Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

August 2016

In this issue

Timely reporting of provider enrollment information changes

Provider types affected

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

Provider action needed

Stop – impact to you

Failure to comply with the requirements to report changes in your Medicare enrollment information could result in the revocation of your Medicare billing privileges. This article does not establish any new or revised policy, but serves as a reminder to comply with existing policy.

Caution – what you need to know

MLN Matters® article SE1617 reinforces the importance of the timely reporting of changes in your Medicare enrollment information.

Go – what you need to do

Comply with the reporting requirements for changes in your enrollment information and avoid disruption of your Medicare claims payments.

Background

In accordance with 42 *Code of Federal Regulations* (CFR) Section 424.516(d), all physicians, non-physician practitioners (for example, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals) and physician and non-physician practitioner organizations must report the following changes in their enrollment information to your MAC via the Internet-based provider enrollment, chain and ownership system (PECOS) or the CMS-855 paper enrollment application within 30 days of the change:

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Contents

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

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

First Coast boosts experience for SPOT users

Live Chat and enhanced alerts to be added to SPOT

Providers using First Coast's (First Coast Service Options Inc.) Secure Online Provider Tool (SPOT) will see several communication enhancements beginning Monday, August 15, 2016.

These improvements will enable SPOT users to remain informed on top issues and easily connect with the SPOT support staff when necessary.

Through Live Chat, First Coast representatives will be available 10 a.m. to 2 p.m., Monday through Friday, to help users locate resources on SPOT as well as the First Coast provider website. Representatives will assist with questions such as:

- Updating passwords in your Enterprise Identity Management (EIDM) account
- Completing the remote identity proofing process (RIDP) and multifactor authentication (MFA)
- Creating additional SPOT profiles
- Locating information on the First Coast provider site

Due to Medicare data security restrictions, First Coast representatives will not have access to claims or provider records in SPOT and will not be able to answer specific claim or Medicare beneficiary questions. Any issues requiring specific account details will be referred to First Coast's provider contact center.

In addition to Live Chat, First Coast is also adding a news and alerts box on the SPOT homepage to help providers stay informed of enhancements and system updates. Providers also will be able to connect with a First Coast representative through Twitter (*www.twitter.com/@TheSPOTPortal*).

TIMELY

From previous page

- A change in ownership
- An adverse legal action, or
- A change in practice location.

You must report all other changes to your MAC within 90 days of the change.

If you are a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), you must report any changes in information supplied on the enrollment application within 30 days of the change to the national supplier clearinghouse (NSC) (42 CFR §424.57(c)(2)).

Independent diagnostic testing facilities must report changes in ownership, location, general supervision, and adverse legal actions to your MAC either online, or via the appropriate CMS-855 form, within 30 calendar days of the change. You must report all other changes to your enrollment information within 90 days of the change (42 CFR §410.33(g)(2).

All providers and suppliers not previously identified must report any changes of ownership, including a change in an authorized or delegated official, within 30 days; and all other informational changes within 90 days (42 CFR §424.516(e)).

It is very important that you comply with these reporting requirements. Failure to do so could result in the revocation of your Medicare billing privileges.

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*.

MLN Matters® Number: SE1617
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

CWF to locate beneficiary record and provide responses to provider queries

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 to Medicare beneficiaries.

Provider action needed

Change request (CR) 9740 informs MACs about the changes to the Medicare's common working file (CWF) to add an auto-search capability to CWF provider queries and eliminate the need for providers to query multiple CWF hosts for Medicare beneficiary eligibility information. Make sure that your billing staffs are aware of these changes, which reduce burden on providers.

Background

Medicare beneficiaries are assigned a primary host at CWF based on their primary address. At the time of querying CWF for eligibility information using CWF provider queries, ELGA, HIQA, ELGH, HIQH, and HUQA, providers may not know the CWF primary host of the Medicare beneficiary. When the CWF primary host of the Medicare beneficiary is not known, Providers must query multiple CWF hosts (up to nine) until they find the host that has the Medicare beneficiary record and get the eligibility information. As the CWF hosts are connected to each other, it is possible for CWF to automatically locate the primary host where the Medicare beneficiary record exists. This will eliminate the need for providers to search and locate the Medicare beneficiary record and may also reduce the number of provider queries received.

Additional information

The official instruction, CR 9740, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1687OTN.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: MM9740
Related Change Request (CR) #: CR 9740
Related CR Release Date: July 29, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R1687OTN
Implementation Date: January 3, 2017

What is Medicare Fraud?

Fraud is defined as making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. Learn more at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf*.

Reopenings update – changes to Chapter 34

Provider types affected

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

Provider action needed

Change request (CR) 9639 provides updates to Chapter 34, Section 10 of the *Medicare Claims Processing Manual* to remove outdated contractor terminology, clarify remittance advice code reference and to add hyperlinks for regulation and statutory obligations. The updates enhance and clarify operating instructions and language in accordance with regulation and statute. CR 9639 includes no policy changes. Make sure that your billing staffs are aware of these updates.

Background

A reopening is a remedial action taken to change a binding determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are different from adjustment bills in that adjustment bills are subject to normal claim processing timely filing requirements (that is, filed within one year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (for example, claim determinations may be reopened within one year of the date of the initial determination for any reason, or within one to four years of the date of the initial determination upon a showing of good cause).

The main clarification in CR 9639 is to note that where Medicare medical review staff request documentation from a provider/supplier for a claim, but did not receive it, and issued a denial based on no documentation, the codes used for the denial are as follows:

- **Group code: CO** – contractual obligation
- **Claim adjustment reason code (CARC) 50** – These are non-covered services because this is not deemed a 'medical necessity' by the payer
- **Remittance advice remark code (RARC) M127** – Missing patient medical record for this service).

Additional information

The official instruction, CR 9639 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3568CP.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*.

