Medicare A CONNECTION
medicare.fcso.com
FIRST COAST SERVICE OPTIONS, INC.
A Newsletter for MAC Jurisdiction N Providers
December 2016

In this issue

Procedure code update for preventive services

Provider types affected

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

Provider action needed

Change request (CR) 9888, announces that, effective for dates of service on and after January 1, 2017, CPT® code 76706 replaces HCPCS code G0389. MACs will apply all editing that was applied to HCPCS code G0389 to CPT® code 76706, including the waiver of deductible and coinsurance. Make sure that your billing staffs are aware of these changes.

Background

Section 5112 of the Deficit Reduction Act of 2005 allows for only one ultrasound screening test for an abdominal aortic aneurysm by Medicare. CPT® code 76706 replaces HCPCS code G0389 as of January 1, 2017, for billing this service. CR 9888 also updates the *Medicare Claims Processing Manual*, Chapter 9, to show the current CPT® codes for smoking cessation. The revised Chapter 9 is attached to CR 9888.

Additional information

The official instruction, CR 9888, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3669CP.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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Contents

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Processing Issues

Major joint replacement (hip and knee) – claims may have been returned to the provider in error

Issue

Claims submitted related to local coverage determination (LCD L33618) - major joint replacement (hip and knee) between October 1, 2015 and January 28, 2016, may have been returned to the provider (RTP) in error when billed with ICD-10-CM procedure codes 0SP90JZ, 0SPB0JZ 0SPC0JZ, and 0SPD0JZ.

Resolution

This error was corrected January 28, 2016. Claims processed on or after January 28, 2016, were adjudicated correctly.

Status/date resolved

Closed/January 28, 2016

Provider action

Providers do not need to contact customer service. Providers will need to resubmit their claims and include the following comment/ remark "ICD-10 Major Joint Replacement" on their claims.

Current processing issues

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

Part A services denied due to laboratory NCD edit changes

Issue

Change request (CR) 9806 announces significant changes to 23 national coverage determinations outlined in *Publication 100-03, Sections 190.12 – 190.34 for Laboratory Services* involving ICD-10 diagnosis editing. These changes will be implemented December 5, 2016, for dates of service on and after October 1, 2016.

Therefore, claims submitted prior to the December 5 implementation date will be denied.

Resolution

Part A claims that denied with reason codes in the 5xNCD series with diagnosis codes updated with CR 9806 will be adjusted when brought to our attention after December 5, 2016.

Status/date resolved

Open

Provider action

Denied Part A claims will be adjusted when brought to our attention after December 5, 2016.

Current processing issues

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

General Information

Rural health clinic and federally qualified health center – 'Medicare Benefit Policy Manual' Chapter 13 update

Provider types affected

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

Provider action needed

Change request (CR) 9864 requires Medicare administrative contractors to be aware of the updates to the *Medicare Benefit Policy Manual* – Chapter 13. Make sure that your billing staffs are aware of these changes.

Background

The 2017 update of the *Medicare Benefit Policy Manual*, Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services - provides information on requirements and payment policies for RHCs and FQHCs, as authorized by Section 1861(aa) of the Social Security Act. The Centers for Medicare & Medicaid Services (CMS) has revised Chapter 13 to include that beginning in 2017, the FQHC PPS base rate will be updated by the FQHC market basket, and that services furnished by auxiliary personnel incident to a transitional care management (TCM) or chronic care

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management (CCM) visit may be furnished under general supervision instead of direct supervision, as finalized in the 2017 physician fee schedule final rule. All other revisions serve to clarify existing policy. The key revised areas include the following sections:

- Section 70.3 revised to include that beginning in 2017; the FQHC PPS base rate will be updated by the FQHC market basket. Section 110.3 revised to clarify information on payment for graduate medical education in RHCs and FQHCs.
- Section 110.4 revised to include that services furnished by auxiliary personnel incident to a TCM visit may be furnished under general supervision.
- Section 110.5 revised to include services furnished by auxiliary personnel incident to a CCM visit may be furnished under general supervision.
- Section 130.3 updated to remove the payment restriction for an RHC owned by a physician assistant.
- Section 160 updated to remove services furnished incident to a clinical social worker service.
- Section 180 revised to include speech-language pathology services.
- Section 220.4 revised to clarify copayment for FQHC preventive services under the FQHC prospective payment system (PPS).

