Medicare A CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

November 2016

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MLN Connects® Provider eNews — Special Edition

Tuesday, November 1, 2016

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CMS finalizes hospital OPPS changes to better support hospitals and physicians and improve patient care

On November 1, CMS finalized updated payment rates and policy changes in the hospital outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) payment system for 2017. CMS is also adding new quality measures to the hospital outpatient quality reporting program and the ASC quality reporting program that are focused on improving patient outcomes and experience of care. CMS estimates that the updates in the final rule would increase OPPS payments by 1.7 percent and ASC rates by 1.9 percent in 2017.

Included in the rule:

- Addressing physicians' concerns regarding pain management
- Focusing payments on patients rather than setting
- Improving patient care through technology

For more information:

- *Final Rule*
- *Fact Sheet*

See the full text of this excerpted *CMS Press Release* (issued November 1).

Home health agencies: Final payment changes

On October 31, CMS announced final changes to the Medicare home health (HH) prospective payment system (PPS) for 2017. In the final rule (CMS-1648-F), CMS estimates that Medicare payments to home health agencies in 2017 would be reduced by 0.7 percent, or $130 million based on the finalized policies.

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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.

Issuing compliance letters to specific providers and suppliers regarding inappropriate billing of QMBs for Medicare cost-sharing

Provider types affected

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

Provider action needed

Federal law bars Medicare providers from charging individuals enrolled in the QMB program (QMB) for Medicare Part A and B deductibles, coinsurances, or copays. QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. Change request (CR) 9817 instructs MACs to issue a compliance letter instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing with regard to improper QMB billing. Please make sure your billing staffs are aware of this aspect of your Medicare provider agreement.

Background

In 2013, approximately seven million Medicare beneficiaries were enrolled in QMB, a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost sharing.

State Medicaid programs are liable to pay Medicare providers who serve QMB individuals for the Medicare cost sharing. However, federal law permits states to limit provider payment for Medicare cost sharing to the lesser of the Medicare cost sharing amount, or the difference between the Medicare payment and the Medicaid rate for the service provided. Regardless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost sharing from the beneficiary) as payment in full for services rendered to a QMB individual.

Medicare providers who violate these billing prohibitions are violating their Medicare provider agreement and may be subject to sanctions, as described in Sections 1902(n)(3); 1905(p); 1866(a)(1)(A); and 1848(g)(3) of the Social Security Act (the Act).

In July 2015, the Centers for Medicare & Medicaid Services issued a study finding that:

- Erroneous billing of QMB individuals persists
- Confusion about billing rules exists amongst providers and beneficiaries

Note: The study, titled "Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)," is available at *https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf*.

In September 2016, all Medicare beneficiaries received "Medicare & You 2017," which contains new language to advise QMB individuals about their billing protections. Also, a toll-free number (1-800-MEDICARE) is available to QMB individuals if they cannot resolve billing problems with their providers. In addition, effective September 17, 2016, beneficiary contact center (BCC) customer service representatives (CSRs) can identify a caller's QMB status and advise them about their billing rights.

BCC CSRs will begin escalating beneficiary inquiries involving QMB billing problems that the beneficiary has been unable to resolve with the provider to the appropriate MAC. MACs will issue a compliance letter for all inquiries referred. This compliance letter will instruct named providers and suppliers to refund any erroneous charges and recall any past or existing QMB billing (including referrals to collection agencies).

MACs will also send a copy of the compliance letter to the named beneficiary, with a cover letter advising the beneficiary to show the mailing to the named provider and verify that the provider corrected the billing problem. Examples of these letters are included following the *Additional information* section of this article.

Additional information

The official instruction, CR 9817, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1747OTN.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Example of cover letter for affected QMB individuals sent by MAC

[month] [day], [year]
[address]
[City] ST [Zip}
Reference ID: (NPI, etc.)

Dear [Beneficiary Name]:

You contacted Medicare about a bill you got from [Provider/Supplier Name]. Then we sent [Provider/Supplier Name] the letter on the next page.

You are in the Qualified Medicare Beneficiary (QMB) program. It helps pay your Medicare costs. Medicare providers cannot bill you for Medicare deductibles, coinsurance, or copays for covered items and services.

The letter tells the provider to stop billing you and to refund you any amounts you already paid. Here's what you can do:

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QMBs

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1. Show this letter to your provider to make sure they fixed your bill.
2. Tell all of your providers and suppliers you are in the QMB program.
3. Show your Medicare and your Medicaid or QMB cards each time you get items or services.

If you have questions about this letter, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. Call 1-877-486-2048 if you use TTY.

Sincerely,
[Name]
[Title]
[MAC name]

Example of compliance letter sent to provider by the MAC

[month] [day], [year]
[address]
[City] ST [Zip}
Reference ID: (NPI, etc.)

Dear [Provider/Supplier Name]:

The Centers for Medicare & Medicaid Services (CMS) received information that [Provider/Supplier Name] is improperly billing [Medicare beneficiary name/HICN number] for Medicare cost-sharing.

This beneficiary is enrolled in the Qualified Medicare Beneficiary (QMB) program, a state Medicaid program that helps low-income beneficiaries pay their Medicare cost-sharing. Federal law says Medicare providers can't charge individuals enrolled in the QMB program for Medicare Part A and B deductibles, coinsurances, or copays for items and services Medicare covers.

- Promptly review your records for efforts to collect Medicare cost-sharing from [Medicare beneficiary name/HICN number], refund any amounts already paid, and recall any past or existing billing (including referrals to collection agencies) for Medicare-covered items and services
- Ensure that your administrative staff and billing software exempt individuals enrolled in the QMB program from all Medicare cost-sharing billing and related collection efforts

Medicare providers must accept Medicare payment and Medicaid payment (if any) as payment in full for services given to individuals enrolled in the QMB program. Medicare providers who violate these billing prohibitions are violating their Medicare provider agreement and may be subject to sanctions. (See Sections 1902(n)(3); 1905(p); 1866(a)(1)(A); 1848(g)(3) of the Social Security Act.)

Finally, please refer to this *Medicare Learning Network* (*MLN*®) *Matters*® article for more information on the prohibited billing of QMBs: *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf*. If you have questions, please contact [MAC information].

Sincerely,

[Name]
[Title]
[MAC name]

MLN Matters® Number: MM9817
Related Change Request (CR) #: CR 9817
Related CR Release Date: November 4, 2016
Effective Date: December 6, 2016
Related CR Transmittal #: R1747OTN
Implementation Date: March 8, 2017

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.

FISS implementation of the restructured clinical lab fee schedule

Provider types affected

This *MLN Matters*® article is intended for clinical laboratory providers submitting claims to Medicare administrative contractors (MACs) for services paid under the clinical lab fee schedule (CLFS) and provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9837 informs MACs about the changes to the fiscal intermediary shared system (FISS) to incorporate the revised CLFS containing the national fee schedule rates. Make sure that your billing staffs are aware of these changes.

Background

Section 216 of Public Law 113-93, the "Protecting Access to Medicare Act of 2014," added Section 1834A to the Social Security Act (the Act). This provision requires extensive revisions to the payment and coverage methodologies for clinical laboratory tests paid under the CLFS. The Centers for Medicare & Medicaid Services (CMS) published the CLFS final rule "*Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule*" (CMS-1621-F) was displayed in the *Federal Register* on June 17, 2016, and was published on June 23, 2016, which implemented the provisions of the new legislation.

The final rule set forth new policies for how CMS sets rates for tests on the CLFS and is effective for dates of service on and after January 1, 2018. Beginning on January 1, 2017, applicable laboratories will be required to submit private payor rate data to CMS. (See *MLN Matters*® article *SE1619* for further details of the laboratory data reporting requirements.) In general, with certain designated exceptions, the payment amount for a test on the CLFS furnished on or after January 1, 2018, will be equal to the weighted median of private payer rates determined for the test, based on data collected from laboratories during a specified data collection period. In addition, a subset of tests on the CLFS, advanced diagnostic laboratory tests (ADLTs), will have different data, reporting, and payment policies associated with them. In particular, the final rule discusses CMS' proposals regarding:

- Definition of "applicable laboratory" (who must report data under Section 1834A of the Act)
- Definition of "applicable information" (what data will be reported)
- Data collection period
- Schedule for reporting data to CMS
- Definition of ADLT
- Data Integrity
- Confidentiality and public release of limited data
- Coding for new tests on the CLFS
- Phased in payment reduction

Additional information

The official instruction, CR 9837, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3653CP.pdf*.

MLN Matters® article SE1619 has more details at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1619.pdf*.

The final regulation for the revised CLFS is available at *https://www.gpo.gov/fdsys/pkg/FR-2016-06-23/pdf/2016-14531.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM9837
Related Change Request (CR) #: CR 9837
Related CR Release Date: November 10, 2016
Effective Date: January 1, 2018
Related CR Transmittal #: R3653CP
Implementation Date: July 3, 2017

Modifications to the national coordination of benefits agreement crossover process

Provider types affected

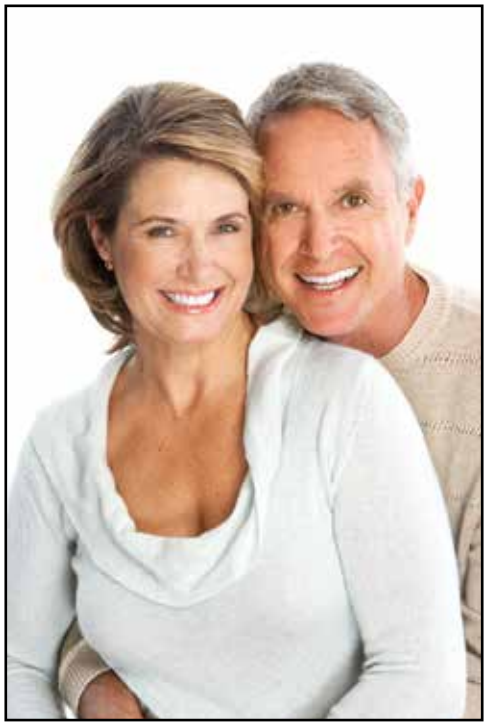
This *MLN Matters*® article is intended for providers, including hospices, submitting institutional claims to Medicare administrative contractors (MACs) requiring coordination of benefits (COB) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9681 modifies Medicare's Part A claim processing system to, among other things:

- Always ensure that a remittance advice remark code (RARC) accompanies claim denials tied to claims adjustment reason code (CARC) 16, as required.
- Prevent duplicate entry of hospital day counts expressed as value codes (for example, value code 80, 81, 82).
- Prevent reporting of present on admission (POA) indicators on outpatient coordination of benefits (COB) facility claims.

Make sure your billing staff is aware of these changes.



Background

The Council for Affordable Quality Healthcare Committee for Operating Rules for Information Exchange (CAQH CORE) dictates which CARC and RARC combinations must be used by all covered entities in the healthcare industry.

Medicare routinely reports CARCs and RARCs on Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Institute (ASC) 835 electronic remittance advice (ERA) transactions in accordance with HIPAA requirements. Medicare also includes CARCs and RARCs within HIPAA ASC 837-N claims transactions, including 837 coordination of benefits (COB) claims transactions.

However, within 837 claims transactions, RARCs are referred to as "claim payment reason codes" and appear within the 2320 Medicare inpatient adjudication information (MIA) and Medicare outpatient adjudication information (MOA) segments.

As a result of systems issues, MACs are not always including a valid and relevant RARC in the 2320 MIA field when they deny Medicare claims. Medicare crossover claims are often being rejected by supplemental payers as a consequence. Though not the only example, this scenario seems to occur frequently when a claim service line is editing to deny with CARC code 16 – "Claim lacks information or has submission/billing error(s) which is needed for adjudication....." CR 9681 will ensure that at least one informational RARC is provided to comply with HIPAA and CAHQ/CORE requirements.

The Part A system is producing instances of duplicated hospital day counts on outbound 837 institutional COB/crossover claims. CR 9681 remedies this situation.

Important: Hospital billing staffs should avoid entering hospital day counts via direct data entry (DDE) screens.

Lastly, at present there is no editing with the Part A system to prevent the entry of a POA indicator on incoming outpatient facility claims. CR 9681 remedies this issue by returning to the provider (RTP) any outpatient claim (type of bill other than 11x, 18x, 21x, 41x, and 82x) that contains a POA indicator.