MLN Matters® Number: MM9639
Related Change Request (CR) #: CR 9639
Related CR Release Date: July 29, 2016
Effective Date: September 30, 2016
Related CR Transmittal #: R3568CP
Implementation Date: September 30, 2016

Hands-on internet-based PECOS training by appointment

Join First Coast Service Options, in Jacksonville, for a free, interactive session on using internet-based PECOS to electronically create or update your Medicare enrollment. Make your appointment today!

Processing Issues

Overpayments resulting from sequestration error

Issue

Claims for "statement through" date on or after April 1, 2016, and received prior to April 27, 2016, did not incur a 2 percent reduction as directed by the Center for Medicare & Medicaid Services, resulting in overpayments. This reduction (also known as "sequestration") covers all payments for services with dates of service or dates on or after April 1, 2013, until further notice.

Resolution

The error was corrected April 26, 2016. The impacted claims are being mass adjusted to recoup the overpaid amounts. The overpayment will be recouped in the normal process of immediate offset or demand letter.

Status/date resolved

Closed July 28, 2016.

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.

Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency? You do – visit the *Improve Your Billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time.

You'll find First Coast's most popular self-audit resources, including the E/M interactive worksheet, provider data summary (PDS) report, and the comparative billing report (CBR).

Your Feedback Matters

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

Multiple procedure payment reduction on the PC of certain diagnostic imaging procedures

Provider types affected

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

Provider action needed

Change request (CR) 9647 informs providers that Section 502(a)(2) of the Consolidated Appropriations Act of 2016 revised the multiple procedure payment reduction (MPPR) for the professional component (PC) of the second and subsequent procedures from 25 percent to 5 percent of the physician fee schedule amount. Make sure that your billing staffs are aware of these changes.

Background

Medicare currently applies the MPPR of 25 percent to the PC of certain diagnostic imaging procedures. The reduction applies to PC-only services, and the PC portion of global services, for the procedures with a multiple surgery value of '4' in the Medicare fee schedule database.

The Centers for Medicare & Medicaid Services (CMS) currently makes full payment for the PC of the highest-priced procedure and payment at 75 percent for the PC of each additional procedure when furnished by the same physician (or physician in the same group practice) to the same patient, in the same session on the same day.

Section 502(a)(2) of the Consolidated Appropriations Act of 2016 revised the MPPR for the PC of the second and subsequent procedures from 25 percent to 5 percent of the physician fee schedule amount. The MPPR on the technical component (TC) of imaging remains at 50 percent.

Effective January 1, 2017, MACs shall pay 95 percent of the fee schedule amount for the PC of each additional procedure furnished by the same physician (or physician in the same group practice) to the same patient, in the same session on the same day.

The current payment, and the payment as of January 1, 2017, is summarized in the example table below:

Table 1: Current vs. revised payments

	Proc 1	Proc 2	Current total payment	Revised total payment
PC	$100	$80	$160 ($100 + (.75 x $80))	$176 ($100 +(.95 x $80))
TC	$500	$400	$700 ($500 + (.50 x $400))	$700 ($500 + (.50 x $400))
Global	$600	$480	$860 ($600 + (.75 x $80) + (.50 x $400))	$876 ($600 + (.95 x $80) + (.50 x $400))

Additional information

The official instruction, CR 9647 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3578CP.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*.

MLN Matters® Number: MM9647
Related Change Request (CR) #: CR 9647
Related CR Release Date: August 5, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3578CP
Implementation Date: January 3, 2017

Mammography coverage and certification of mammography facilities

Providers and suppliers that furnish and bill Medicare for film, digital, or 3-D mammography services are reminded that claims for these mammography services will either deny or reject as unprocessable if:

- There is no FDA certification number reported on the claim
- The facility is not certified for the type of mammogram submitted on the claim (film, digital, or 3-D)
- A facility's certificate is suspended or revoked
- The HCPCS/CPT® code billed does not match the certification on file for the facility, or
- There is no FDA certification number on the MQSA file for the facility listed on the claim

For additional information, providers and suppliers that furnish and bill Medicare for film, digital, or 3-D mammography services can refer to Medicare's internet-only manual (IOM) Publication 100-04, Chapter 18, Section 20, and its subsections found here: *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf*.

Editing update for screening for sexually transmitted infections

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 to Medicare beneficiaries.

Provider action needed

Change request (CR) 9719 informs MACs about the changes to certain edits that should have been written as line level denials rather than claim denials if you do not report the appropriate diagnosis code. Make sure that your billing staffs are aware of these changes.

Background

CR 7610, Transmittal 2476, provided billing instructions for screening for sexually transmitted infections (STIs) and high-intensity behavioral counseling to prevent STIs. It was brought to Centers for Medicare & Medicaid Services (CMS) attention that 072x type of bill (TOB) claims containing STI codes and diagnosis V74.5 or V73.89, received on or after October 1, 2015, were incorrectly being denied. Per CR 7610, current editing would deny a claim for STI services submitted with diagnosis code V74.5 or V73.89 on a TOB other than 13x, 14x, or 85x (without revenue code 096x, 097x, or 098x).

To correct these problems, CR 9719 instructs the MACs to modify existing editing to deny line items on claims for STIs (CPT® 86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800, 87590, 87591, 87850, 86592, 86593, 86780, 87340, or 87341) containing ICD-9 code V74.5 or V73.89 (for claims with dates of service before October 1, 2015) and ICD-10 code Z11.3 or Z11.59 (with dates of service on or after October 1, 2015) when submitted on a TOB other than 13x, 14x, or 85x (without revenue code 096x, 097x, or 098x). When denying these line items, MACs will use the following messages:

- **CARC 170**: "Payment is denied when performed/ billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- **RARC N95**: "This provider type/provider specialty may not bill this service."
- **Group code PR** (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed Advance Beneficiary Notice (ABN) is on file).

- **Group code CO** (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

CR 9719 represents no change in policy. CMS is modifying existing editing to ensure correct payment for claims related to STIs.

Additional information

The official instruction, CR 9719 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1698OTN.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*.

The article related to CR 7610 is at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7610.pdf*.