Additional information

The official instruction, CR 9864, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R230BP.pdf*. The revised *Medicare Benefit Policy Manual*, Chapter 13, is attached to CR 9864.

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 CR Release Date: December 9, 2016
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Implementation Date: March 9, 2017

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Provider file updates and PECOS to FISS interface

Provider types affected

This *MLN Matters*® article is intended for hospitals with off-campus outpatient departments submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider action needed

Change request (CR) 9613 reminds you that all off-campus outpatient departments of a hospital provider are required to be correctly identified. Make sure that your billing staffs are aware of these requirements.

Background

Hospital providers are required to include all practice locations on the CMS 855A enrollment form. The Centers for Medicare & Medicaid Services (CMS) has performed a re-validation process (March 25, 2011-March 23, 2015) where in the last four years all hospital providers have completed an 855A enrollment form to either 1) initially enroll in Medicare, 2) add a new practice location, or 3) revalidate its enrollment information. If a hospital claim is submitted with a service facility location that was not included on the CMS 855A enrollment form, it will be returned to the provider until the CMS 855A enrollment form and claims processing system is updated.

Section 1833(t) of the Social Security Act (the Act), as amended by Section 603 of the Bipartisan Budget Act of 2015, requires that certain off-campus departments of a hospital provider be paid under the "applicable payment system" rather than under the hospital outpatient prospective payment system. CMS established payment policies to pay nonexcepted off-campus departments of a hospital provider under the Medicare physician fee schedule effective for services furnished on or after January 1, 2017. It is important for hospitals to ensure that an accurate address for each hospital department practice location is included on the CMS 855A enrollment form.

Additional information

The official instruction, CR 9613, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1704OTN.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: MM9613
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2017 Medicare deductible, coinsurance and premium rates

Provider types affected

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

Provider action needed

Change request (CR) provides instruction for MACs to update the claim processing system with the new 2017 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.

Background

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

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

Under Part B of the supplementary medical insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

2017 Part A – hospital insurance (HI)

- **Deductible**: $1,316.00
- **Coinsurance**
  - $329.00 a day for 61st-90th day
  - $658.00 a day for 91st-150th day (lifetime reserve days)
  - $164.50 a day for 21st-100th day (skilled nursing facility coinsurance)
- **Base premium (BP):** $413.00 a month
- **BP with 10 percent surcharge:** $454.30 a month
- **BP with 45 percent reduction:** $227.00 a month (for those who have 30-39 quarters of coverage)
- **BP with 45 percent reduction and 10 percent surcharge:** $249.70 a month

2017 Part B – supplementary medical insurance (SMI)

- **Standard premium:** $134.00 a month
- **Deductible:** $183.00 a year
- **Pro rata data amount**
  - $125.73 1st month
  - $57.27 2nd month
- **Coinsurance:** 20 percent

Additional information

The official instruction, CR 9902, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R103GI.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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Clarification of certification statement signature and contact person requirements

Provider types affected

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

Provider action needed

Change request (CR) 9776 clarifies the certification statement signature requirements for the internet-based provider enrollment, chain, and ownership system (PECOS) and paper Medicare enrollment applications, and addresses contact person requirements.

CR 9776 does not involve any legislative or regulatory policies. Make sure that you are familiar with these requirements.

Background

CR 9776 informs the MACs that the Centers for Medicare & Medicaid Services (CMS) is updating Chapter 15 of the *Medicare Program Integrity Manual* in order to clarify the certification statement signature requirements for online and paper Medicare enrollment submissions, and to address contact person requirements. The main points of the updates are summarized below; and you can find the details in the manual's updated Chapter 15 (Medicare Enrollment), which is an attachment to CR 9776.