Important: Billing vendors for hospitals should make it a practice to only include POA indicators on 11x, 18x, 21x, 41x, and 82x type of bill (TOB) claims submitted to Medicare.

Additional information

The official instruction, CR 9681, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1733OTN.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM9681
Related Change Request (CR) #: CR 9681
Related CR Release Date: October 27, 2016
Effective Date: April 1, 2017
Related CR Transmittal #: R1733OTN
Implementation Date: April 3, 2017

Instructions to process services not authorized by the VA in a non-VA facility reported with value code 42

Provider types affected

This *MLN Matters*® article is intended for hospitals and skilled nursing facilities who submit inpatient claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9818 corrects a misinterpretation of the changes made with CR 8198, which updated the shared systems and common working file (CWF) to no longer create Veteran Affairs (VA) "I" records in the Medicare secondary payer (MSP) auxiliary file.

CR 9818 clarifies how Medicare contractors will process inpatient claims for services in a non-VA facility that was not authorized by the VA. Make sure that your billing staff is aware of these changes.

Background

The Social Security Act (Section 1862(a) (3) precludes Medicare from making payment for services or items that are paid for directly or indirectly by another government entity.

The Centers for Medicare & Medicaid Services (CMS) issued *MLN Matters*® special edition article (SE) 1517 to provide clarification and coding reminders for billing Medicare when the Department of Veterans Affairs (VA) is involved for a portion of the services.

CMS was recently notified of a scenario where a hospital cannot follow the instructions in SE1517 to split the claim to bill Medicare for only the non-VA authorized services as instructed in SE1517.

Currently hospitals submit no pay inpatient claims paid by the VA to Medicare for the purpose of crediting the Part A deductible and coinsurance amounts. This process is not changing.

Medicare is precluded from making payment for services or items that are paid for directly or indirectly by another government entity. For inpatient claims where the VA is the Payer, the covered VA services are exclusions to the Medicare program per Section 1862 of the Social Security Act. If the VA doesn't approve all the services, any Medicare covered services not considered by the VA may be billed to the Medicare program.

When a VA- eligible beneficiary chooses to receive services in a Medicare certified facility for which the VA has not authorized, the facility shall use condition code 26 to indicate the patient is a VA eligible patient and chooses to receive services in a Medicare certified provider instead of a VA facility and value code 42 with the amount of the VA payment for the authorized days.

MACs will accept value code '42' on inpatient claims with type of bill codes 11x, 18x, 21x, 41x, and 51x. MACs will calculate the Medicare payment for an inpatient claim when condition code '26' and value code '42' are present on a claim. However, MACs will return the claim to the provider if CC '26' is present without VC '42' or vice versa.

Additional information

The official instruction, CR 9818, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3635CP.pdf*.

Special edition article (SE) 1517 is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1517.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM9818
Related Change Request (CR) #: CR 9818
Related CR Release Date: October 28, 2016
Effective Date: October 1, 2013
Related CR Transmittal #: R3635CP
Implementation Date: April 3, 2017

New physician specialty code for hospitalist

Provider types affected

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

Provider action needed

Change request (CR) 9716 announces that the Centers for Medicare & Medicaid Services (CMS) has established a new physician specialty code for hospitalist. The new code for hospitalist is C6. Make sure your billing staffs are aware of this physician specialty code.

Background

When they enroll in the Medicare program, physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O), or in the internet-based Provider Enrollment, Chain and Ownership System (PECOS). CMS uses these Medicare physician specialty codes, which describe the specific/unique types of medicine that physicians (and certain other suppliers) practice, for programmatic and claim processing purposes.

Medicare will also recognize the new code of C6 as a valid specialty for the following edits:

- Ordering/certifying Part B clinical laboratory and imaging, durable medical equipment (DME), and Part A home health agency (HHA) claims
- Critical access hospital (CAH) method II attending and rendering claims
- Attending, operating, or other physician or non-physician practitioner listed on CAH claims

Additional information

The official instruction, CR 9716, issued to your MAC regarding this change consists of two transmittals. The first updates the *Medicare Claims Processing Manual* and

it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3637CP.pdf*. The second updates the *Medicare Financial Management Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R274FM.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM9716
Related Change Request (CR) #: CR 9716
Related CR Release Date: October 28, 2016
Effective Date: April 1, 2017
Related CR Transmittal #: R3637CP and R274FM
Implementation Date: April 3, 2017

January 2017 quarterly ASP Medicare Part B drug pricing files and revisions to prior files

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) 9843 provides the January 2017 quarterly update and instructs MACs to download and implement the January 2017 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised October 2016, July 2016, April 2016, and the January 2016 average sales price (ASP) drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 3, 2017, with dates of service January 1, 2017, through March 31, 2017. MACs will not search and adjust claims previously processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the outpatient prospective payment system (OPPS) are incorporated into the outpatient code editor (OCE) through separate instructions that are in Chapter 4, Section 50 of the *Medicare Claims Processing Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*.

The following table shows how the quarterly payment files will be applied:

Files	Effective dates of service
January 2017 ASP and ASP NOC	January 1, 2017, through March 31, 2017
October 2016 ASP and ASP NOC	October 1, 2016, through December 31, 2016
July 2016 ASP and ASP NOC	July 1, 2016, through September 30, 2016

Files	Effective dates of service
April 2016 ASP and ASP NOC	April 1, 2016, through June 30, 2016
January 2016 ASP and ASP NOC	January 1, 2016, through March 31, 2016

Additional information

The official instruction, CR 9843, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3640CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM9843
Related Change Request (CR) #: CR 9843
Related CR Release Date: October 28, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3640CP
Implementation Date: January 3, 2017

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.

Notification of CMS approval to First Coast Service Options for TAVR/TAMR

The Centers for Medicare & Medicaid Services (CMS) covers transcatheter aortic valve replacement (TAVR) and transcatheter mitral valve repair (TMVR) under coverage with evidence development (CED) when specific conditions are met, as outlined in the *Medicare National Coverage Determination (NCD) Manual*, Chapter 1, Part 1, Section 20.32 for TAVR and NCD 20.33 for TMVR. Therefore, Medicare administrative contractors (MACs) do not require study investigators to submit the same documentation for an additional review.

However, it would be beneficial to both contractor and physician/facility if the cost and coding form for CMS-approved studies along with the CMS approval letter were sent to First Coast before claims are submitted. This will allow the contractor to make any necessary decisions and preparations for claims receipt especially if unlisted procedure codes are considered and/or applicable. This should not cause any delays in study participation and will help claim adjudication.

Prior to submitting claims to MAC jurisdiction N (JN), your study site should follow the CMS guidelines available in Pub. 100-04 *Medicare Claims Processing Manual*, Chapter 32, Sections 290.1 and 340. The CMS approval is not a claim-level coverage decision, and participating providers (study sites submitting claims to A/B MAC JN) must be able to demonstrate if audited (pre or post payment) that all applicable requirements of the program were met, including but not limited to having an active Investigational Review Board approval, documentation supporting reasonable and necessary services, and accurate billing/coding of claims.

Investigational device exemption process for studies approved by CMS

The Centers for Medicare & Medicaid Services (CMS) made changes to the investigational device exemption (IDE) regulations (42 CFR § 405 Subpart B), effective January 1, 2015. CMS outlined criteria for coverage of IDE studies and changed from local Medicare administrative contractor (MAC) review and approval of investigational device exemption (IDE) studies to a centralized review and approval of IDE studies (with a 2015 Food and Drug Administration (FDA) approval letter).

Assuming all applicable requirements for the program are met, an approval for a Category A (Experimental) IDE study allows coverage of routine care items and services furnished in the study, but not of the Category A device, which is statutorily excluded from coverage. An approval for a Category B (Nonexperimental/investigational) IDE study will allow coverage of the Category B device and the routine care items and services in the trial. The CMS review is generally a request from the principal investigator, and CMS will post the study title, sponsor name, NCT number, IDE number, and CMS approval date on the following website: *https://www.cms.gov/Medicare/Coverage/IDE/Approved-IDE-Studies.html*. However, in order to administer the MAC JN claims for CMS approved studies prior to submission of these claims, the provider must submit to the MAC JN medical policy department (*clinicaltrials@fcso.com*) the CMS approval letter, as well as, the cost and coding form so that the claims system (FISS) is updated to allow payment. This will avoid claims from being inappropriately denied for an IDE study that has been approved by CMS.

For FDA IDE approvals prior to January 1, 2015, First Coast will continue to require investigational study sites to submit for the contractor's review all documentation that is currently required. Please refer to the following article titled "Investigational device exemption (IDE) approval requirements" and request form for a complete list of items the contractor requires for each investigational site. Study sites should submit all of the documentation electronically to *clinicaltrials@fcso.com*.

Link to CMS approval process:

https://www.cms.gov/Medicare/Coverage/IDE/index.html

Link to First Coast cost and coding form:

http://medicare.fcso.com/Clinical_trials/138007.pdf

Therapy services cap values for 2017

Provider types affected

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

Provider action needed

Change request (CR) 9865, from which this article was developed, describes the amounts and policies for outpatient therapy caps for 2017. **For physical therapy and speech-language pathology combined, the 2017 therapy cap will be $1,980. For occupational therapy, the cap for 2017 will be $1,980.** Make sure that your billing staffs are aware of these therapy cap value updates.

Background

The Balanced Budget Act of 1997 (P.L. 105-33), Section 4541(c) applies annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B per beneficiary, commonly referred to as "therapy caps." Therapy caps are updated each year based on the Medicare economic index.

An exception for the therapy caps for reasonable and medically necessary services has been in place since 2006. Originally required by Section 5107 of the Deficit Reduction Act of 2005, the exceptions process for the therapy caps has been continuously extended multiple times through subsequent legislation.

The current therapy caps exceptions process, as required by Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015, expires December 31, 2017. CR 9865 establishes that therapy caps for 2017 will be $1,980. MACs will update to this amount for physical therapy and speech-language pathology combined, and for occupational therapy.

Additional information

The official instruction, CR 9865, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3644CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

MLN Matters® Number: MM9865
Related Change Request (CR) #: CR 9865
Related CR Release Date: November 4, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3644CP
Implementation Date: January 3, 2017

Medicare Learning Network®

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

2017 annual update to the therapy code list

Provider types affected

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

What you need to know

This article is based on change request (CR) 9782 which updates the therapy code list for 2017 by adding eight "always therapy" codes (97161-97168) for physical therapy (PT) and occupational therapy (OT) evaluative procedures. CR 9782 also deletes the four codes currently used to report these services (97001-97004). Make sure your billing staffs are aware of these updates.

Background

Section 1834(k)(5) of the Social Security Act requires that all claims for outpatient rehabilitation therapy services and CORF services be reported using the uniform coding system. The 2017 healthcare common procedure coding system and *Current Procedural Terminology*, Fourth Edition (HCPCS/CPT®-4) is the coding system used for reporting these services.

For 2017, the CPT® editorial panel created eight new codes (97161-97168) to replace the four-code set (97001-97004) for physical therapy (PT) and occupational therapy (OT) evaluative procedures. The new CPT® code descriptors for PT and OT evaluative procedures include specific components that are required for reporting as well as the corresponding typical face-to-face times for each service.

Evaluation codes. The CPT® editorial panel created three new codes to replace each existing PT and OT evaluation code, 97001 and 97003, respectively. These new evaluation codes are based on patient complexity and the level of clinical decision-making – low, moderate, and high complexity: for PT, codes 97161, 97162 and 97163; and for OT, codes 97165, 97166, and 97167.

Re-evaluation codes. One new PT code, 97164, and one new OT code, 97168, were created to replace the existing codes – 97002 and 97004, respectively. The re-evaluation codes are reported for an established patient's when a revised plan of care is indicated.

Just as their predecessor codes were, the new codes are "always therapy" and must be reported with the appropriate therapy modifier, GP or GO, to indicate that the services are furnished under a PT or OT plan of care, respectively.

The new PT evaluative procedure codes are listed in the chart below with their short descriptors* and the required corresponding therapy modifier:

CPT® code	Short descriptor*	Modifier
97161	PT eval low complex 20 min	GP
97162	PT eval mod complex 30 min	GP
97163	PT eval high complex 45 min	GP
97164	PT re-eval est plan care	GP

The new OT evaluative procedure codes are listed in the chart below with their short descriptors* and the required OT therapy modifier:

CPT® code	Short descriptor*	Modifier
97165	OT eval low complex 30 min	GO
97166	OT eval mod complex 45 min	GO
97167	OT eval high complex 60 min	GO
97168	OT re-eval est plan care	GO

***Note**: Please note that the short descriptors cannot be used in place of the CPT® long descriptions which officially define each new PT and OT service. Refer to the two tables with these new CPT® codes and their long descriptions that appear at the end of this article.