MLN Matters® Number: MM9719
Related Change Request (CR) #: CR 9719
Effective Date: For claims received on or after October 1, 2015
Related CR Release Date: August 5, 2016
Related CR Transmittal #: R1698OTN
Implementation Date: January 3, 2017

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

Hyperbaric oxygen (HBO) therapy – revision to the Part A and Part B LCD

LCD ID number: L36504 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for hyperbaric oxygen (HBO) therapy (L36504) was revised to remove the link to the Centers for Medicare & Medicaid Services (CMS) covered diagnoses codes. Since CMS updates the links for national coverage determination (NCD) for hyperbaric oxygen therapy (20.29) with each new change request (CR), a determination was made to remove the link from the LCD and provide an instructional note for stakeholders to locate ICD-10 diagnosis codes and other coding updates specific to NCDs.

Effective date

The effective date for the revision is for dates of service **on and after August 11, 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, please *click here*.

Multiple Part A/B local coverage determinations (LCDs) revised – article correction

LCD ID number: L33693, L33695, L33696, L33667 (Florida/Puerto Rico/U.S. Virgin Islands)

An article revising multiple local coverage determinations (LCDs) related to CPT® code 93881 and its replacement CPT® code 93882 was previously published on page 31 of the February 2016 Connection. Since that time, it was determined that the incorrect effective date was published in error.

Effective date

The correct effective date should be for claims processed **on or after January 12, 2016**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *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, please *click here*.

Pemetrexed – revision to the Part A and Part B LCD

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

Based on a reconsideration request, the local coverage determination (LCD) for pemetrexed has been revised to include the off-label indication of malignant peritoneal mesothelioma. Also, the "ICD-10 Codes that Support Medical Necessity" section of the LCD has been updated to include ICD-10-CM diagnosis code C45.1. In addition, the "Sources of Information and Basis for Decision" section of the LCD has been updated.

Effective date

This LCD revision is effective for services rendered **on or after August 18, 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*.

Where do I find...

Looking for something specific and don't know where to find it? Find out how to perform routine tasks or locate information that visitors frequently visit our site to accomplish or find. Check out the "Where do I find" page.

Next generation accountable care organization – implementation

Provider types affected

This *MLN Matters*® article is intended for providers who are participating in next generation accountable care organizations (NGACOs) and submitting claims to Medicare administrative contractors (MACs) for certain skilled nursing facility, telehealth, and post-discharge home visit services to Medicare beneficiaries that would not otherwise be covered by original fee-for-service (FFS) Medicare.

Provider action needed

This *MLN Matters*® special edition article provides information on the NGACO model's benefit enhancement waiver initiatives and supplemental claim processing direction. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) implemented the next generation ACO model (NGACO or the model) January 1, 2016. The model is the first in the next generation of ACO provider-based models that will test opportunities for increased innovation around care coordination and management through greater accountability for the total cost of care.

The aim of the model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare FFS through greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs.

Core principles of the model are:

- Protecting Medicare FFS beneficiaries' freedom to seek the services and providers of their choice
- Creating a financial model with long-term sustainability
- Utilizing a prospectively set benchmark that:
  - Rewards quality
  - Rewards both attainment of and improvement in efficiency, and
  - Ultimately transitions away from updating benchmarks based on the ACO's recent expenditures
- Engaging beneficiaries in their care through benefit enhancements that directly improve the patient experience and incentivize coordinated care from ACOs
- Mitigating fluctuations in aligned beneficiary populations and respecting beneficiary preferences through supplementing a prospective claims-based alignment process with a voluntary process, and
- Smoothing ACO cash flow and improving investment capabilities through alternative payment mechanisms.

Additional information on NGACO is available at *https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/*.

Participants and preferred providers

NGACO defines two categories of providers/suppliers and their respective relationships to the ACO entity: Next generation participants and next generation preferred providers. Next generation participants are the core providers/suppliers in the model. Beneficiaries are aligned to the ACO through the next generation participants and these providers/suppliers are responsible for, among other things, reporting quality through the ACO and committing to beneficiary care improvement. Preferred providers contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO. For example, preferred providers may participate in certain benefit enhancements. Services furnished by preferred providers will not be considered in alignment and preferred providers are not responsible for reporting quality through the ACO. (see table at end of article)

Three benefit enhancements

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, CMS uses the authority under Section 1115A of the Social Security Act (Section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the NGACO model. An ACO may choose not to implement all or any of these benefit enhancements.

1. Three-day SNF rule waiver

CMS makes available to qualified NGACOs a waiver of the three-day inpatient stay requirement prior to admission to a SNF or acute-care hospital or critical access hospital (CAH) with swing-bed approval for SNF services ("swing-bed hospital"). This benefit enhancement allows beneficiaries to be admitted to qualified next generation ACO SNF participants and preferred providers either directly or with an inpatient stay of fewer than three days. The waiver will apply only to eligible aligned beneficiaries admitted to next generation ACO SNF participants and preferred providers.

An aligned beneficiary will be eligible for admission in accordance with this waiver if:

1) The beneficiary does not reside in a nursing home, SNF, or long-term nursing facility and receiving Medicaid at the time of the decision to admit to an SNF, and
2) The beneficiary meets all other CMS criteria for SNF admission, including that the beneficiary must:
   a. Be medically stable
   b. Have confirmed diagnoses (for example, does not have conditions that require further testing for proper diagnosis)

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c. Not require inpatient hospital evaluation or treatment; and

d. Have an identical skilled nursing or rehabilitation need that cannot be provided on an outpatient basis or through home health services.

NGACOs identify the SNF participant and preferred providers with which they will partner in this waiver through the annual submission of next generation participant and preferred provider lists.