Certification signature requirements

A. Paper submissions

A signed certification statement shall accompany all paper CMS-855 applications, which your MAC will only accept if the signature date is within 120 days of the receipt date of the application. If the provider submits an invalid certification statement or fails to submit a certification statement, your MAC will still proceed with processing the application, however, a valid certification statement will be solicited as part of the development process. This includes certification statements that are: (a) unsigned; (b) undated; (c) contains a copied or stamped signature; (d) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the MAC received the application); (e) for paper form CMS-855I and form CMS-855O submissions, someone other than the physician or non-physician practitioner signed the form, except as noted in Section 15.5.14.1; or (f) missing certification statements. **The MAC will send one development request to include a list of all of the missing required data/documentation, including the certification statement.** The MAC may reject the provider's application if the provider fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30-calendar days from the date the MAC requested the missing information or documentation. The certification statement may be returned via scanned email, fax or mail to the MAC (as long as an original certification statement signature exist on file).

B. Internet-based PECOS submissions

A signed certification statement shall accompany all web-submitted CMS-855 applications. You may choose to electronically sign the application or submit the paper certification statement to your MAC. Paper certification statements may be submitted by email, fax, or mail (as long as an original certification statement signature exists on file).

You should note that your MAC will not compare the signature on the application with the same provider, authorized or delegated official's signature on file to ensure that it is the same person; nor will they request the submission of a driver's license or passport to verify a signature.

Specific form signature requirements follow:

- Form CMS-855R (Medicare Enrollment Application - Reassignment of Medicare Benefit), submitted for initial applications, **must** be signed and dated by the physician or non-physician practitioner and the authorized official of the provider or supplier; while those submitted to change and/or update the provider or supplier's Medicare enrollment data (to include updates to the primary practice location) **may** be signed by either the physician or non-physician practitioner or the authorized or delegated official of the provider or supplier.
- Form CMS-855A (Medicare Enrollment Application - Institutional Providers), CMS-855B (Medicare Enrollment Application - Clinics/Group Practices and Certain Other Suppliers), and CMS-855S (Medicare Enrollment Application - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers), submitted for initial applications, **must** be signed and dated by an authorized official of the provider or supplier; while those submitted to change, update and/or revalidate the provider or supplier's Medicare enrollment data **may** be signed and dated by the authorized or delegated official of the provider or supplier.

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The certification statement for the CMS-855A, CMS-855B and CMS-855S Medicare enrollment applications must be signed by an individual who has the authority to bind the provider or supplier, both legally and financially, to the requirements set forth in *42 CFR 424.510*. This person must also have an ownership or control interest in the provider or supplier, such as, the general partner, chairman of the board, chief financial officer, chief executive officer, president, or hold a position of similar status and authority within the provider or supplier organization. The signature attests that the information submitted is accurate; and that the provider or supplier is aware of, and abides by, all applicable statutes, regulations, and program instructions.

Your MAC will verify and validate all information collected on the enrollment application, provided that a data source is available. You should remember that:

1. If you submit an invalid certification statement or do not submit a certification statement, your MAC will treat this as missing information and will request that you submit a correct certification statement, preferably via e-mail or fax. Returning only the signature page is required, you do not have to include the additional page containing the certification terms.
2. If the provider chooses to submit its certification statement via paper rather than through e-signature, MACs will permit the provider to submit the certification statement via email, fax or mail.
3. MACs will not request a driver's license or passport to verify the signature.
4. Your MAC will send approval letters to the contact person listed on the application via email (if there is no contact person on file, they will send the approval letter to the provider or supplier at their correspondence address).

Contact person requirement clarifications

MACs will accept end dates to contact persons via phone, scanned email, fax or mail from the individual provider, the authorized or delegated official or a current contact person. This is an interim process until the form CMS-855s can be updated to delete contact persons.

If any contact person listed on a provider or supplier's enrollment record requests a copy of their Medicare approval letter or revalidation notice, MACs will send it to the contact person via email, fax or mail.

Additional information

While the above provides the key points of CR 9776, providers may wish to review the entire revision to Chapter 15, which is attached to CR 9776. CR 9776 is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R689PI.pdf*.

42 CFR 424.5120 is available at *http://www.ecfr.gov/cgi-bin/text-idx?SID=7abb0c441a8cabde6594ca609fd194c5&mc=true&node=se42.3.424_1510&rgn=div8*.

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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December 22, 2016 - The article was revised December 22, 2016, to clarify certain information in the bullet points on pages 3 and 4.