Additional information

The official instruction, CR 9782, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3654CP.pdf*.

The therapy code list of "always" and "sometimes" therapy services is available at *https://www.cms.gov/Medicare/Billing/TherapyServices/index.html*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

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Related Change Request (CR) #: CR 9782
Related CR Release Date: November 10, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3654CP
Implementation: 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.

Before you file an appeal...

Each month, thousands of medical providers send written inquiries to First Coast Service Options Inc. (First Coast) to check the status of an appealed claim. Unfortunately, many of these appeals and subsequent inquiries are submitted on claims that were ineligible for appeal.

Before you appeal a denied claim, check out *these resources*.

Revisions to LCDs

Hemophilia clotting factors – revision to the Part AB LCD

LCD ID number: L33684 (Florida, Puerto Rico/ U.S. Virgin Islands)

Based on the October 2016 update, change request (CR) 9768 (Hospital OPPS), CR 9773 (ASC Payment System), and CR 9754 (I/OCE), the local coverage determination (LCD) for hemophilia clotting factors was revised.

HCPCS code C9139 for Idelvion replaced HCPCS code C9399 in the "CPT®/HCPCS Codes" and "ICD-10 Codes that Support Medical Necessity" sections of the LCD. The effective date of this revision is based on date of service.

Effective date

This LCD revision is effective for services rendered **on or after October 1, 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*.

Ranibizumab (Lucentis®) – revision to the Part A and Part B LCD

LCD ID number: L33407 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for ranibizumab (Lucentis®) has been revised to remove the dual diagnosis requirement when reporting the indication of retinal vein occlusion (RVO) with macular edema from the "ICD-10 Codes that Support Medical Necessity" section of the LCD. The associated editing will be adjusted within the next several weeks. First Coast Service Options Inc. will perform adjustments to correct any inappropriately denied claims. No action is required by the provider.

Effective date

This LCD revision is effective for claims processed **on or after November 18, 2016**, for services rendered **on or after October 1, 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*.

Transthoracic Echocardiography (TTE) – revision to the Part A and Part B LCD

LCD ID number: L33768 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for transthoracic echocardiography (TTE) has been revised to comply with the indications and limitations section of the LCD. ICD-10-CM diagnosis code Z51.81 was added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

Effective date

This LCD revision is effective for claims processed **on or after November 21, 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*.

Manual updates to correct remittance advice messages

Provider types affected

This *MLN Matters*® article is intended for physicians and providers, especially clinical diagnostic laboratories, ambulatory surgical centers, and end stage renal disease facilities submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

What you need to know

Change request (CR) 9841 revises Chapters 8, 13, and 14 of the *Medicare Claims Processing Manual* to ensure that all remittance advice coding is consistent with nationally standard operating rules. CR 9841 also provides a format for consistently showing remittance advice coding throughout the *Medicare Claims Processing Manual*.

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 claims adjustment reason codes (CARCs) and remittance advice remark codes (RARCs), regulates the way in which group codes, CARCs, and 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. The Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) authored this rule.

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 9841 updates Chapters 8, 13, and 14 of the manual to reflect the standard format and to correct any non-compliant code combinations. Certain sections of Chapter 8 that contained remittance advice codes are deleted since the instructions are now obsolete. Additional CRs will follow to provide similar revisions to the remaining chapters of the *Medicare Claims Processing Manual*.

Additional information

The official instruction, CR 9841, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3650CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

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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*, ***located here***.

Network fee reduction for acute kidney injury services submitted on type of bill 72x

Provider types affected

This *MLN Matters*® article is intended for providers at end-stage renal disease (ESRD) facilities who submit claims to Part A Medicare administrative contractors (MACs) for services related to acute kidney injury (AKI) provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9814, from which this article was developed, advises providers of the removal of the 50 cent ESRD network fee reduction from claims submitted by ESRD facilities for AKI services. Please make sure your billing staff is aware of this fee reduction removal.

Background

On June 29, 2015, the Trade Preference Extension Act (TPEA) of 2015 was enacted. Section 808 of the TPEA amended Section 1861(s)(2)(F) of the Social Security Act (the Act) (42 U.S.C. 1395x(s)(2)(F)) by extending renal dialysis services paid under Section 1861(b)(14) of the Act to beneficiaries with AKI, effective January 1, 2017.

Policy

Beginning January 1, 2017, ESRD facilities will be able to furnish dialysis to AKI patients. The AKI provision was signed into law June 29, 2015. The pertinent section is available online at *https://www.congress.gov/bill/114th-congress/house-bill/1295/text#toc-HEE69B51CC87340E2B2AB6A4FA73D2A82*.

This provision provides Medicare payment beginning on dates of service from January 1, 2017, and after to ESRD facilities (hospital-based and freestanding), for renal dialysis services furnished to beneficiaries with AKI (both adult and pediatric). Medicare will reimburse ESRD facilities for the dialysis treatment using the ESRD prospective payment system (PPS) base rate adjusted by the applicable geographic adjustment factor (wage index). In addition to the dialysis treatment, the ESRD PPS base rate reimburses ESRD facilities for the items and services considered to be renal dialysis services as defined in 42 CFR Section 413.171 and there will be no separate payment for those services.

Renal dialysis services as defined in 42 CFR, Section 413.171 would be considered to be renal dialysis services for patients with AKI. As such, no separate payment would be made for renal dialysis drugs, biologicals, laboratory services, and supplies that are included in the ESRD PPS base rate when they are furnished by an ESRD facility to an individual with AKI. Other items and services that are furnished to beneficiaries with AKI that are not considered to be renal dialysis services but are related to their dialysis as a result of their AKI would be separately payable. This includes drugs, biologicals, laboratory services, and supplies that ESRD facilities are certified to furnish and that would otherwise be furnished to a beneficiary with AKI in a hospital outpatient setting.

For payment under Medicare, ESRD facilities will report all items and services furnished to beneficiaries with AKI by submitting type of bill (TOB) 72x with condition code 84 (Dialysis for acute kidney injury (AKI)) on a monthly basis. Since ESRD facilities bill Medicare for renal dialysis services by submitting TOB 72x for ESRD beneficiaries, condition code 84 will differentiate an ESRD PPS claim from an AKI claim.

AKI claims will require one of the following diagnosis codes:

1. N17.0 Acute kidney failure with tubular necrosis
2. N17.1 Acute kidney failure acute cortical necrosis
3. N17.2 Acute kidney failure with medullary necrosis
4. N17.8 Other acute kidney failure
5. N17.9 Acute kidney failure, unspecified
6. T79.5XXA Traumatic anuria, initial encounter
7. T79.5XXD Traumatic anuria, subsequent encounter
8. T79.5XXS Traumatic anuria, sequela
9. N99.0 Post-procedural (acute)(chronic) renal failure

In addition, ESRD facilities must include revenue code 082x, 083x, 084x, or 085x for the modality of dialysis furnished with the *Current Procedural Terminology* (CPT®) code G0491:

- Long descriptor: Dialysis procedure at a Medicare certified ESRD facility for acute kidney injury without ESRD
- Short descriptor: dialysis Acu Kidney no ESRD

AKI claims will not have limits on how many treatments can be billed for the monthly billing cycle, however, there will only be payment for one treatment per day across settings, except in the instance of uncompleted treatments:

- If a dialysis treatment is started, that is, a patient is connected to the machine and a dialyzer and blood lines are used, but the treatment is not completed for some unforeseen, but valid, reason, for example, a medical emergency when the patient must be rushed to an emergency room, the facility is paid based on the full base rate. This is a rare occurrence and must be fully documented to the MAC's satisfaction.

CR 9598 implemented the majority of the claims processing changes for this policy; however, the 50-cent ESRD network fee reduction was not considered in the implementation of that CR. This CR implements the removal of that fee from AKI claims.

The content of this CR was finalized in the 2017 ESRD PPS final rule is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-*

See **AKI**, next page

Changes to payments for AKI services in ESRD facilities

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9807 which implements the 2017 rate updates for the ESRD PPS and implements the payment for renal dialysis services furnished to beneficiaries with acute kidney injury (AKI) in ESRD facilities for 2017. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) implemented the ESRD PPS (effective January 1, 2011) based on the requirements of the Social Security Act (Section 1881(b)(14)) as amended by the *Medicare Improvements for Patients and Providers Act* (MIPPA; Section 153(b)).

The Social Security Act (Section 1881(b)(14)(F)), **as added by** MIPPA (Section 153(b)) **and amended by** *the Patient Protection and Affordable Care Act* (Section 3401(h)), **established that** beginning 2012 (and each subsequent year), CMS will annually increase payment amounts by an ESRD market basket increase factor, **reduced by the productivity adjustment described in** the *Social Security Act (Section 1886(b)(3)(B)(xi)(II))*.

The ESRD bundled (ESRDB) market basket increase factor **minus the productivity adjustment** will update the ESRD PPS base rate. *The Protecting Access to*

Medicare Act of 2014 (PAMA; Section 217(b)(2)) included a provision that dictated how the market basket should be reduced for 2017.

Beginning 2017, in accordance with the *Trade Preferences Extension Act of 2015* (TPEA; Section 808(b)), CMS will pay ESRD facilities for furnishing renal dialysis services to Medicare beneficiaries with AKI.

CR 9598 implemented the payment for renal dialysis services and provides detailed information regarding payment policies.

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

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Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices-Items/CMS-1651-F.html.

Note: MACs will adjust all 72x TOBs with AKI with dates of service from January 1, 2017, to March 31, 2017, within 45 days of implementation of CR 9814.

Additional information

The official instruction, CR 9814, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1738OTN.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

Document history

Date	Description
November 4, 2016	Initial issuance

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Implementation Date: April 3, 2017

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2017 ESRD PPS updates

ESRD PPS base rate:

1. A 0.55 percent update to the 2016 payment rate. ($230.39 x 1.0055 =$231.66).
2. A wage index budget-neutrality adjustment factor of 0.999781. ($231.66 x 0.999781 = $231.61)
3. A home dialysis training budget-neutrality adjustment factor of 0.999737. Therefore, the 2017 ESRD PPS base rate is $231.55 ($230.39 x 1.0055 x 0.999781 x 0.999737 =$231.55).

Wage index:

1. The wage index adjustment will be updated to reflect the latest available wage data.
2. The wage index floor will remain at 0.4000.

Labor-related share:

- The labor-related share will remain at 50.673.

Home dialysis training add-on payment:

- The home dialysis training add-on payment will increase from $50.16 to $95.60.

Outlier Policy:

CMS made the following updates to the adjusted average outlier service Medicare allowable payment (MAP) amount per treatment:

1. For adult patients, the adjusted average outlier service MAP amount per treatment is $45.00.
2. For pediatric patients, the adjusted average outlier service MAP amount per treatment is $38.29.

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

1. The fixed dollar loss amount is $82.92 for adult patients.
2. The fixed dollar loss amount is $68.49 for pediatric patients.

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

1. Renal dialysis drugs that are oral equivalents to injectable drugs are based on the most recent prices retrieved from the Medicare prescription drug plan finder, are updated to reflect the most recent mean unit cost. In addition, CMS will add or remove any renal dialysis items and services that are eligible for outlier payment. (See Attachment A in CR 9807.)
2. The mean dispensing fee of the national drug codes (NDCs) qualifying for outlier consideration is revised to $0.88 per NDC per month for claims with dates of service on or after January 1, 2017. (See Attachment A in CR 9807.)

Consolidated billing requirements:

The consolidated billing requirements for drugs and biologicals included in the ESRD PPS is updated by:

1. Adding the following Healthcare Common Procedure Coding System (HCPCS) codes to the bone and mineral metabolism category:
   - J0620 – Injection, calcium glycerophosphate and calcium lactate, per 10 ml, and
   - J3489 – Injection, zoledronic acid, 1 mg.
2. J0620 and J3489 are drugs that are used for bone and mineral metabolism. Bone and mineral metabolism is an ESRD PPS functional category where drugs and biologicals that fall in this category are always considered to be used for the treatment of ESRD. ESRD facilities will not receive separate payment for J0620 and J3489 with or without the AY modifier and the claims will process the line item as covered with no separate payment under the ESRD PPS.
3. Adding HCPCS J0884 – Injection, argatroban, 1 mg (for ESRD on dialysis) to the access management category.

