

Medicare Learning Network® Publications and Multimedia

- Medicare Coverage of Substance Abuse Services *MLN Matters®* Article — New
- Medicare Policy Clarified for Prolonged Drug and Biological Infusions Started Incident to a Physician's Service Using an External Pump *MLN Matters®* Article — New

Announcements

- CMS Releases NPRM on the Medicare Access and CHIP Reauthorization Act of 2015
- DMEPOS Competitive Bidding: Round 2 Recompete/ National Mail-Order Recompete Contract Suppliers Announced
- CMS Adds New Quality Measures to Nursing Home Compare

MLN Connects® Provider eNews for May 12, 2016

MLN Connects® Provider eNews for May 12, 2016

[View this edition as a PDF](#)

In this edition:

MLN Connects® Events

- 2015 Mid-Year QRURs Webcast — Last Chance to Register

Medicare Learning Network® Publications and Multimedia

- Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims *MLN Matters®* Article — Revised
- Transitional Care Management Services Fact Sheet — Revised
- Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens Fact Sheet — Revised
- DMEPOS Competitive Bidding Program Fact Sheets



- CMS Publishes Final Rule on Fire Safety Requirements for Certain Health Care Facilities
- CMS Finalizes its Quality Measure Development Plan
- 2017 Medicare Shared Savings Program: Notice of Intent to Apply Period Closes May 31
- New PEPPERs Available for Hospices, SNFs, IRFs, IPFs, CAHs, LTCHs
- CMS to Release a CBR on Podiatry: Nail Debridement and E/M Services in May
- Focusing on Women's Health

Claims, Pricers, and Codes

- Reprocessing of Selected Dialysis Claims

— Revised

Announcements

- Updates to Data Initiatives Increase Transparency of the Medicare Program
- HHS Awards over \$260 Million to Health Centers Nationwide to Build and Renovate Facilities to Serve More Patients
- Open Payments: Physician and Teaching Hospital Review and Dispute Period Ends May 15
- 2016 Electronic Clinical Quality Measures: Updated Files Available
- Teaching Hospitals: Submitting Medicare GME Affiliation Agreements
- May is National Osteoporosis Month

Claims, Pricers, and Codes

- Coinsurance Correction for Certain RHC Claims
- Billing Requirements for RHCs

MLN Connects® Provider eNews for May 19, 2016

MLN Connects® Provider eNews for May 19, 2016

[View this edition as a PDF](#)

In this edition:

MLN Connects® Events

- Comparative Billing Report on Psychotherapy and E/M Services Webinar

Medicare Learning Network® Publications and Multimedia

- Part C Appeals: Organization Determinations, Appeals, and Grievances WBT — Revised
- Part D Coverage Determinations, Appeals, and Grievances WBT — Revised
- Resources for Medicare Beneficiaries Booklet — Revised
- How to Use the Searchable Medicare Physician Fee Schedule Booklet — Revised
- Updated *MLN Matters*® Search Indices

Announcements

- 2017 Medicare Shared Savings Program: Notice of



Intent to Apply Period Closes May 31

- SNF Value-Based Purchasing Program: Specifications for New Measure
- 2014 PQRS Experience Report Available
- How to Use ICD-10 and Maintain Your Progress
- Talk to Your Patients about Mental Health

Medicare A Connection subscription

Medicare A Connection is published monthly and is available online in both English and Spanish.

Non-provider entities or providers who need additional copies may purchase an annual hardcopy subscription. This subscription includes all issues published in the current fiscal year.

To order an annual subscription, complete the [Medicare A Connection Subscription Form](#).

Your feedback matters

Your opinion is important to us. If you haven't already completed the MAC Satisfaction Indicator (MSI) survey, please take a moment to complete it now. Share your experience with the services we provide. It will take about 10 minutes. You can access the survey by clicking here.



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) (<https://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