December 14, 2016 – Initial issuance

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To order an annual subscription, complete the *Medicare A Connection Subscription Form*, ***located here***.

Internet-only manual revision regarding provider liability

Provider types affected

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

What you need to know

Change request (CR) 9708 provides additional criteria for determining when a contractor shall assume a physician, provider, or supplier should have known about a policy or rule. CR 9708 updates Chapter 3, Section 90 of the *Medical Financial Management Manual*. Make sure your billing staff is aware of these updates.

Background

Contractors shall assume the provider, physician, or supplier should have known about a policy or rule, if:

- The policy or rule is in the provider, physician, or supplier manual or in federal regulations;
- The Centers for Medicare & Medicaid Services (CMS) or a CMS contractor provided general notice to the medical community concerning the policy or rule;
- CMS, a CMS contractor, or the Office of Inspector General (OIG) gave written notice of the policy or rule to the particular provider/physician/supplier;
- The provider, physician, or supplier was previously investigated or audited as a result of not following the policy or rule;
- The provider, physician, or supplier previously agreed to a corporate integrity agreement as a result of not following the policy or rule;
- The provider, physician, or supplier was previously informed that its claims had been reviewed/denied as a result of the claims not meeting certain Medicare requirements which are related to the policy or rule; or
- The provider, physician, or supplier previously received documented training/outreach from CMS or one of its contractors related to the same policy or rule.

Additional information

The official instruction, CR 9708, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R275FM.pdf*. The revised Chapter 3, Section 90, of the manual is attached to CR 9708.

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: MM9708
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Processing time frames for enrollment applications

As the Medicare administrative contractor (MAC) for jurisdiction N (JN), First Coast Service Options Inc. (First Coast) is not only responsible for processing Medicare claims but also for processing enrollment applications for providers and suppliers located in Florida, Puerto Rico, and the U.S. Virgin Islands.

The Centers for Medicare & Medicaid Services (CMS) has established the following timeliness standards for contractors responsible for processing enrollment applications within their assigned jurisdictions:

- PECOS web applications (initial enrollment with no site visit) – *80 percent* must be processed within **45 days**
- Paper-based applications (initial enrollment with no site visit) – *80 percent* must be processed within **60 days**
- Paper-based applications (initial enrollment with site visit) – *80 percent* must be processed within **80 days**
- Paper-based applications (changes to enrollment record or reassignment) – *80 percent* must be processed within **60 days**

First Coast provider enrollment average YTD processing times (through December 31)

	Part A	Part B
PECOS web applications		
No development	14 days	38 days
With development	32 days	57 days
Paper applications		
No development	16 days	48 days
With development	37 days	72 days

Factors affecting total processing times

Although First Coast processes each enrollment application as quickly as possible, the following key factors may affect the total processing time needed:

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New physician specialty code for hospitalist

***Note**: This article was updated November 28, 2016, to reflect a revised change request (CR) 9716, issued November 25. In the article, the CR release date, transmittal number, and the web address for accessing the CR are revised. All other information remains the same. This information was previously published in the November 2016 Medicare A Connection, page 8.*

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/R276FM.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

- **November 28, 2016** – This article was updated to reflect a revised CR 9716, issued November 25. In the article, the CR release date, transmittal number, and the web address for accessing the CR are revised. All other information remains the same.
- **October 28, 2016** – Initial issuance.

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- **Provider type**:
  - **Part A** – institutional providers
  - **Part B** – physicians, non-physician practitioners, clinics, and group practices

  Shortest processing times: *Enrollment applications for Part B providers and suppliers*
- **Application type**:
  - **PECOS web application** – an electronic enrollment application submitted through *the internet-based Provider Enrollment, Chain, and Ownership System (PECOS) website*.
  - **Paper-based application** – application that is printed and submitted through mail.

  Shortest processing times: *PECOS web applications*
- **Development required:**
  - **No development** – the enrollment application (paper-based or electronic) is accurate, complete, and is submitted with all *required support documentation*.
  - **With development** – the enrollment application (paper-based or electronic) falls into one or more of the following categories:
    - Contains errors or inconsistencies
    - Incomplete (e.g., missing information or signature)
    - Support documentation missing or insufficient

    Shortest processing times: *Enrollment applications that do not require development*

Documentation requirements for the hospice physician certification/recertification

Provider types affected

This special edition *MLN Matters*® article is intended for hospices and for physicians who prepare certification or recertification for benefit periods for Medicare beneficiaries electing the hospice benefit.