Note: There is a new HCPCS J0883 for argatroban for non-ESRD use. This code will not be permitted on the ESRD type of bill 072x.

4. J0884 is a drug used for access management. Access management is an ESRD PPS functional category where drugs and biologicals that fall in this category are always considered to be used for the treatment of ESRD. ESRD facilities will not receive separate payment for J0884 with or without the AY modifier and the claims will process the line item as covered with no separate payment under the ESRD PPS.
5. In accordance with 42 CFR 413.237(a)(1), HCPCS J0620, J3489, and J0884 are considered to be eligible outlier services. Drugs and biologicals are included in the outlier calculation when the manufacturer submits average sales price (ASP) data to CMS. Details regarding submitting ASP data can be found on the CMS website: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html*.
6. Adding the following HCPCS to the composite rate drugs and biologicals category since these drugs meet the definition of a composite rate drug in Pub. 100-02, Chapter 11, Section 20.3.F, and are renal dialysis services:
   - J0945 - Injection, brompheniramine maleate, per 10 mg.
   - J3265 - Injection, torsemide, 10 mg/ml
   - J7131 - Hypertonic saline solution, 1 ml

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7. HCPCS J0945, J3265, and J7131 do not meet the definition of an outlier service and therefore do not qualify for an outlier payment. In accordance with CR 8978, ESRD facilities should report J0945, J3265, and J7131 along with any other composite rate drugs listed in Attachment B in CR 9807 (See related *MLN Matters*® article *MM8978*).
8. Removing HCPCS J3487 – Injection, zoledronic acid (zometa), 1 mg from the bone and mineral metabolism category. This code was terminated December 31, 2013, and replaced by J3489 effective January 1, 2014.
9. Removing HCPCS C9121 – Injection, argatroban, per 5 mg from the access management category. This code is terminated effective December 31, 2016, and will be replaced by J0884 (Injection, Argatroban, 1 mg (for ESRD on dialysis), effective January 1, 2017.
10. Removing J0635 – calcitriol. This code is no longer an active code.
11. Removing HCPCS S0169 – calcitriol. S codes are not payable under Medicare. Attachment B in CR 9807 reflects the items and services that are subject to the ESRD PPS consolidated billing requirements.

2017 AKI dialysis payment rate for renal dialysis services

1. Beginning January 1, 2017, CMS will pay ESRD facilities $231.55 per treatment.
2. The labor-related share is 50.673.
3. The AKI dialysis payment rate will be adjusted for wages using the same wage index that is used under the ESRD PPS.

4. The AKI dialysis payment rate is not reduced for the ESRD QIP.

Additional information

The official instruction, CR 9807, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R229BP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

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Comprehensive care for joint replacement model provider education

***Note**: This article was revised November 9, 2016, to correct a typo in the list of G-codes in the "Billing and payment for telehealth services" section. The original article mentioned code G9499 and it should have stated G9489. All other information remains the same. This information was previously published in the March 2016 Medicare A Connection, pages 16-19.*

Provider types affected

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

What you need to know

Change request (CR) 9533 supplies information to providers about the CJR model. The intent of the CJR model is to promote quality and financial accountability for episodes of care surrounding a lower-extremity joint replacement (LEJR) or reattachment of a lower extremity procedure. CJR will test whether bundled payments to certain acute care hospitals for LEJR episodes of care will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. Make sure that your billing staffs are aware of these changes.

Background

Section 1115A of the Social Security Act (the Act) authorizes the Centers for Medicare & Medicaid Services (CMS) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance program beneficiaries. Under this authority, CMS published a rule to implement a new five-year payment model called the CJR model April 1, 2016.

Under the CJR model, acute care hospitals in certain selected geographic areas will take on quality and payment accountability for retrospectively calculated bundled payments for LEJR episodes. Episodes will begin with admission to an acute care hospital for an LEJR procedure that is paid under the inpatient prospective payment system (IPPS) through Medical Severity Diagnosis-Related Group (MS-DRG) 469 (Major joint replacement or reattachment of lower extremity with MCC) or 470 (Major joint replacement or reattachment of lower extremity without MCC) and end 90 days after the date of discharge from the hospital.

Key points of CR 9533

CJR episodes of care

LEJR procedures are currently paid under the IPPS through: MS-DRG 469 or MS-DRG 470. The episode will include the LEJR procedure, inpatient stay, and all related care covered under Medicare Parts A and B within the 90 days after discharge. The day of discharge is counted as the first day of the 90-day bundle.

CJR participant hospitals

The model requires all hospitals paid under the IPPS in selected geographic areas to participate in the CJR model, with limited exceptions. A list of the selected geographic areas and participant hospitals is available at *https://innovation.cms.gov/initiatives/cjr*. Participant hospitals initiate episodes when an LEJR procedure is performed within the hospital and will be at financial risk for the cost of the services included in the bundle. Eligible beneficiaries who elect to receive care at these hospitals will automatically be included in the model.

CJR model beneficiary inclusion criteria

Medicare beneficiaries whose care will be included in the CJR model must meet the following criteria upon admission to the anchor hospitalization:

- The beneficiary is enrolled in Medicare Part A and Part B;
- The beneficiary's eligibility for Medicare is not on the basis of the end-stage renal disease benefit;
- The beneficiary is not enrolled in any managed care plan;
- The beneficiary is not covered under a United Mine Workers of America health plan; and
- Medicare is the primary payer.

If at any time during the episode the beneficiary no longer meets all of these criteria, the episode is canceled.

CJR performance years

CMS will implement the CJR model for five performance years, as detailed in the table below. Performance years for the model correlate to calendar years with the exception of performance year one, which is April 1, 2016, through December 31, 2016.

CJR model: Five performance years

Performance year	Date for episodes
Performance year one (2016)	Episodes that start on or after April 1, 2016, and end on or before December 31, 2016
Performance year two (2017)	Episodes that end between January 1, 2017, and December 31, 2017, inclusive
Performance year three (2018)	Episodes that end between January 1, 2018, and December 31, 2018, inclusive
Performance year four (2019)	Episodes that end between January 1, 2019, and December 31, 2019, inclusive
Performance year five (2020)	Episodes that end between January 1, 2020, and December 31, 2020, inclusive

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CJR episode reconciliation activities

CMS will continue paying hospitals and other providers and suppliers according to the usual Medicare fee-for-service payment systems during all performance years. After completion of a performance year, Medicare will compare or "reconcile" actual claims paid for a beneficiary during the 90 day episode to an established target price. The target price is an expected amount for the total cost of care of the episode. Hospitals will receive separate target prices to reflect expected spending for episodes assigned to MS-DRGs 469 and 470, as well as hip fracture status. If the actual spending is lower than the target price, the difference will be paid to the hospital, subject to certain adjustments, such as for quality. This payment will be called a reconciliation payment. If actual spending is higher than the target price, hospitals will be responsible for repayment of the difference to Medicare, subject to certain adjustments, such as for quality.

Identifying CJR claims

To validate the retroactive identification of CJR episodes, CMS is associating the demonstration code 75 with the CJR initiative. This code will also be utilized in future CRs to operationalize a waiver of the three-day stay requirement for covered skilled nursing facility (SNF) services, effective for CJR episodes beginning on or after January 1, 2017.

Medicare will automatically apply the CJR demonstration code to claims meeting the criteria for inclusion in the demonstration. Participant hospitals need not include demonstration code 75 on their claims. Instructions for submission of claims for SNF services rendered to beneficiaries in a CJR episode of care will be communicated once the waiver of the three-day stay requirement is operationalized.

Waivers and amendments of Medicare program rules

The CJR model waives certain existing payment system requirements to provide additional flexibilities to hospitals participating in CJR, as well as other providers that furnish services to beneficiaries in CJR episodes. The purpose of such flexibilities would be to increase LEJR episode quality and decrease episode spending or provider and supplier internal costs, or both, and to provide better, more coordinated care for beneficiaries and improved financial efficiencies for Medicare, providers, and beneficiaries.

Post-discharge home visits

In order for Medicare to pay for home health services, a beneficiary must be determined to be "home bound." A beneficiary is considered to be confined to the home if the beneficiary has a condition, due to an illness or injury, that restricts his or her ability to leave home except with the assistance of another individual or the aid of a supportive device (that is, crutches, a cane, a wheelchair or a walker) or if the beneficiary has a condition such that leaving his or her home is medically contraindicated. Additional information regarding the homebound requirement is available in the *Medicare Benefit Policy Manual*; *Chapter 7*, Home Health Services, Section 30.1.1, Patient Confined to the Home.

Medicare policy allows physicians and non-physician practitioners (NPPs) to furnish and bill for visits to any beneficiary's home or place of residence under the Medicare physician fee schedule (MPFS). Medicare policy also allows such physicians and practitioners to bill Medicare for services furnished incident to their services by licensed clinical staff. Additional information regarding the "incident to" requirements is available in *42 CFR 410.26*.

For those CJR beneficiaries who could benefit from home visits by licensed clinical staff for purposes of assessment and monitoring of their clinical condition, care coordination, and improving adherence with treatment, CMS will waive the "incident to" direct physician supervision requirement to allow a beneficiary who does not qualify for Medicare home health services to receive post-discharge visits in his or her home or place of residence any time during the episode, subject to the following conditions:

- Licensed clinical staff will provide the service under the general supervision of a physician or NPP. These staff can come from a private physician office or may be either an employee or a contractor of the participant hospital.
- Services will be billed under the MPFS by the supervising physician or NPP or by the hospital or other party to which the supervising physician has reassigned his or her billing rights.
- Up to nine post-discharge home visits can be billed and paid per beneficiary during each CJR episode, defined as the 90-day period following the anchor hospitalization.
- The service cannot be furnished to a CJR beneficiary who has qualified, or would qualify, for home health services when the visit was furnished.
- All other Medicare rules for coverage and payment of services incident to a physician's service continue to apply.

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As described in the *Medicare Claims Processing Manual*, *Chapter 12*, Sections 40-40.4, Medicare policy generally does not allow for separate billing and payment for a postoperative visit furnished during the global period of a surgery when it is related to recovery from the surgery. However, for CJR, CMS will allow the surgeon or other practitioners to bill and be paid separately for a post-discharge home visit that was furnished in accordance with these conditions. All other Medicare rules for global surgery billing during the 90 day post-operative period continue to apply.

CMS expects that the post-discharge home visits by licensed clinical staff could include patient assessment, monitoring, assessment of functional status and fall risk, review of medications, assessment of adherence with treatment recommendations, patient education, communication and coordination with other treating clinicians, and care management to improve beneficiary connections to community and other services.

The service will be billed under the MPFS with a HCPCS G-code (G9490) specific to the CJR post-discharge home visit, as listed in Attachment A. The post-discharge home visit HCPCS code will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for post-discharge home visits for the CJR model will be accepted only when the claim contains the CJR specific HCPCS G-code. Although CMS is associating the demonstration code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-code.

Additional information on billing and payment for the post-discharge home visit HCPCS G-code will be available in the April 2016 release of the MPFS recurring update. Future updates to the relative value units (RVUs) and payment for this HCPCS code will be included in the MPFS final rules and recurring updates each year.

Billing and payment for telehealth services

Medicare policy covers and pays for telehealth services when beneficiaries are located in specific geographic areas. Within those geographic areas, beneficiaries must be located in one of the health care settings that are specified in the statute as eligible originating sites. The service must be on the list of approved Medicare telehealth services. Medicare pays a facility fee to the originating site and provides separate payment to the distant site practitioner for the service. Additional information regarding Medicare telehealth services is available in the *Medicare Benefit Policy Manual*, *Chapter 15*, Section 270 and the *Medicare Claims Processing Manual*, *Chapter 12*.