Claims

Next generation model three-day SNF rule waiver claims do not require a demo code to be manually affixed to the claim. When a qualifying stay does not exist, the fiscal intermediary standard system (FISS) checks whether:

1. The beneficiary is aligned to an NGACO approved to use the SNF three-day rule waiver;
2. The SNF provider is also approved to use the waiver; and
3. The SNF is a provider for the same NGACO for which the beneficiary is aligned. Once eligibility is confirmed, demo code 74 (for the NGACO model) and indicator value 4 (for the three-day SNF rule waiver) is placed on the claim.

If an eligible NGACO SNF three-day waiver claim includes demo code 62 (for the BPCI model 2 SNF three-day rule waiver), for example, the FISS will not check to validate whether the claim is a valid NGACO SNF three-day rule waiver. CMS has instructed that FISS only validate when no demo code has been affixed and no qualifying three-day inpatient hospital stay has been met.

To assist MACs in troubleshooting provider SNF three-day rule waiver claim questions, CMS instructed the FISS and the multi-carrier system (MCS) maintainers to create screens. The FISS maintainer created a sub-menu of the 6Q – CMS demonstrations screen to allow for inquiry of both the NGACO provider file data and the NGACO beneficiary file data. The screen shows the following data value for this waiver: Three-day SNF waiver = value 4. The MCS maintainer created two screens to allow for SNF three-day rule waiver validation inquiry as listed:

- MCS created screen PROVIDER ACCOUNTABLE CARE ORGANIZATION (ACO) so that MACs would be able to see which ACO a provider is aligned with.
- MCS created screen BENEFICIARY ACCOUNTABLE CARE ORGANIZATION (ACO) so that MACs would be able to see which ACO a beneficiary is aligned with.

2. Telehealth expansion

CMS makes available to qualified NGACOs a waiver of the requirement that beneficiaries be located in a rural area and at a specified type of originating site in order to be eligible to receive telehealth services. This benefit enhancement will allow payment of claims for telehealth services delivered by next generation ACO participants or preferred providers to aligned beneficiaries in specified facilities or at their residence regardless of the geographic location of the beneficiary.

Claims

For those telehealth services originating at the beneficiary's home (in a rural or non-rural geographic setting) place of service (POS) code 12 (home) must be added to the claim.

Claims will ***not*** be allowed for the following telehealth services rendered to aligned beneficiaries located at their residence:

- Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs. Healthcare Common Procedure Coding System (HCPCS) codes G0406-G0408.
- Subsequent hospital care services, with the limitation of one telehealth visit every three days. Current Procedural Terminology (CPT®) codes 99231-99233.
- Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days. CPT® codes 99307-99310.

For those telehealth services originating in a non-rural area a provider does not need to insert a demonstration code in order for the claim to process successfully.

Notwithstanding these waivers, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria, and no additional reimbursement will be made to cover set-up costs, technology purchases, training and education, or other related costs. In particular, the services allowed through telehealth are limited to those described under Section 1834(m)(4)(F) of the Social Security Act and subsequent additional services specified through regulation.

3. Post-discharge home visits

CMS makes available to qualified NGACOs waivers to allow "incident to" claims for home visits to non-homebound aligned beneficiaries by licensed clinicians under the general supervision—instead of direct supervision—of next generation participants or preferred providers.

Licensed clinicians, as defined in 42 C.F.R. § 410.26(a)(1), may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform the ordered services under physician (or other practitioner) supervision. A participant or preferred provider may contract with licensed clinicians to provide this service and the service is billed by the participant or preferred provider.

Claims for these visits will only be allowed following discharge from an inpatient facility (including, for example, inpatient prospective payment system (IPPS) hospitals, critical access hospitals (CAHs), SNFs, inpatient rehabilitation facilities (IRFs) and will be limited to no more than one visit in the first 10 days following discharge

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and no more than one visit in the subsequent 20 days. Payment of claims for these visits will be allowed as services and supplies that are incident to the service of a physician or other practitioner as described under 42 CFR §410.26. This provision is not generally applicable to home visits; however, for purposes of this payment waiver, CMS intends to use the same definition of general supervision as outlined in this provision.

Claims

Post-discharge home visit service waiver claims must contain one of the following evaluation and management (E/M) CPT® codes:

- 99324-99337
- 99339-99340
- 99341-99350

Providers are not required to add a demonstration code to process these claims.

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*.

Additional information about the next generation ACO model is available at: *https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/*.

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Table 5.1 Types of providers/suppliers and associated functions[1]

Provider type	Alignment	Quality reporting through ACO	Eligible for ACO shared savings	PBP	All-inclusive PBP	Coordinated care reward	Telehealth	three-day SNF rule	Post-discharge home visit
Next generation participant	X	X	X	X	X	X	X	X	X
Preferred provider			X	X	X	X	X	X	X

[1] This table is a simplified depiction of key design elements with respect to next generation participant and preferred provider roles. It does not necessarily imply that this list is exhaustive with regards to possible ACO relationships and activities.

Rural health clinics reporting requirement and billing updates

***Note**: This article was revised August 2, 2016 to show in Table 1 that codes G0436 and G0437 are replaced by 99406 and 99407, respectively, October 1, 2016. All other information remains the same. This information was previously published in the May 2016 Medicare A Connection, page 29.*

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 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/CPT® code	Short descriptor
G0101	Ca screen; pelvic/breast exam
G0296	Visit to determ LDCT elig
G0402	Initial preventive exam
99406	Tobacco-use counsel 3-10 min
99407	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

Note: HCPCS code G0436 and G0437 will be discontinued effective 10/1/2016. CPT® codes 99406 and 99407 are the remaining codes for tobacco cessation counseling. The beneficiary copayment is waived for CPT® codes 99406 and 99407.

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

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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*.

Document History

- **May 9, 2016** – Initial issuance.
- **August 2, 2016** - This article was revised to show in

Table 1 that codes G0436 and G0437 are replaced by 99406 and 99407, respectively, October 1, 2016.

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October update to Medicare physician fee schedule database

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9749, which informs you that payment files were issued to MACs based upon the MPFS final rule. This change request amends those payment files. Make sure that your billing staffs are aware of these changes.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services. Unless otherwise stated, the changes included in the October update to the 2016 MPFSDB are effective for dates of service on and after January 1, 2016.