What you need to know

This article provides information on specific elements that are required for a physician certification and recertification as stated in the *Medicare Benefit Policy Manual*, *Chapter 9*, Section 20.1- Timing and Content of Certification. This article is intended to provide guidance on the requirements for a valid physician certification and recertification.

The article is informational only and does not convey any new or revised policy. In addition, any examples provided in this article are for illustration purposes only and do not in any way imply this is the only acceptable format. Hospice providers may choose to design their own forms or format, so long as all requirements of a valid physician certification are met.

Background

In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. A valid physician certification or recertification is required for each benefit period that the beneficiary is on the Medicare hospice benefit. This article is intended to provide guidance on the requirements for a valid physician certification and recertification.

A written certification must be on file in the hospice beneficiary's record prior to submission of a claim to your Medicare administrative contractor (MAC). Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification. Initially, the clinical information may be provided verbally, but must be documented in the medical record and included as part of the hospice's eligibility assessment.

Content of written certifications, including initial and subsequent certifications

A complete written certification must include:

1. The statement that the individual's medical prognosis is that the beneficiary's life expectancy is six months or less if the terminal illness runs its normal course

   Guidance: A simple statement on the certification/recertification that states, the beneficiary has a medical prognosis of six months or less if the terminal illness runs its normal course.

2. Patient-specific clinical findings and other documentation supporting a life expectancy of six months or less

   Guidance: The certification should give specific clinical findings, for example, signs, symptoms, laboratory testing, weights, anthropomorphic measurements, oral intake.

3. The signature(s) of the physician(s), the date signed, and the benefit period dates that the certification or recertification covers (for more on signature requirements, see the *Medicare Program Integrity Manual*, *Chapter 3*, Section 3.3.2.4).

Guidance:

Physician signature and date signed: The physician must sign and make an appropriate date entry for his/her signature, for example, John Smith M.D. MM/DD/YY. If the physician signature is not legible, you may type or print the name below the signature. Another alternative to ensure a legible signature is to submit a signature log with the physician's printed name and signature. Also, note that the location of the physician signature for the narrative and attestation is important. See the example below regarding the physician signature.

Certification/recertification benefit period: Make an entry on the certification that gives the specific "from" and "through" dates, for example, benefit period date MM/DD/YY to MM/DD/YY. Simply stating benefit period three is not acceptable documentation. The "from" and "through" dates must appear on the certification.

4. As of October 1, 2009, the physician's brief narrative explanation of the clinical findings that supports a life expectancy of six months or less is part of the certification and recertification forms, or is an addendum to the certification and recertification forms.
   - If the narrative is part of the certification or recertification form, then the narrative must be located immediately above the physician's signature.
   - If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.
   - The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient. The physician may dictate the narrative.
   - The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. The physician must synthesize the patient's comprehensive medical information in order to compose this brief clinical justification narrative.

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Guidance: According to the *Medicare Benefit Policy Manual*, Chapter 9, Section 20.1, Timing and Content of Certification, the regulations state if the narrative is part of the certification or recertification form, then the narrative must be located immediately above the physician signature. As part of the narrative, the narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient. It would not be acceptable to have any other language such as the certification from and through dates, the attestation of a face-to-face, or any other documentation located between the narrative and the physicians signature.

5. Face-to-face encounter and attestation. For recertification's on or after 1/1/2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice beneficiary prior to the beginning the beneficiary's third benefit period, and prior to each subsequent benefit period. The face-to-face encounter (when applicable) is a part of the recertification. For additional information and guidance on the face-to-face encounter, refer to the *Medicare Benefit Policy Manual*, Chapter 9, Section 20.1.