Under CJR, CMS will allow a beneficiary in a CJR episode in any geographic area to receive services via telehealth. CMS also will allow a home or place of residence to be an originating site for beneficiaries in a CJR episode. This will allow payment of claims for telehealth services delivered to beneficiaries at eligible originating sites or at their residence, regardless of the geographic location of the beneficiary. CMS will waive these telehealth requirements, subject to the following conditions:

- Telehealth services cannot substitute for in-person home health visits for patients under a home health episode of care.
- Telehealth services performed by social workers for patients under a home health episode of care will not be covered under the CJR model.
- The telehealth geographic area waiver and the allowance of home as an originating site under the CJR model does not apply for instances where a physician or allowed NPP is performing a face-to-face encounter for the purposes of certifying patient eligibility for the Medicare home health benefit.
- The principal diagnosis code reported on the telehealth claim cannot be one that is specifically excluded from the CJR episode definition.
- If the beneficiary is at home, the physician cannot furnish any telehealth service with a descriptor that precludes delivering the service in the home (for example, a hospital visit code).
- If the physician is furnishing an evaluation and management visit via telehealth to a beneficiary at home, the visit must be billed by one of nine unique HCPCS G-codes developed for the CJR model that reflects the home setting.
- For CJR telehealth home visits billed with HCPCS codes G9484, G9485, G9488, and G9489, the physician must document in the medical record that auxiliary licensed clinical staff were available on site in the patient's home during the visit or document the reason that such a high-level visit would not require such personnel.
- Physicians billing distant site telehealth services under these waivers must include the GT modifier on the

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claim, which attests that the service was furnished in accordance with all relevant coverage and payment requirements.

- The facility fee paid by Medicare to an originating site for a telehealth service will be waived if the service was originated in the beneficiary's home.

The telehealth home visits will be billed under the MPFS with one of nine HCPCS G-code specific to the CJR telehealth home visits. Those codes are G9481, G9482, G9483, G9484, G9485, G9586, G9487, G9488, and G9489. Attachment A of CR 9533 provides the long descriptors of these codes. The telehealth home visit HCPCS codes will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for telehealth home visits for the CJR model will be accepted only when the claim contains one of nine of the CJR specific HCPCS G-code.

Although CMS is associating the demonstration code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-code. Additional information on billing and payment for the telehealth home visit HCPCS G-codes will be available in the April 2016 release of the MPFS recurring update. Future updates to the RVUs and payment for these HCPCS codes will be included in the MPFS final rules and recurring updates each year.

Additional information

The official instruction, CR 9533, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R140DEMO.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.

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- November 9, 2016 - article revised to correct typo and to show correct code of G9489 on page 6.
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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*.

Fiscal year 2017 inpatient prospective payment system and long-term care hospital PPS changes

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9723 which implements policy changes for fiscal (FY) 2017 IPPS and LTCH PPS and covers services effective for hospital discharges occurring on or after October 1, 2016, through September 30, 2017, unless otherwise noted. Failure to adhere to these new policies could affect payment of Medicare claims. Make sure that your billing staff is aware of these IPPS and LTCH PPS changes for FY 2017.

Background

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

CMS displayed the following policy changes for FY 2017 in the *Federal Register* August 2, 2016, with a publication date of August 22, 2016. All items covered in CR 9723 are effective for hospital discharges occurring on or after October 1, 2016, through September 30, 2017, unless otherwise noted.

IPPS FY 2017 update

FY 2017 IPPS rates and factors

Table 1--FY 2017 IPPS rates and factors

Factors	Rate
Standardized amount applicable percentage increase	▪ 1.0165 if quality = '1' and EHR = 'blank' in provider specific file (PSF); or ▪ 1.00975 if quality = '0'and EHR = 'blank' in PSF; or ▪ 0.99625 if quality = '1'and EHR = 'Y' in PSF; or ▪ 0.9895 if quality = '0'and EHR = 'Y' in PSF
Common fixed loss cost outlier threshold	$23,573
Federal capital rate	$446.79

Operating rates for wage index > 1

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Operating rates for wage index < or = 1

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MS-DRG grouper and Medicare code editor changes

For discharges occurring on or after October 1, 2016, the fiscal intermediary shared system (FISS) calls the appropriate grouper based on discharge date. For discharges occurring on or after October 1, 2016, the MCE selects the proper internal code edit tables based on discharge date. Medicare contractors should have received the MCE documentation in August 2016. Note that the MCE version continues to match the grouper version.

Effective October 1, 2016, MS-DRGs 228 through 230 (Other cardiothoracic procedures w MCC, w CC and w/o CC/MCC, respectively) are collapsed from three severity levels to two severity levels by deleting MS-DRG 230 and revising MS-DRG 229, as follows:

- MS-DRG 229 Other cardiothoracic procedures w/o MCC
- MS-DRG 230 Other cardiothoracic procedures w/o CC/MCC

Effective October 1, 2016, the title for MS-DRG 884 (Organic disturbance and mental retardation) is revised to MS-DRG 884 (Organic disturbances and intellectual disability).

Post-acute transfer and special payment policy

No new MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy and special payment policy. See Table 5 of the FY 2017 IPPS/LTCH PPS final rule for a listing of all post-acute and special post-acute MS-DRGs at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html*. Then click on the link on the left side of the screen titled, "FY 2017 IPPS Final Rule Home Page" or "Acute Inpatient Files for Download."

New technology add-on

The following items will continue to be eligible for new-technology add-on payments in FY 2017:

1. Name of approved new technology: CardioMEMS™ HF Monitoring System
   - Maximum add-on payment: $8,875
   - Identify and make new technology add-on payments with ICD-10-PCS procedure code 02HQ30Z or 02HR30Z
2. Name of approved new technology: Blinatumomab (BLINCYTO™)

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- Maximum add-on payment: $27,017.85
- Identify and make new technology add-on payments with ICD 10 PCS procedure code XW03351 or XW04351

3. Name of approved new technology: LUTONIX® drug coated balloon (DCB) percutaneous transluminal angioplasty (PTA) and IN.PACT™Admiral™ pacliaxel coated percutaneous transluminal angioplasty (PTA) balloon catheter
   - Maximum add-on payment: $1,035.72
   - Identify and make new technology add-on payments with any of the following ICD-10-PCS procedure codes: 047K041, 047K0D1, 047K0Z1, 047K341, 047K3D1, 047K3Z1, 047K441, 047K4D1, 047K4Z1, 047L041, 047L0D1, 047L0Z1, 047L341, 047L3D1, 047L3Z1, 047L441, 047L4D1, 047L4Z1, 047M041, 047M0D1, 047M0Z1, 047M341, 047M3D1, 047M3Z1, 047M441, 047M4D1, 047M4Z1, 047N041, 047N0D1, 047N0Z1, 047N341, 047N3D1, 047N3Z1, 047N441,047N4D1, 047N4Z1

The following items will be eligible for new-technology add-on payments in FY 2017:

4. Name of approved new technology: MAGEC® Spinal Bracing Distraction system
   - Maximum add-on payment: $15,750
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes XNS0032, XNS0432, XNS3032, XNS3432, XNS4032, or XNS4432
5. Name of approved new technology: GORE IBE device system
   - Maximum add-on payment: $5,250
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes: 04VC0EZ; 04VC0FZ; 04VC3EZ; 04VC3FZ; 04VC4EZ; 04VC4FZ; 04VD0EZ; 04VD0FZ; 04VD3EZ; 04VD3FZ; 04VD4EZ; or 04VD4FZ
6. Name of approved new technology: Idarucizumab
   - Maximum add-on payment: $1,750
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03331 or XW04331
7. Name of approved new technology: Defitelio®
   - Maximum add-on payment: $75,900
   - Identify and make new technology add-on payments with ICD-10-PCS procedure codes: XW03392 and XW04392
8. Name of approved new technology: Vistogard™
   - Maximum add-on payment: $37,500
   - Identify and make new technology add-on payments with any of the following ICD-10-PCS diagnosis codes T45.1X1A, T45.1X1D, T45.1X1S, T45.1X5A, T45.1X5D, and T45.1X5S in combination with ICD-10-PCS procedure code XW0DX82

Cost of living adjustment (COLA) update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2017, and are the same COLAs established for FY 2014. These COLAs are shown in the following table:

Table 2: FY 2017 cost-of-living adjustment factors (COLAs): Alaska hospitals

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

Table 2: FY 2017 cost-of-living adjustment factors (COLAs): Hawaii hospitals

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

FY 2017 wage index changes and issues

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

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

In order to mitigate potential negative payment impacts due to the adoption of the new OMB delineations, for the few hospitals that were located in an urban county prior to October 1, 2014, that became rural effective October 1, 2014, under the new OMB delineations, CMS assigned a hold-harmless urban wage index value of the labor market area in which they are physically located for FY 2014 for 3 years beginning in FY 2015. That is, for FYs 2015, 2016, and 2017, assuming no other form of wage index reclassification or redesignation is granted, these hospitals are assigned the area wage index value of the urban CBSA in which they were geographically located in FY 2014.

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Note that for hospitals that are receiving the 3-year hold-harmless wage index, the transition is only for the purpose of the wage index and does not affect the hospital's urban or rural status for any other payment purposes.

b. As discussed in the FY 2017 IPPS/LTCH PPS final rule (*81 FR 56913*), among other changes, OMB Bulletin No. 15-01 made the following changes that are relevant to the IPPS wage index:

   - Garfield County, OK, with principal city Enid, OK, which was a Micropolitan geographically rural) area, now qualifies as an urban new CBSA 21420 called Enid, OK.

2. Treatment of certain providers redesignated under the Social Security Act (Section 1886(d)(8)(B))

42 CFR 412.64(b)(3)(ii) implements Section (1886(d)(8)(B)) of the Social Security Act which redesignates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as "Lugar counties".) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are redesignated. A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes.

3. Section 505 hospitals (out-commuting adjustment)

Section 505 of the Medicare Modernization Act of 2003 (MMA), also known as the "outmigration adjustment, is an adjustment that is based primarily on commuting patterns and is available to hospitals that are not reclassified by the Medicare Geographic Classification Review Board (MGCRB), reclassified as a rural hospital under *§412.103*, or redesignated under the Social Security Act (Section 1886(d)(8)(B)).

Treatment of certain urban hospitals reclassified as rural hospitals under § 412.103 and hospitals reclassified under the MGCRB

An urban hospital that reclassifies as a rural hospital under § 412.103 is considered rural for all IPPS purposes. Note, hospitals reclassified as rural under §412.103 are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see §412.320(a)(1)).

Prior to April 21, 2016, the regulations at § 412.230(a)(5)(ii) and §412.230(a)(5)(iii) prohibited hospitals from simultaneously receiving an urban to rural reclassification under §412.103 and a reclassification under the MGCRB. Also, the regulations did not allow a LUGAR hospital (that is, a hospital located in a Lugar county) to keep its LUGAR status if it was approved for an urban to rural reclassification under § 412.103. In light of court decisions that ruled as unlawful the regulation precluding a hospital from maintaining simultaneous MGCRB and § 412.103 reclassifications, on April 18, 2016, CMS issued an interim final rule with comment period (CMS-1664-IFC) amending the regulations to conform to the court decisions. The IFC is effective April 21, 2016, and was finalized in the *Federal Register* published August 2, 2016. The IFC allows hospitals nationwide that have an MGCRB reclassification or LUGAR status during FY 2016 and subsequent years the opportunity to simultaneously seek urban to rural reclassification under §412.103 for IPPS payment and other purposes, and keep their existing MGCRB reclassification or LUGAR status.

Multicampus hospitals with inpatient campuses in different CBSAs

Beginning with the FY 2008 wage index, CMS instituted a policy that allocates the wages and hours to the CBSA in which a hospital campus is located when a multi-campus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility at which the discharge occurred. Note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA. In general, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers.

Medicare-dependent, small rural hospital (MDH) program expiration

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

In the 2016 OPPS final rule, CMS provided for a transition period for these hospitals to mitigate the financial impact of losing MDH status to hospitals that (1) lost their MDH status because they are no longer in a rural area due to the adoption of the new OMB delineations in FY 2015 and (2) have not reclassified from urban to rural under the regulations at §412.103 before January 1, 2016. During the transition period (January 1, 2016, through September 30, 2017), such hospitals ("qualifying former MDHs") will receive a transitional add-on payment. For discharges occurring on or after October 1, 2016, through September 30, 2017, qualifying former MDHs will receive an add-on payment equal to one-third of "the MDH add-on" (that is, one-third of 75 percent of the amount by which the federal rate payment is exceeded by the hospital's hospital-specific rate). Information on the requirements implementing this transitional add-on payment for former MDHs are in CR 9408, which is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3390CP.pdf*.

Based on the best available information, CMS has identified the hospitals it believes qualify for this

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transitional add-on payment. The pricer logic has been modified to calculate this transitional add-on payment in the HSP-payment field in the pricer for the qualifying hospitals identified by CMS.