The key changes for the October update are the following:

Code	Action
G0436	Procedure status = I (Effective for services on or after 10-1-2016.)
G0437	Procedure status = I (Effective for services on or after 10-1-2016.)
44799	Procedure status = C; Global surgery days = YYY
32666	Bilateral indicator = 1

The HCPCS codes listed below have been added to the MPFSDB effective for dates of service on and after October 1, 2016. All of these new codes were communicated through other instructions. Please consult those instructions for the description and other information.

Code	Action
G0490	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9679	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9680	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9681	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9682	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9683	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9684	Procedure status = X; there are no RVUs; all policy indicators = concept does not apply
G9685	Procedure status = A; RVUs = Work 3.86, non-facility 1.55, facility 1.55, MP 0.29
G9686	Procedure status = A; RVUs = Work 1.50, non-facility 0.61, facility 0.61, MP 0.10

The following payment policy indicators apply to G9685 and G9686: multiple surgery = 0, bilateral surgery = 0, assistant at surgery = 0, co-surgeons = 0, team surgeons = 0, PC/TC = 0, physician supervision of diagnostic procedures = 09, and diagnostic imaging family = 99. The global surgery says = XXX.

New code G0498, listed below, has been added to the MPFSDB effective for dates of service on and after January 1, 2016. The procedure status is C and there are no RVUs. The following payment policy indicators apply to G0498: multiple surgery = 0, bilateral surgery = 0, assistant at surgery = 0, co-surgeons = 0, team surgeons = 0, PC/TC = 5, physician supervision of diagnostic procedures = 09, and diagnostic imaging family = 99. The global surgery days = YYY.

Code	Short descriptor	Long descriptor
G0498	Chemo extend iv infus w/ pump	Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/other outpatient setting using office/other outpatient setting pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/other outpatient setting, includes follow up office/other outpatient visit at the conclusion of the infusion.

Additional information

The official instruction, CR 9749, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3594CP.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*.

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October 2016 integrated outpatient code editor specifications version 17.3

Provider types affected

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

What you need to know

Change request (CR) 9754 provides the integrated outpatient code editor (I/OCE) instructions and specifications for the I/OCE that will be used under the outpatient prospective payment system (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the home health prospective payment system or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes.

The I/OCE specifications will be posted at *https://www.cms.gov/OutpatientCodeEdit/*. These specifications contain the appendices mentioned in the table below.

Key changes for October 2016 I/OCE

The modifications of the I/OCE for the October 2016 release are summarized in the table below. Readers should also read through the entire document and note the highlighted sections, which also indicate changes from the prior release of the software. Some I/OCE modifications may be retroactively added to prior releases. If so, the retroactive date appears in the 'Effective date' column.

Effective date	Edits affected	Modification
10/1/16	1, 2, 3, 86	Updated diagnosis code editing for validity, age, gender, and manifestation based on the FY 2017 ICD-10-CM code revisions to the Medicare code editor (MCE).
10/1/16	29	Updated the mental health diagnosis list based on the FY 2017 ICD-10-CM code revisions.
1/1/16	99	**Implement new edit 99:** Claim with pass-through or non-pass-through drug or biological lacks OPPS payable procedure (return to provider (RTP)). **Criteria**: There is a pass-through drug or biological HCPCS code present on a claim without an associated OPPS procedure with status indicator (SI) = J1, J2, P, Q1, Q2, Q3, R, S, T, U, V. **Note**: Refer to special OPPS processing logic and Appendix P.
1/1/16	98	Revise the logic for edit 98 to remove the pass-through drugs and biologicals; editing for pass-through devices remains. The revised description is "Claim with pass-through device lacks required procedure (RTP)" (refer to special OPPS processing logic and Appendix P).
7/1/16	95, 96, 97	Deactivate edits 95, 96, and 97 retroactive to the implementation date (refer to special OPPS processing logic and Appendix C for weekly partial hospitalization program (PHP) processing).
10/1/13	41	Add revenue code 953 (chemical dependency) to the list of valid revenue codes.
1/1/16		Assign payment adjustment flag 10 (Coinsurance not applicable) for pass-through drugs and biologicals when reported with an OPPS payable procedure that is not subject to payment offset (refer to Appendix G).

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Effective date	Edits affected	Modification
1/1/16		Update the payment indicator assignment for pass-through (SI=G) and non-pass-through (SI=K) drugs to a value of 2 (Services not paid under OPPS; paid under fee schedule or other payment system); update the payment method flag assignment to a value of 2 (refer to special OPPS processing logic, Table 7 and Appendix E).
1/1/15		Update the conditional ambulatory payment classification (APC) processing logic for STV-packaged (SI=Q1) and T-packaged (SI=Q2) codes to ignore already packaged codes from the selection of highest paying service for the day (refer to special OPPS processing logic).
1/1/15		Correct the program logic to remove complexity-adjusted comprehensive APC values from the claim output of non-OPPS claims (OPPS flag = 2).
1/1/15		Update the comprehensive APC exclusion list to correct the omission of certain laboratory and non-covered services (see quarterly data files).
10/1/16		Updated the following lists for the release (see quarterly data files): ▪ Deductible/coinsurance not applicable (see also Appendix O) ▪ Comprehensive APC exclusions ▪ Federally qualified health venter (FQHC) preventive and FQHC qualifying visit code pairs (see also Appendix M) ▪ Conditional bilateral list ▪ PHP duration list ▪ Valid revenue codes

Effective date	Edits affected	Modification
10/1/16		Make all HCPCS/APC/SI changes as specified by the Centers for Medicare & Medicaid Services (CMS) (quarterly data files).
10/1/16	20, 40	Implement version **22.3** of the NCCI (as modified for applicable outpatient institutional providers).
10/1/16		Update Appendix F-a to add new edit 99.
10/1/16		Updated effective versions for payment adjustment flag values, and reformatted table in Appendix G.