Examples of the narrative for a physician certification

Example 1: Initial certification of terminal illness (eith narrative included)

I certify that John Doe is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. Certification period dates: 1/1/2016 to 3/30/2016

Brief narrative statement: (Review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to the hospice services) 78 year old male with a diagnosis of stage four lung cancer. Completed three rounds of chemotherapy, but cancer has metastasized to the liver and bone. Patient no longer wants to continue chemotherapy and states he wants comfort measures only. Increased dyspnea and pain over past two weeks. Is now oxygen dependent with 2LNC and requires morphine every six hours for bone pain and shortness of breath.

Attestation: I confirm that I composed this narrative and it is based on my review of the patient's medical record and/or examination of the patient (circle one).

Physician (printed name): Dr. Marcus Welby

Physician (signature): Dr. Marcus Welby

Date: 1/1/2016

Example 2: Initial certification of terminal illness (narrative as an addendum)

I certify that John Doe is terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course. Certification period dates: 1/1/2016 to 3/30/2016

Physician (printed name): Dr. Marcus Welby

Physician (signature): Dr. Marcus Welby

Date: 1/1/2016

Please note: Physician narrative addendum below. (Physician narrative addendum must accompany the initial certification of terminal illness (CTI) when the narrative is not included on the certification).

Example 2 physician narrative addendum

Name of beneficiary: John Doe

Certification period dates: 1/1/2016 to 3/30/2016

Brief narrative statement: (Review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to the hospice services) 78 year old male with a diagnosis of stage 4 lung cancer. Completed three rounds of chemotherapy but cancer has metastasized to the liver and bone. Patient no longer wants to continue chemotherapy and states he wants comfort measures only. Increased dyspnea and pain over the past two weeks. Is now oxygen dependent with 2LNC and requires morphine every six hours for bone pain and shortness of breath.

Attestation: I confirm that I composed this narrative and it is based on my review of the patient's medical record and/or examination of the patient (circle one).

Physician (printed name): Dr. Marcus Welby

Physician (signature): Dr. Marcus Welby

Date: 1/1/2016

Example 3: Recertification of terminal illness (At 90 days and each subsequent 60 days) (With narrative included)

I certify that John Doe is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Certification period dates: 3/31/2016 to 6/28/2016

Brief narrative statement: (Review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to the hospice services) 78 year old male with a diagnosis of stage four lung cancer who has been receiving hospice services since 1/1/2016. Oxygen dependent and has been increased to 6LNC. Increasing somnolence and is only out of bed for short periods of time with max assist. Poor appetite and is only taking small sips of water and broth. Evident cachexia. Receiving morphine every two hours for pain.

Attestation: I confirm that I composed this narrative and it is based on my review of the patient's medical record and/or examination of the patient (circle one).

Physician (printed name): Dr. Marcus Welby

Physician (signature): Dr. Marcus Welby

Date: 1/1/2016

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For third and subsequent benefit periods: N/A (not the third or subsequent benefit period): Face to face encounter hospice physician

Attestation: I confirm that I had a face-to-face encounter with (beneficiary's name) on __/__/__ (date) and that I used the clinical findings from that encounter in determining continued eligibility for hospice care.

Hospice medical director/hospice physician/ NP (printed name):_____

Hospice medical director/hospice physician/NP (signature):_____

Date: _____

Example 4: Recertification of terminal illness (At 90 days and each subsequent 60 days) (With narrative as addendum)

I certify that John Doe is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. Certification period dates: 3/31/2016 to 6/28/2016

Physician (printed name): Dr. Marcus Welby

Physician (signature): Dr. Marcus Welby

Date: 03/30/2016

Physician narrative addendum (Must accompany certification/recertification form if not included in the CTI)

Name of beneficiary: John Doe

Certification period dates: 3/31/2016 to 6/28/2016

Brief narrative statement: (Review the individual's clinical circumstance and synthesize the medical information to provide clinical justification for admission to hospice services) 78 year old male with a diagnosis of stage four lung cancer who has been receiving hospice services since 1/1/2016. Oxygen dependent and has been increased to 6LNC. Increasing somnolence and is only out of bed for short periods of time with max assist. Poor appetite and is only taking small sips of water and broth. Evident cachexia. Receiving morphine every two hours for pain.

Attestation: I confirm that I composed this narrative and it is based on my review of the patient's medical record and or examination of the patient (circle one).