Hospital-specific (HSP) rate factors for sole-community hospitals (SCHs) and Medicare-dependent, small rural hospitals (MDHs)

For FY 2017, the HSP amount in the PSF for SCHs and MDHs will continue to be entered in FY 2012 dollars. PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 through 2014 of 0.9480, the FY 2017 two-midnight rule one-time prospective increase of 1.006 (as well as the removal of 0.998 two-midnight rule adjustment applied in FY 2014), and apply all of the updates and DRG budget neutrality factors to the HSP amount for FY 2013 and beyond.

Low-volume hospitals – criteria and payment adjustments for FY 2017

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

In order to qualify as a low-volume hospital in FY 2017, a hospital must be located more than 15 road miles from another "subsection (d) hospital" and have less than 1600 Medicare discharges (which includes Medicare Part C discharges and is based on the latest available MedPAR data). The applicable low-volume percentage increase is determined using a continuous linear sliding scale equation that results in a low-volume hospital payment adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more Medicare discharges. For FY 2017, qualifying low-volume hospitals and their payment adjustment are determined using Medicare discharge data from the March 2016 update of the FY 2015 MedPAR file. Table 14 of the FY 2017 IPPS/LTCH PPS final rule (available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html*) lists the "subsection (d)" hospitals with fewer than 1,600 Medicare discharges based on the March 2016 update of the FY 2015 MedPAR file and their low-volume hospital payment adjustment for FY 2017 if eligible). CMS notes that the list of hospitals with fewer than 1,600 Medicare discharges in Table 14 does not reflect whether or not the hospital meets the mileage criterion (that is, the hospital is located more than 15 road miles from any other subsection (d) hospital, which, in general, is an IPPS hospital).

A hospital must notify and provide documentation to its MAC that it meets the mileage criterion as outlined in prior program guidance and the FY 2017 IPPS/LTCH PPS final rule.

To receive a low-volume hospital payment adjustment under § 412.101 for FY 2017, a hospital must make a written request for low-volume hospital status that was received by its MAC no later than September 1, 2016, in order for the applicable low-volume hospital payment adjustment to be applied to payments for discharges occurring on or after October 1, 2016. Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment in FY 2016 may continue to receive a low-volume hospital payment adjustment for FY 2017 without reapplying if it continues to meet the Medicare discharge criterion established for FY 2017 (as shown in Table 14 of the FY 2017 IPPS/LTCH PPS final rule) and the mileage criterion. However, the hospital must have send written verification that was received by its MAC no later than September 1, 2016, stating that it continues to be more than 15 miles from any other "subsection (d)" hospital. This written verification could be a brief letter to the MAC stating that the hospital continues to meet the low-volume hospital distance criterion as documented in a prior low-volume hospital status request. If a hospital's written request for low-volume hospital status for FY 2017 was received after September 1, 2016, and if the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC shall apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital's FY 2017 discharges, effective prospectively within 30 days of the date of its low-volume hospital status determination.

Hospital quality initiative

The hospitals that will receive the quality initiative bonus are listed at *www.qualitynet.org*.

Hospital acquired condition reduction program (HAC)

Section 3008 of the Affordable Care Act establishes a program, beginning in FY 2015, for IPPS hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain HACs. Under the HAC reduction program, a one (1) percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital's discharges for the specified fiscal year.

A list of providers subject to the HAC reduction program for FY 2017 was not publicly available in the final rule because the review and correction process was not yet completed. Updated hospital level data for the HAC reduction program will be made publicly available following the review and corrections process.

Hospital value-based purchasing

Section 3001 of the Affordable Care Act added Section 1886(o) to the Social Security Act, establishing the hospital value-based purchasing (VBP) program. This program

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began adjusting base operating DRG payment amounts for discharges from subsection (d) hospitals, beginning in FY 2013. Under its current agreement with CMS, Maryland hospitals are not subject to the hospital VBP program for the FY 2017 program year. The regulations that implement this provision are in subpart I of 42 CFR part 412 *(§412.160* through *§412.162*).

For FY 2017 CMS will implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2017. CMS expects to post the value-based incentive payment adjustment factors for FY 2017 in the near future in *Table 16B of the FY 2017 IPPS/LTCH PPS final rule*.

Hospital readmissions reduction program

The readmissions payment adjustment factors for FY 2017 are in *Table 15 of the FY 2017 IPPS/LTCH PPS final rule*. Hospitals that are not subject to a reduction under the hospital readmissions reduction program in FY 2017 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. For FY 2017, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.

Note: Hospitals located in Maryland (for FY 2017) and in Puerto Rico are not subject to the hospital readmissions reduction program, and therefore, are not listed in Table 15.

Medicare disproportionate share hospitals (DSH) program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014, by providing that hospitals received 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of this uncompensated care pool based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital' s share of uncompensated care is based on its share of insured low income days, defined as the sum of Medicare supplemental security income (SSI) days and Medicaid days, relative to all Medicare DSH hospitals' insured low income days.

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

The total uncompensated care payment amount to be paid to Medicare DSH hospitals was finalized in the FY 2017 IPPS final rule. The uncompensated care payment will be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2017. The estimated per claim amount is determined by dividing the total uncompensated care payment by the average number of claims from the most recent three years of claims data (FY 2013-2015). The estimated per discharge uncompensated care payment amount will be included in the outlier payment determinations. In addition, the estimated per discharge uncompensated care payment amount will be included as a federal payment for sole-community hospitals to determine if a claim is paid under the hospital-specific rate or federal rate and for Medicare-dependent hospitals to determine if the claim is paid 75 percent of the difference between payment under the hospital-specific rate and payment under the federal rate. The total uncompensated care payment amount displayed in the Medicare DSH supplemental data file on the CMS website will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis.

Recalled devices

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

New MS-DRGs are added to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they are formed from procedures previously assigned to MS-DRGs that were already on the list.

There are no new MS-DRGs for FY 2017 subject to the policy for replaced devices offered without cost or with a credit.

LTCH PPS FY 2017 update

FY 2017 LTCH PPS rates and factors

Factors	Rates
LTCH PPS standard federal rates	Rates based on successful reporting of quality data. ▪ Full update (quality indicator on PSF = 1): $42,476.41 ▪ Reduced update (quality indicator on PSF = 0 or blank): $41,641.49
Labor share	66.5 percent
Non-labor share	33.5 percent
High-cost outlier fixed-loss amount for standard federal rate discharges	$21,943
High-cost outlier fixed-loss amount for site-neutral rate discharges	$23,573

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The LTCH PPS pricer has been updated with the version 34.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2016, and on or before September 30, 2017.

1. Application of the site-neutral payment rate

Section 1206(a) of Public Law 113–67 amended Section 1886(m) of the Social Security Act to establish patient-level criteria for payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015.

The application of the site-neutral payment rate is codified in the regulations at *§412.522*. Additional information on the final policies implementing the application of the site neutral payment rate can be found in the FY 2016 final rule (80 FR 49601-49623). Section 231 of the Consolidated Appropriations Act created a temporary exception to the site neutral payment rate for certain discharges from certain LTCHs. Additional information on the provisions of Section 231 can be found in the interim final rule with comment period (IFC) published in the *Federal Register* April 21, 2016 (81 FR 25430) and finalized in the FY 2017 IPPS/LTCH final rule (81 FR 57068). Information on the requirements implementing the application of the site neutral payment rate is available in CRs 9015 and 9599.

The provisions of Section 1206(a) of Public Law 113-67 establishes a transitional blended payment rate for site neutral payment rate LTCH discharges occurring in cost reporting periods beginning during FY 2016 or FY 2017, which is implemented in the regulations at §412.522(c)(1). The blended payment rate is comprised of 50 percent of the site neutral payment rate for the discharge and 50 percent of the LTCH PPS standard federal payment rate that would have applied to the discharge if the provisions of Public Law 113-67 had not been enacted. This transitional blended payment rate for site neutral payment rate LTCH discharges is included in the pricer logic.

Discharge payment percentage

Beginning with LTCHs' FY 2016 cost reporting periods, the statute requires LTCHs to be notified of their "discharge payment percentage" (DPP), which is the ratio (expressed as a percentage) of the LTCHs' FFS discharges which received LTCH PPS standard federal rate payment to the LTCHs' total number of LTCH PPS discharges. MACs shall continue to provide notification to the LTCH (other than a sub-clause II LTCH) of its DPP upon final settlement of the cost report.

LTCH quality reporting (LTCHQR) program

The Affordable Care Act (Section 3004(a)) requires the establishment of the long-term care hospital quality reporting (LTCHQR) program. For FY 2017, the annual update to a standard federal rate will continue to be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance with the LTCHQR program for that year.

Cost of living adjustment (COLA) under the LTCH PPS

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2017, and are the same COLAs established in the FY 2014 IPPS/LTCH PPS final rule. The applicable COLAs are the same as those in Tables 2 listed earlier in this article.

Additional information

The official instruction, CR 9723, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3626CP.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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Operating rates for wage index > 1

	Hospital submitted quality data and is a meaningful electronic health record (EHR) user (Update = 1.65 percent)		Hospital did NOT submit quality data and is a meaningful EHR user (Update = 0.975 percent)		Hospital submitted quality data and is NOT a meaningful EHR user (Update = -0.375 percent)		Hospital did NOT submit quality data and is NOT a meaningful EHR user (Update = -1.05 percent)	
	Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
National	$3,839.23	$1,676.91	$3,813.74	$1,665.77	$3,762.75	$1,643.50	$3,737.25	$1,632.37
PR national	$3,839.23	$1,676.91	$3,839.23	$1,676.91	$1,676.91	$3,839.23	$3,839.23	$1,676.91

Operating rates for wage index < or = 1

	Hospital submitted quality data and is a meaningful EHR user (Update= 1.65 percent)		Hospital did NOT submit quality data and is a meaningful EHR user (Update= 0.975 percent)		Hospital submitted quality data and is NOT a meaningful EHR user (Update= -0.375 percent)		Hospital did NOT submit quality data and is NOT a meaningful EHR user (Update= -1.05 percent)	
	Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
National	$3,420.01	$2,096.13	$3,397.30	$2,082.21	$3,351.88	$2,054.37	$3,329.16	$2,040.46
PR national	$3,420.01	$2,096.13	$3,420.01	$2,096.13	$3,420.01	$2,096.13	$3,420.01	$2,096.13

Clarification of immediately preceding hospital in transmittal 1544, CR 9015

LTCH: Clarification of immediately preceding hospitals for exclusion from site-neutral payment rate

The description of a qualifying immediately preceding hospital as inpatient prospective payment system (IPPS) hospital in *MLN Matters*® article *MM9015*) has been changed to "subsection (d) hospital" to be consistent with the *Code of Federal Regulations*. Discharges in cost reporting periods beginning on or after October 1, 2015, may have been incorrectly paid at the site neutral rate if:

- The immediately preceding hospital claim was not present in Medicare claim processing claims history, or
- The patient came from a "subsection (d)" immediately preceding hospital other than an IPPS hospital.

Long-term care hospitals (LTCHs) should contact their Medicare administrative contractors (MACs) about these claims. MACs will work with LTCHs to obtain additional documentation for affected claims and make any appropriate adjustments to payment.

Reprocess of some inpatient prospective payment system claims

Some inpatient prospective payment system (IPPS) hospital and long-term care hospital (LTCH) claims with discharge dates on or after October 1, 2016, may be grouped to an incorrect Medicare severity diagnosi-related group (MS-DRG). A revision to the ICD-10 MS-DRG version 34 software file was made and affected claims will be reprocessed by your Medicare administrative contractor by February 1, 2017. No action is required by IPPS and LTCH hospitals.

2017 home health prospective payment system rate update

Provider types affected

This *MLN Matters*® article is intended for home health agencies (HHAs) submitting claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9820 updates the national, standardized 60-day episode rates, the national per-visit rates, and the non-routine medical supply payment amounts under the HH PPS for 2017. Make sure your billing staff is aware of these changes.

Background

The Affordable Care Act (Section 3131(a)) mandates that starting in 2014, the Centers for Medicare & Medicaid Services (CMS) must apply an adjustment to the national, standardized 60-day episode payment rate and other amounts applicable under the Social Security Act (Section 1895(b)(3)(A)(i)(III)) to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. The Affordable Care Act (Section 3131(a)) mandates that this rebasing must be phased-in over a four-year period in equal increments, not to exceed 3.5 percent of the amount (or amounts), as of the date of enactment, applicable under the Social Security Act (Section 1895(b)(3)(A)(i)(III)), and be fully implemented by 2017.