Additional information

The official instruction, CR 9754, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3591CP.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*.

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Update-inpatient psychiatric facilities PPS fiscal year 2017

Provider types affected

This *MLN Matters*® article is intended for inpatient psychiatric facilities (IPFs) that submit claims to Medicare administrative contractors (MACs) for services provided to inpatient Medicare beneficiaries and are paid under the inpatient psychiatric facilities prospective payment system (IPF PPS).

What you need to know

Change request (CR) 9732 identifies changes required as part of the annual IPF PPS update from the FY 2017 IPF PPS notice displayed July 28, 2016. These changes are applicable to IPF discharges occurring from October 1, 2016, through September 30, 2017. In addition, CR 9732 removes two ICD-10 PCS electroconvulsive therapy (ECT) codes, GZB1ZZZ and GZB3ZZZ, in accordance with national coverage determination (NCD) 160.25. Make sure your billing staffs are aware of these IPF PPS changes for FY 2017.

Background

Payments to IPFs under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (bad debts, and graduate medical education). The Centers for Medicare & Medicaid Services (CMS) is required to make updates to this prospective payment system annually.

CR 9732 identifies changes required by the annual IPF PPS update from the IPF PPS FY 2017 notice. These changes are applicable to IPF discharges occurring during the FY October 1, 2016, through September 30, 2017.

Key points of CR 9732

Market basket update

For FY 2017, CMS is using the 2012-based IPF market basket to update the IPF PPS payments (that is, the federal per diem base rate and ECT payment per treatment). The 2012-based IPF market basket update for FY 2017 is 2.8 percent. However, this 2.8 percent is subject to two reductions required by the Social Security Act (the Act), as described below.

Section 1886(s)(2)(A)(ii) of the Act (*http://www.ssa.gov/OP_Home/ssact/title18/1886.htm*) requires the application of an "Other Adjustment" that reduces any update to the IPF market basket update by percentages specified in Section 1886(s)(3) of the Act for rate year (RY) beginning in 2010 through the FY beginning in 2019. For the FY beginning in 2016 (that is, FY 2017), Section 1886(s)(3)(C) of the Act requires the reduction to be 0.2 percentage point. CMS implemented that provision in the FY 2017 IPF PPS notice.

In addition, the Act Section 1886(s)(2)(A)(i) requires the application of the productivity adjustment described in the Act (Section 1886(b)(3)(B)(xi)(II)) to the IPF PPS for the RY beginning in 2012 (that is, a RY that coincides with a FY), and each subsequent FY. For the FY beginning in 2016 (that is, FY 2017), the reduction is 0.3 percentage point. CMS implemented that provision in the FY 2017 IPF PPS notice.

Specifically, CMS updated the IPF PPS base rate for FY 2017 by applying the adjusted market basket update of 2.3 percent (which includes the 2012-based IPF market basket update of 2.8 percent, the required 0.2 percentage point "other adjustment" reduction to the market basket update, and the required productivity adjustment reduction of 0.3 percentage point) and the wage index budget neutrality factor of 1.0007 to the FY 2016 federal per diem base rate of $743.73 to yield a FY 2017 federal per diem base rate of $761.37. Similarly, applying the adjusted market basket update of 2.3 percent and the wage index budget neutrality factor of 1.0007 to the FY 2016 ECT payment per treatment of $320.19 yields an ECT payment per treatment of $327.78 for FY 2017.

IPF quality reporting program (IPFQR)

Section 1886(s)(4) of the Act requires the establishment of a quality data reporting program for the IPF PPS beginning in FY 2014. CMS finalized requirements for quality reporting for IPFs in the "Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates" final rule (August 31, 2012) (77 FR 53258, 53644 through 53360).

Section 1886(s)(4)(A)(i) of the Act requires that, for FY 2014 and each subsequent fiscal year, the Secretary of Health and Human Services reduce any annual update to a standard federal rate for discharges occurring during the FY by two percentage points for any IPF that does not comply with the quality data submission requirements with respect to an applicable year. Therefore, CMS applies a two percentage point reduction to the federal per diem base rate and the ECT payment per treatment as follows:

- For IPFs that fail to submit quality reporting data under the IPFQR program, CMS applies a 0.3 percent annual update (an update consisting of 2.3 percent reduced by 2.0 percentage points) and the wage index budget neutrality factor of 1.0007 to the FY 2016 federal per diem base rate of $743.73, yielding a Federal per diem base rate of $746.48 for FY 2017.
- Similarly, CMS applies a 0.3 percent annual update and the 1.0007 wage index budget neutrality factor to the FY 2016 ECT payment per treatment of $320.19, yielding an ECT payment per treatment of $321.38 for FY 2017.

IPF PPS pricer updates for FY 2017

- The federal per diem base rate is $761.37 for IPFs complying with quality data submission requirements.
- The federal per diem base rate is $746.48 for IPFs that do not comply with quality data submission requirements.

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- The fixed dollar loss threshold amount is $10,120.00.
- The IPF PPS wage index is based on the FY 2016 pre-floor, pre-reclassified acute care hospital wage index.
- The labor-related share is 75.1 percent.
- The non-labor related share is 24.9 percent.
- The ECT payment per treatment is $327.78 for IPFs that complied with quality data submission requirements.
- The ECT payment per treatment is $321.38 for IPFs that failed to comply with quality data submission requirements.

Cost-to-charge ratios (CCR) for the IPF PPS FY 2017

Cost-to-charge ratios	Median	Ceiling
Urban	0.4455	1.6374
Rural	0.5960	1.9315

CMS is applying the national CCRs to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, CMS is using these national ratios until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
- The IPFs whose operating or capital CCR is in excess of three standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the MAC obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

IPF PPS ICD-10 CM/PCS updates

The adjustment factors are unchanged for the FY 2017 IPF PPS. However, CMS updated the ICD-10-CM/PCS code set as of October 1, 2016. These updates affected the ICD-10-CM/PCS codes which underlie the IPF PPS MS-DRG categories and the IPF PPS comorbidity categories. The updated FY 2017 IPF PPS comorbidity categories and code first lists are available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html*.

FY 2017 IPF PPS wage index

The FY 2017 final IPF PPS wage index is available online at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html*. This FY 2017 IPF PPS final wage index fully incorporates the Office of Management and Budget statistical area delineations that were adopted in the FY 2016 IPF PPS transitional wage index.

Cost Of living (COLA) adjustment for the IPF PPS 2017

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

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

Rural adjustment

Due to the Office of Management and Budget (OMB) core-based statistical area (CBSA) changes implemented in FY 2016, several rural IPFs had their status changed to "urban" as of FY 2016. As a result, these rural IPFs were no longer eligible for the IPF PPS 17 percent rural adjustment. Rather than ending the adjustment abruptly, CMS is phasing out the adjustment for these providers over a three year period.

- In FY 2016, the adjustment for these newly-urban providers is two-thirds of 17 percent, or 11.3 percent.
- For FY 2017, the adjustment for these providers will be one-third of 17 percent, or 5.7 percent.
- No rural adjustment will be given to these providers after FY 2017.

Additional information

The official instruction, CR 9732 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3575CP.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*.

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Inpatient rehabilitation facility annual update: Prospective payment system pricer changes for fiscal year 2017

Provider types affected

This *MLN Matters*® article is intended for inpatient rehabilitation facility (IRFs)submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9669 provides updated rates used to pay IRF PPS claims for fiscal year (FY) 2017. A new IRF PRICER software package will be released prior to October 1, 2016, and will contain the updated rates that are effective for claims with discharges that fall within October 1, 2016, through September 30, 2017. Make sure your billing staff is aware of these changes.

Background

On August 7, 2001, the Centers for Medicare & Medicaid Services (CMS) published a final rule in the *Federal Register* (see *https://www.gpo.gov/fdsys/pkg/FR-2001-08-07/pdf/01-19313.pdf*) that established the IRF PPS as authorized under the Social Security Act (see Section 1886(j) at *http://www.ssa.gov/OP_Home/ssact/title18/1886.htm*). The FY 2017 IRF PPS final rule, issued on July 29, 2016, sets forth the prospective payment rates applicable for IRFs for FY 2017.

Key points

Take note of the phase out of the rural adjustment:

CMS will implement a three-year budget neutral phase out of the rural adjustment for those IRFs that meet the definition in Section 412.602 as rural in FY 2015 and became urban under the FY 2016 core-based statistical area (CBSA) designations. CMS will afford existing IRFs designated in FY 2015 as rural IRFs (pursuant to Section 412.602) and re-designated as an urban facility in FY 2016 (pursuant to Section 412.602) a three-year phase out in order to mitigate the payment effect upon a rural facility that is re-designated as an urban facility (effective FY 2016) and thereby loses the rural adjustment of 1.149.

PRICER updates: For IRF PPS FY 2017

(October 1, 2016 – September 30, 2017)

Category	Amount
Standard federal rate	$15,708
Adjusted standard federal rate	$15,399
Fixed loss amount	$7,984
Labor-related share	0.709
Non-labor related share	0.291
Urban national average cost-to-charge ratio (CCR)	0.421
Rural national average CCR	0.522
Low-income patient (LIP) adjustment	0.3177
Teaching adjustment	1.0163
Rural adjustment	1.149

The Social Security Act (Section 1886(j)(7)(A)(i) requires application of a 2 percentage point reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. The mandated reduction will be applied in FY 2017 for IRFs that failed to comply with the data submission requirements during the data collection period January 1, 2015, through December 31, 2015. Thus, in compliance with Section 1886(j)(7)(A)(i) of the Act, CMS will apply a 2 percentage point reduction to the applicable FY 2017 market basket increase factor (1.65 percent) in calculating an adjusted FY 2017 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements.

Application of the 2 percentage point reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Also, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

The adjusted FY 2017 standard payment conversion factor that will be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the period from January 1, 2015, through December 31, 2015, will be $15,399.

Additional information

The official instruction, CR 9669, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3576CP.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*.

MLN Matters® Number: MM9669
Related Change Request (CR) #: CR 9669
Related CR Release Date: August 5, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3576CP
Implementation October 3, 2016

Upcoming provider outreach and educational events

Medicare Part A changes and regulations

Date: Tuesday, September 20
Time: 10:00-11:30
Type of Event: Webcast
http://medicare.fcso.com/Events/0338439.asp

Medicare Speaks 2016 Orlando

Date: Wednesday-Thursday, September 28-29
Time: 7:30 AM-4:15 PM
Type of Event: Face-to-face
http://medicare.fcso.com/Medicare_Speaks/0343241.pdf

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 July 28, 2016

MLN Connects® Provider eNews for July 28, 2016

View this edition as a PDF

News & Announcements

- Overall Hospital Quality Star Ratings: Evaluation of National Distributions
- Million Hearts® Cardiovascular Disease Risk Reduction Model
- New Payment Models and Rewards for Better Care at Lower Cost
- $42 Billion Saved in Medicare and Medicaid Primarily Through Prevention
- SNF Quarterly Reports Available through Nursing Home Compare
- SNF QRP: Requirements for the FY 2018 Reporting Year Fact Sheet Available
- EHR Incentive Programs: Submit Comments on CY 2017 Hospital OPPS and ASC Proposed Rule by September 6
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis

Provider Compliance

- Home Health Care: Proper Certification Required

Claims, Pricers & Codes

- July 2016 OPPS Pricer File Update

Upcoming Events

- ESRD QIP: Reviewing Your Facility's PY 2017 Performance Data Call – August 2
- Special Open Door Forum: Open Payments Notice to Inform Future Rulemaking – August 2
- Medicare Diabetes Prevention Program Webinar – August 9
- IRF Quality Reporting Program Provider Training – August 9 and 10
- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call – August 10
- Comparative Billing Report on IHC and Special Stains Webinar – August 10
- LTCH Quality Reporting Program Provider Training – August 11