In addition, the Affordable Care Act (Section 3401(e)) requires that the market basket percentage under the HH PPS be annually adjusted by changes in economy-wide productivity for 2015 and each subsequent year.

The Medicare Modernization Act (MMA; Section 421(a)), as amended by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; Pub. L. 114–10; Section 210), provides an increase of 3 percent of the payment amount otherwise made under the Social Security Act (Section 1895) for home health services furnished in a rural area (as defined in the Social Security Act (Section 1886(d)(2)(D)), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2018. The statute waives budget neutrality related to this provision, as the statute specifically states that CMS will not reduce the standard prospective payment amount (or amounts) under the Social Security Act (Section 1895) applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

Market basket update

The 2017 HH market basket update is 2.8 percent which is then reduced by a multi-factor productivity (MFP) adjustment of 0.3 percentage points. The resulting home health (HH) payment update is equal to 2.5 percent. HHAs that do not report the required quality data will receive a 2 percentage point reduction to the HH payment update.

National, standardized 60-day episode payment

As described in the 2017 HH PPS final rule, in order to calculate the 2017 national, standardized 60-day episode payment rate, CMS applies a wage index budget neutrality factor of 0.9996 and a case-mix budget neutrality factor of 1.0214 to the previous year's national, standardized 60-day episode rate. In order to account for nominal case-mix growth from 2012 to 2014, CMS applies a payment reduction of 0.97 percent to the national, standardized 60-day episode payment rate. CMS then applies an $80.95 rebasing reduction (which is 3.5 percent of the 2010 national, standardized 60-day episode rate of $2,312.94) to the national, standardized 60-day episode rate.

Lastly, the national, standardized 60-day episode payment rate is updated by the 2017 HH payment update percentage of 2.5 percent for HHAs that submit the required quality data and by 2.5 percent minus 2 percentage points, or 0.5 percent, for HHAs that do not submit quality data. These two episode payment rates are shown in Table 1 and Table 2. (Page 32) These payments are further adjusted by the individual episode's case-mix weight and by the wage index.

National per-visit rates

In order to calculate the 2017 national per-visit payment rates, CMS starts with the 2016 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0000 to ensure budget neutrality for low utilization payment adjustment (LUPA) per-visit payments after applying the 2017 wage index, and then applies the maximum rebasing adjustments to the per-visit rates for each discipline. The per-visit rates are then updated by the 2017 HH payment update of 2.5 percent for HHAs that submit the required quality data and by 0.5 percent for HHAs that do not submit quality data. The per-visit rates are shown in Table 3 and Table 4 (Page 32).

Non-routine supply payments

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by an NRS conversion factor. To determine the 2017 NRS conversion factors, CMS starts with the 2016 NRS conversion factor and applies a 2.82 percent rebasing adjustment as described in the 2017 HH PPS final rule. CMS then updates the conversion factor by the 2017 HH payment update of 2.5 percent for HHAs that submit the required quality data and by 0.5 percent for HHAs that do not submit quality data. CMS does not apply any standardization factors as the NRS payment amount calculated from the conversion factor is neither wage nor case-mix adjusted when the final payment amount is computed. The NRS conversion factor for 2017 payments for HHAs that do submit the required quality data is shown in Table 5a and the payment amounts for the various NRS severity levels are shown in Table 5b. The NRS

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conversion factor for 2017 payments for HHAs that do not submit quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b.

Table 5a: 2017 NRS conversion factor for HHAs that DO submit the required quality data 2016 NRS conversion factor

2017 rebasing adjustment	2017 HH payment update	2017 NRS conversion factor
$52.71	X 0.9718	X 1.025

Table 5b: 2017 relative weights and payment amounts for the six-severity NRS system for HHAs that DO submit quality data

Severity level	Points (scoring)	Relative weight	2017 NRS payment amounts
1	0	0.2698	$14.16
2	1 to 14	0.9742	$51.15
3	15 to 27	2.6712	$140.24
4	28 to 48	3.9686	$208.35
5	49 to 98	6.1198	$321.29
6	99+	10.5254	$552.58

Table 6a: 2017 NRS conversion factor for HHAs that DO NOT submit the required quality data

2016 NRS conversion factor	2017 rebasing adjustment	2017 HH payment update percentage minus 2 percentage points	2017 NRS conversion factor
$52.71	X 0.9718	X 1.005	$51.48

Table 6b: 2017 relative weights and payment amounts for the six-severity NRS system for HHAs that DO NOT submit quality data

Severity level	Points (scoring)	Relative weight	2017 NRS payment amounts
1	0	0.2698	$13.89
2	1 to 14	0.9742	$50.15
3	15 to 27	2.6712	$137.51
4	28 to 48	3.9686	$204.30
5	49 to 98	6.1198	$315.05
6	99+	10.5254	$541.85

Rural add-on

As stipulated in the MMA (Section 421(a)), the 3 percent rural add-on is applied to the national, standardized 60-day episode rate, national per-visit payment rates, LUPA add-on payments, and the NRS conversion factor when home health services are provided in rural (non-CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2018. Refer to Table 7, Table 8 (Page 33), Table 9a and Table 9b on Pages 33-34 for the 2017 rural payment rates.

These changes are implemented through the home health pricer software in Medicare's shared systems.

Additional information

The official instruction, CR 9820, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3624CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

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Table 1: For HHAs that DO submit quality data – national, standardized 60-day episode amount for 2017

2016 national, standardized 60-day episode payment	Wage index budget neutrality factor	Case-mix weights budget neutrality factor	Nominal case-mix growth adjustment	2017 rebasing adjustment	2017 HH payment update	2017 national, standardized 60-day episode payment
$2,965.12	X 0.9996	X 1.0214	X 0.9903	-$80.95	X 1.025	$2,989.97

Table 2: For HHAs that DO NOT submit quality data – national, standardized 60-day episode amount for 2017

2016 national, standardized 60-day episode payment	Wage index budget neutrality factor	Case-mix weights budget neutrality factor	Nominal case-mix growth adjustment	2017 rebasing adjustment	2017 HH payment update minus 2 percentage points	2017 national, standardized 60-day episode payment
$2,965.12	X 0.9996	X 1.0214	X 0.9903	-$80.95	X 1.005	$2,931.63

Table 3: For HHAs that DO submit quality data – 2017 national per-visit amounts for LUPAs and outlier calculations

HH discipline type	2016 per-visit payment	Wage index budget neutrality factor	2017 rebasing adjustment	2017 HH payment update	2017 per-visit payment
Home health aide	$60.87	X 1.0000	+ $1.79	X 1.025	$64.23
Medical social services	$215.47	X 1.0000	+ $6.34	X 1.025	$227.36
Occupational therapy	$147.95	X 1.0000	+ $4.35	X 1.025	$156.11
Physical therapy	$146.95	X 1.0000	+ $4.32	X 1.025	$155.05
Skilled nursing	$134.42	X 1.0000	+ $3.96	X 1.025	$141.84
Speech-language pathology	$159.71	X 1.0000	+ 4.70	X 1.025	$168.52

Table 4: For HHAs that DO NOT submit quality data – 2017 national per-visit amounts for LUPAs and outlier calculations

HH discipline type	2016 per-visit payment	Wage index budget neutrality factor	2017 rebasing adjustment	2017 HH payment update	2017 per-visit payment
Home health aide	$60.87	X 1.0000	+ $1.79	X 1.005	$62.97
Medical social services	$215.47	X 1.0000	+ $6.34	X 1.005	$222.92
Occupational therapy	$147.95	X 1.0000	+ $4.35	X 1.005	$153.06

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HH discipline type	2016 per-visit payment	Wage index budget neutrality factor	2017 rebasing adjustment	2017 HH payment update	2017 per-visit payment
Physical therapy	$146.95	X 1.0000	+ $4.32	X 1.005	$152.03
Skilled nursing	$134.42	X 1.0000	+ $3.96	X 1.005	$139.07
Speech-language pathology	$159.71	X 1.0000	+ 4.70	X 1.005	$165.23

Table 7: 2017 national, standardized 60-day payment amounts for services provided in a rural area

For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
2017 national, standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	2017 rural national, standardized 60-day episode payment rate	2017 national, standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	2017 rural national, standardized 60-day episode payment rate
$2,989.97	X 1.03	$3,079.67	$2,931.63	X 1.03	$3,019.58

Table 8: 2017 national per-visit amounts for services provided in a rural area

	For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
HH discipline type	2017 per-visit rate	Multiply by the 3 percent rural add-on	2017 rural per-visit rates	2017 per-visit rate	Multiply by the 3 percent rural add-on	2017 rural per-visit rates
HH Aide	$64.23	X 1.03	$66.16	$62.97	X 1.03	$64.86
MSS	$227.36	X 1.03	$234.18	$222.92	X 1.03	$229.61
OT	$156.11	X 1.03	$160.79	$153.06	X 1.03	$157.65
PT	$155.05	X 1.03	$159.70	$152.03	X 1.03	$156.59
SN	$141.84	X 1.03	$146.10	$139.07	X 1.03	$143.24
SLP	$168.52	X 1.03	$173.58	$165.23	X 1.03	$170.19

Table 9a: 2017 NRS conversion factor for services provided in rural areas

For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
2017 conversion factor	Multiply by the 3 percent rural add-on	2017 rural NRS conversion factor	2017 conversion factor	Multiply by the 3 percent rural add-on	2017 rural NRS conversion factor
$52.50	X 1.03	$54.08	$51.48	X 1.03	$53.02

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Table 9b: 2017 relative weights and payment amounts for the six-severity NRS system for services provided in rural areas

For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
Severity Level	Points (Scoring)	Relative weight	2017 NRS payment amounts for rural areas	Relative weight	2017 NRS payment amounts for rural areas
1	0	0.2698	$14.59	0.2698	$14.30
2	1 to 14	0.9742	$52.68	0.9742	$51.65
3	15 to 27	2.6712	$144.46	2.6712	$141.63
4	28 to 48	3.9686	$214.62	3.9686	$210.42
5	49 to 98	6.1198	$330.96	6.1198	$324.47
6	99+	10.5254	$569.21	10.5254	$558.06

These changes are implemented through the home health pricer software in Medicare's shared systems.

Announcement of 2017 payment rate increases for rural health clinic

Provider types affected

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

What you need to know

Change request (CR) 9829 provides MACs instructions for 2017 payment rate increases for RHCs. Section 1833(f) of the Social Security Act (the Act) authorizes that the payment limits for a subsequent year shall be increased in accordance with the rate of increase in the Medicare economic index (MEI).

Based on historical data through second quarter 2016, the 2017 MEI is 1.2 percent. The RHC upper payment limit per visit for 2017 is $82.30, effective January 1, 2017, through December 31, 2017. The 2017 RHC rate reflects a 1.2 percent increase above the 2016 payment limit of $81.32.

Your MAC will not retroactively adjust individual RHC bills paid at previous upper payment limits. However, MACs retain the discretion to make adjustments to the interim payment rate or a lump sum adjustment to total payments already made to take into account any excess or deficiency in payments to date.

Additional information

The official instruction, CR 9829, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3627CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

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Update to the 2017 federally qualified health centers PPS – recurring file updates

Provider types affected

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

Provider action needed

Change request (CR) 9831 updates the FQHC PPS base payment rate and the geographic adjustment factors (GAFs) for the FQHC pricer for 2017. Please ensure your billing staffs are aware of these changes.

Background

Payment for FQHCs under the prospective payment system (PPS)

The Affordable Care Act (Section 10501(i)(3)(A); *Pub. L. 111–148* and *Pub. L. 111–152*) added *Section 1834(o)* of the Social Security Act to establish a payment system for the costs of FQHC services under Medicare Part B based on prospectively set rates. In the PPS for FQHC final rule published in the May 2, 2014, *Federal Register* (*79 FR 25436*), the Centers for Medicare & Medicaid Services (CMS) implemented a methodology and payment rates for FQHCs under the PPS beginning on October 1, 2014.

Payment for grandfathered tribal FQHCs that were provider-based clinics on or before April 7, 2000

Effective for dates of service on or after January 1, 2016, Indian health service (IHS) and tribal facilities and organizations that met the conditions of Section 413.65(m) on or before a 2013-based FQHC market basket.

- Based on historical data through second quarter 2016, the final FQHC market basket for 2017 is 1.8 percent.
- From January 1, 2017, through December 31, 2017, the FQHC PPS base payment rate is $163.49.
- The 2017 base payment rate reflects a 1.8 percent increase above the 2016 base payment rate of $160.60.

In accordance with the Social Security Act (Section 1834(o)(1)(A)), the FQHC PPS base rate is adjusted for each FQHC by the FQHC GAF, based on the geographic practice cost Indices (GPCIs) used to adjust payment under the PFS. The FQHC GAF is adapted from the work and practice expense GPCIs, and are updated when the work and practice expense GPCIs are updated for the PFS. For 2017, the FQHC GAFs have been updated in order to be consistent with the statutory requirements.

Grandfathered tribal FQHC PPS rate

Grandfathered tribal FQHCs are paid the lesser of their charges or a grandfathered tribal FQHC PPS rate for all FQHC services furnished to a beneficiary during a medically-necessary, face-to-face FQHC visit. From January 1, 2016, through December 31, 2016, the grandfathered tribal FQHC PPS rate is $324. FQHC claims (TOB 77x) for grandfathered tribal FQHCs submitted with dates of service on or after January 1, 2016, through December 31, 2016, paid at the 2015 rate of $305 must be adjusted and paid at the 2016 rate of $324.

Grandfathered tribal FQHC claims with dates of service on or after January 1, 2017, through December 31, 2017, should be paid at the 2016 rate of $324 until CMS provides an updated payment rate for 2017. The grandfathered tribal FQHC PPS rate will not be adjusted by the FQHC PPS GAFs or be eligible for the special payment adjustments under the FQHC PPS for new patients, patients receiving an IPPE or an AWV. The rate is also ineligible for exceptions to the single per diem payment that is available to FQHCs paid under the FQHC PPS. In addition, the FQHC market basket adjustment that is applied annually to the FQHC PPS base rate, will not apply to the grandfathered tribal FQHC PPS rate.

Additional information

The official instruction, CR 9831, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3638CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/*.

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Upcoming provider outreach and educational events

Medicare Part A changes and regulations

Date: Tuesday, December 13
Time: 10:00 a.m.-11:30 a.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0353837.asp

Ask-the-contractor teleconference (ACT): Skilled nursing facility (SNF) billing and documentation requirements (Part A)

Date: Thursday, December 15
Time: 10:00 a.m.-11:30 a.m.
Type of Event: Face-to-face
https://medicare.fcso.com/Events/0354913.asp

Note: Unless otherwise indicated, designated times for educational events 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.

MLN Connects®

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 October 27, 2016

MLN Connects® Provider eNews for October 27, 2016

View this edition as a PDF

News & Announcements

- Quality Payment Program: Additional Opportunities for Clinicians to Join Innovative Care Approaches
- Hospital Compare Updated with VA Hospital Performance Data
- CMS Awards Special Innovation Projects to QIN-QIOs
- Meeting the Health Challenges of Rural America
- IRF and LTCH Quality Reporting Program Data Submission Deadline: November 15
- Revised Home Health Change of Care Notice: Effective January 17, 2017
- Prepare for ESRD QIP PY 2017 Reporting Documents by Updating your Account
- Technical Update to 2016 QRDA I Schematrons for eCQM Reporting
- Check Your Patients Addresses
- Connect with Us on LinkedIn

Provider Compliance

- Duplicate Claims

Upcoming Events

- Social Security Number Removal Initiative Open Door Forum – November 1
- How to Report Across 2016 Medicare Quality Programs Call – November 1
- Comparative Billing Report on Subsequent Hospital Care Webinar – November 2
- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call – November 2
- Solutions to Reduce Disparities Webinar – November 14

- Quality Payment Program Final Rule Call – November 15

Medicare Learning Network® Publications & Multimedia

- Implementation of LTCH PPS Based on Specific Clinical Criteria *MLN Matters*® Article – New
- Provider Compliance Fact Sheets – New
- IMPACT Act Call: Audio Recording and Transcript – New
- PECOS FAQs Fact Sheet – Revised
- DMEPOS Information for Pharmacies Fact Sheet – Revised
- Complying with Documentation Requirements for Laboratory Services Fact Sheet – Reminder
- Electronic Mailing Lists: Keeping Health Care Professionals Informed Fact Sheet – Reminder

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.

MLN Connects® Provider eNews for November 3, 2016

MLN Connects® Provider eNews for November 3, 2016
View this edition as a PDF

News & Announcements

- Updates to Dialysis Facility Compare: Patient Experience Ratings Available
- Hospital Value-Based Purchasing Program Results for FY 2017
- DMEPOS Competitive Bidding Program: CMS Awards Contracts for Round 1 2017
- 2017 PQRS Results: Submit an Informal Review by November 30
- IRF and LTCH Quality Reporting Program: NHSN Rebaseline Guidance
- Recovery Audit Contractor Awards
- Antipsychotic Drug use in Nursing Homes: Trend Update
- November is Home Care and Hospice Month

Provider Compliance

- Chiropractic Services: High Part B Improper Payment Rate

Claims, Pricers & Codes

- Billing for Influenza: New CPT® Code 90674

Upcoming Events

- Quality Payment Program Final Rule Call – November 15
- 2016 Hospital Appeals Settlement Call – November 16
- IRF and LTCH: Transition to NHSN Rebaseline Webinar – November 16
- IRF and LTCH Quality Measure Report Call – December 1
- National Partnership to Improve Dementia Care and QAPI Call – December 6
- CMS 2016 Quality Conference – December 13-15

Medicare Learning Network® Publications & Multimedia

- Provider Compliance Fact Sheets – New
- QRUR Call: Audio Recording and Transcript – New
- Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision Fact Sheet – Revised

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MLN Connects® Provider eNews for November 10, 2016

MLN Connects® Provider eNews for November 10, 2016
View this edition as a PDF

News & Announcements

- Proposed Rule on Fire Safety Requirements for Applicable Dialysis Facilities
- IMPACT Act Cross-Setting Quality Measure on Pressure Ulcers: Comments due November 17
- 2017 PQRS Results: Submit an Informal Review by November 30
- Value Modifier: Informal Review Request Period Open through November 30
- IRF-PAI and LTCH Provider Reports Retention Change: Take Action by December 1
- Open Payments: Physicians and Teaching Hospitals Review Pubic Data by December 31
- Quality Payment Program Presentations Available
- New Guide Helps Nursing Homes Tackle Antimicrobial Stewardship
- Raising Awareness of Diabetes in November

Provider Compliance

- Compliance Program Basics

Claims, Pricers & Codes

- Re-release of V34 ICD-10 MS-DRG Grouper, Definitions Manual, and Errata Available

Upcoming Events

- Quality Payment Program Final Rule Call – November 15
- 2016 Hospital Appeals Settlement Call – November 16
- Medicare Diabetes Prevention Program Model Expansion Call – November 30
- IRF and LTCH Quality Measure Report Call – December 1
- National Partnership to Improve Dementia Care and QAPI Call – December 6

Medicare Learning Network® Publications & Multimedia

- Inappropriate Billing of Qualified Medicare Beneficiaries *MLN Matters®* Article – New
- Long-Term Care Call: Audio Recording and Transcript – New
- PECOS for Physicians and Non-Physician Practitioners Fact Sheet – Revised
- Power Mobility Devices Fact Sheet – Revised
- IMPACT Act Videos – Reminder

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MLN Connects® Provider eNews for November 17, 2016

MLN Connects® Provider eNews for November 17, 2016
View this edition as a PDF

News & Announcements

- CMS and Indian Health Service Expand Collaboration to Improve Health Care in Hospitals
- CMS to Release a Comparative Billing Report on Knee Orthoses in January
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Provider Compliance

- False Claims Act

Claims, Pricers & Codes

- Sunsetting of Section 1011: Emergency Health Services Furnished to Undocumented Aliens
- LTCH: Clarification of Immediately Preceding Hospitals for Exclusion from Site Neutral Payment Rate

Upcoming Events

- Medicare Diabetes Prevention Program Model Expansion Call – November 30
- IRF and LTCH Quality Measure Report Call–December 1
- National Partnership to Improve Dementia Care and QAPI Call – December 6
- 2016 Hospital Appeals Settlement Update Call – December 12
- Comparative Billing Report on Viscosupplementation of the Knee Webinar – December 14

Medicare Learning Network® Publications & Multimedia

- Hard Copy Claims Not Crossing Over Due to Duplicate Diagnosis Codes *MLN Matters®* Article – New
- Medicare Basics: Parts A and B Claims Overview Video – New
- Medicare Quality Programs Call: Audio Recording and Transcript – New
- Clinical Labs Call: Audio Recording and Transcript – New
- Medicare Fraud & Abuse: Prevention, Detection, and Reporting Booklet – Revised

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MLN Connects® Provider eNews – Special Edition

Wednesday, November 2, 2016

2017 physician fee schedule final rule

Medicare finalizes substantial improvements that focus on primary care, mental health, and diabetes prevention

On November 2, CMS finalized the 2017 physician fee schedule final rule that recognizes the importance of primary care by improving payment for chronic care management and behavioral health. The rule also finalizes many of the policies to expand the diabetes prevention program model test to eligible Medicare beneficiaries, the Medicare Diabetes Prevention Program (MDPP) expanded model, starting January 1, 2018.

The annual physician fee schedule updates payment policies, payment rates, and quality provisions for services provided in 2017. In addition to physicians, a variety of practitioners and entities are paid under the physician fee schedule. Additional policies finalized in the 2017 payment rule include:

- Primary care and care coordination
- Mental and behavioral health
- Cognitive impairment care assessment and planning

The 2017 payment rule will also:

- Finalize a data collection strategy for global services with significantly reduced burden for practitioners compared to the proposal

- Finalize a change that will more accurately reflect local costs and significantly increase payments to practitioners in Puerto Rico
- Enhance program integrity and data transparency in the Medicare Advantage program.

For more information:

- *Final Rule*
- *PFS Fact Sheet*
- *MDPP Fact Sheet*
- *Blog*

See full text of this excerpted *CMS press release* (issued November 2)

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SPECIAL

front page

- Payment policy provisions:
- Rebasing the 60-day episode rate
- Updates to reflect case-mix growth
- Negative pressure wound therapy
- Change in methodology and the fixed-dollar loss ratio used to calculate outlier payments
- Other updates

The final rule also includes:

- Home Health Quality Reporting Program
- Home health value-based purchasing model

For more information:

- *Final Rule*
- *HH PPS* website
- *HH Value-Based Purchasing Model* web page

See the full text of this excerpted *CMS fact sheet* (issued October 31).

ESRD PPS: Policies and payment rates for end-stage renal disease

On October 28, CMS issued a final rule (CMS 1651-F) that updates payment policies and rates under the end-stage renal disease (ESRD) prospective payment system (PPS) for renal dialysis services furnished to beneficiaries on or after January 1, 2017. This rule also:

- Finalizes new quality measures to improve the quality of care by dialysis facilities treating patients with ESRD
- Implements the Trade Preferences Extension Act of 2015 provisions regarding the coverage and payment of renal dialysis services furnished by ESRD facilities to individuals with acute kidney injury
- Makes changes to the ESRD Quality Incentive Program (QIP), including payment years (PYs) 2019 and 2020
- Makes changes to the scoring methodology for the ESRD QIP for PY 2019 and added one new measure
- Addresses issues related to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and the DMEPOS Competitive Bidding Program

The finalized 2017 ESRD PPS base rate is $231.55. CMS projects that the updates for 2017 will increase the total payments to all ESRD facilities by 0.73 percent compared with 2016. For hospital-based ESRD facilities, CMS projects an increase in total payments of 0.9 percent, while for freestanding facilities; the projected increase in total payments is 0.7 percent. Aggregate ESRD PPS expenditures are projected to increase by approximately $80 million from 2016 to 2017.

Changes to the ESRD PPS:

- Update to the base rate
- Annual update to the wage index and wage index floor
- Update to the outlier policy
- Home and self-dialysis training add-on payment adjustment

Changes to the DMEPOS competitive bidding program:

- Bid surety bond
- State licensure
- Appeals process for breach of contract actions
- Bid limits
- Changes for similar items with different features

For more information:

- *Final Rule*

See the full text of this excerpted *CMS fact sheet* (issued October 28).

Medicare Learning Network®

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

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