- SNF Quality Reporting Program Provider Training – August 24
- Comparative Billing Report on Modifier 25: Physician Assistant Webinar – August 24
- IMPACT Act: Data Elements and Measure Development Call – August 31

Medicare Learning Network® Publications & Multimedia

- Protecting Patient Personal Health Information MLN Matters Article – New
- SNF Quality Reporting Program Call: Audio Recording and Transcript – New
- Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody under a Penal Authority Fact Sheet – Revised
- Electronic Mailing Lists: Keeping Health Care Professionals Informed Fact Sheet – Revised
- SNF Billing Reference Fact Sheet – Reminder
- Suite of Products & Resources for Compliance Officers Educational Tool – Reminder
- Suite of Products & Resources for Educators & Students Educational Tool – Reminder
- Suite of Products & Resources for Inpatient Hospitals Educational Tool – Reminder
- Suite of Products & Resources for Billers & Coders Educational Tool – Reminder

MLN Connects® Provider eNews for August 4, 2016

MLN Connects® Provider eNews for August 4, 2016
View this edition as a PDF

News & Announcements

- Hospital IPPS and LTCH PPS Final Rule Policy and Payment Changes for FY 2017
- SNFs: Final FY 2017 Payment and Policy Changes
- Hospice Benefit: Final FY 2017 Payment and Policy Changes
- IRFs: Final FY 2017 Payment and Policy Changes
- Inpatient Psychiatric Facilities: Final FY 2017 Payment and Policy Changes
- CMS Announces Next Phase in Largest-ever Initiative to Improve Primary Care in America
- CMS Extends, Expands Fraud-Fighting Enrollment Moratoria Efforts in Six States
- First Release of the Overall Hospital Quality Star Rating on Hospital Compare
- Home Health Agencies: New PEPPER Available
- Partial Hospitalization Programs: New PEPPER Available
- Physician Compare: 2014 Quality Data Available
- Teaching Hospital Closures: Apply for Resident Slots by October 31, 2016
- PQRS: EIDM Accounts Required to Access Feedback Reports and 2015 Annual QRURs
- Replacement of Accessories for Beneficiary-Owned CPAP Device or RAD
- Administrative Simplification Statutes and Regulations
- ICD-10 Coding Resources
- Vaccines are Not Just for Kids

Provider Compliance

- Hospital Discharge Day Management Services

Upcoming Events

- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call — August 10
- Data Collection on Resources Used in Furnishing Global Services Information Session — August 11
- IMPACT Act: Data Elements and Measure Development Call – August 31
- National Partnership to Improve Dementia Care and QAPI Call – September 15

Medicare Learning Network® Publications & Multimedia

- Remittance Advice Information: An Overview Fact Sheet — Reminder
- Medicare Costs at a Glance: 2016 Educational Tool – Revised

MLN Connects® Provider eNews for August 11, 2016

MLN Connects® Provider eNews for August 11, 2016
View this edition as a PDF

News & Announcements

- Medicare Announces Participants in Effort to Improve Access, Quality of Care in Rural Areas
- Affordable Care Act Payment Model Continues to Improve Care, Lower Costs
- ESRD QIP PY 2020 Proposed Rule: New Fact Sheet and Video
- CMS to Release a CBR on Positive Airway Pressure Devices, Respiratory Assist Devices and Accessories in August
- TEP on IMPACT Act Quality Measures: Nominations due August 21

Provider Compliance

- Preventive Services

Claims, Pricers & Codes

- ICD-10 GEMS for 2017 Available

Upcoming Events

- ESRD QIP PY 2020 Proposed Rule Call-In Session – August 16
- Global Surgery Proposed Data Collection Town Hall – August 25
- IMPACT Act: Data Elements and Measure Development Call – August 31
- National Partnership to Improve Dementia Care and QAPI Call – September 15

Medicare Learning Network® Publications & Multimedia

- Timely Reporting of Provider Enrollment Information Changes MLN Matters® Article – New
- IRFs: Improving Documentation Positively Impacts CERT Web-Based Training Course – New
- Physician Compare Call: Addendum – New
- RHCs HCPCS Reporting Requirement and Billing Updates MLN Matters® Article – Revised
- MLN Guided Pathways Provider Specific Medicare Resources Booklet – Revised
- PECOS Technical Assistance Contact Information Fact Sheet – Revised

MLN Connects® Provider eNews for August 18, 2016

MLN Connects® Provider eNews for August 18, 2016
View this edition as a PDF

News & Announcements

- CMS Updates Nursing Home Five-Star Quality Ratings
- IMPACT Act Standardized Assessment Data: Comments due August 26
- Medicare Outpatient Observation Notice: Public Comment Period Ends September 1
- Open Payments: Limited Time for Physicians to Dispute 2015 Data
- Programs of All-Inclusive Care for the Elderly
- Administrative Simplification: Adopted Standards and Operating Rules

Provider Compliance

- Nasal Endoscopy

Claims, Pricers & Codes

- 2017 ICD-10-CM and ICD-10-PCS Code Updates
- Hospice Claim Adjustments Will Correct Routine Home Care Day Count

Upcoming Events

- IRF and LTCH Quality Reporting Program: Public Reporting Webinar – August 23
- Global Surgery Proposed Data Collection Town Hall – August 25
- IMPACT Act: Data Elements and Measure Development Call – August 31
- SNF Quality Reporting Program Webcast – September 14

- National Partnership to Improve Dementia Care and QAPI Call – September 15

Medicare Learning Network® Publications & Multimedia

- Medicare Part B Clinical Laboratory Fee Schedule: Guidance to Laboratories for Collecting and Reporting Data for the Private Payor Rate-Based Payment System MLN Matters Article – New
- ESRD QIP Call: Audio Recording and Transcript – New
- Health Insurance Portability and Accountability Act (HIPAA) EDI Standards Web-Based Training Course – Revised

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.

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