Physician (printed name): Dr. Marcus Welby

Physician (signature): Dr. Marcus Welby

Date: 3/30/2016

Example 5: Recertification of terminal illness (At 90 days and each subsequent 60 days) (With narrative & face-to-face attestation included)

I certify that Jane Smith is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Certification period dates: 6/29/2016 to 8/27/2016

Brief narrative statement: (Review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to hospice services). 83 year old female with end-state CHF, NYHA Class IV. Dyspnea at rest. Bilateral 2+ pitting edema in feet, calves and thighs not responsive to diuretic therapy. Increasing episodes of angina. Was ambulatory one month ago but is now bedbound and sleeps most of the time. Is arousable but with increasing confusion. Taking only small sips of water. Patient has been under hospice services since 1/1/2016.

Attestation: I confirm that I composed this narrative and it is based on my review of the patient's medical record and/ or examination of the patient (circle one)

Physician (printed name): Dr. Marcus Welby

Physician (signature): Dr. Marcus Welby

Date: 06/28/2016

Attestation of face-to-face encounter (For 3rd and subsequent benefit periods): N/A (not the third or subsequent benefit period):

Conducted by certifying physician: I confirm that I had a face-to-face encounter with (beneficiary's name) on (__/__/___ date) and that I used the clinical findings from that encounter in determining continued eligibility for hospice care.

Hospice medical director (printed name): John Doe, M.D.

Hospice medical director (signature): John Doe

Date: 06/28/2016

Conducted by allowed provider type: I confirm that a face-to-face encounter occurred with Jane Smith on 06/27/2016 (date) and the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of six months or less, should the illness run its normal course.

Hospice physician/NP (printed name): Mary Jones, CRNP

Hospice physician/NP (signature): Mary Jones, CRNP

Date: 06/27/2016

Example 6: Recertification of terminal illness (At 90 days and each subsequent 60 days) (With narrative but without face-to-face attestation included)

I certify that Jane Smith is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Certification period dates: 06/29/2016 – 8/27/2016

Brief narrative statement: (review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to hospice services) 83 year old female with end-state CHF, NYHA Class IV. Dyspnea at rest. Bilateral 2+ pitting edema in feet, calves and thighs not responsive to diuretic therapy. Increasing episodes of angina. Was ambulatory one month ago but is now bedbound and sleeps most of the time. Is arousable but with increasing confusion. Taking only small sips of water. Patient has been under hospice services since 1/1/2016.

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Attestation: I confirm that I composed this narrative and it is based on my review of the patient's medical record and/or examination of the patient (circle one).

Physician (printed name): Dr. Marcus Welby

Physician (signature): Dr. Marcus Welby

Date: 06/28/2016

Nurse practitioner/hospice physician attestation of face-to-face encounter with beneficiary (For third and subsequent benefit periods)

Hospice nurse practitioner/non-certifying hospice physician attestation: I confirm that I had a face-to-face encounter with Jane Smith on 06/27/2016 (date) and that the clinical findings of that encounter have been provided to the certifying physician for use in determining continued eligibility for hospice care.

Hospice nurse practitioner (NP)/physician (printed name): Mary Jones CRNP

Hospice nurse practitioner (NP)/physician (signature): Mary Jones CRNP

Date: 06/27/2016

Example 7: Recertification of terminal illness (At 90 days and each subsequent 60 days) (With narrative & face-to-face attestation included) I certify that Jane Smith is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. Certification period dates: 06/29/2016-08/27/2016

Brief narrative statement: (Review the individual's clinical circumstances and synthesize the medical information to provide clinical justification for admission to hospice services) 83 year old female with end-state CHF, NYHA Class IV. Dyspnea at rest. Bilateral 2+ pitting edema in feet, calves and thighs not responsive to diuretic therapy. Increasing episodes of angina. Was ambulatory one month ago but is now bedbound and sleeps most of the time. Is arousable but with increasing confusion. Taking only small sips of water. Patient has been under hospice services since 1/1/2016.

Attestation: I confirm that I composed this narrative and it is based on my review of the patient's medical record and/or examination of the patient (circle one).

Physician (printed name): Dr. Marcus Welby

Physician (signature): Dr. Marcus Welby

Date: 06/28/2016

Attestation of face-to-face encounter (for third and subsequent benefit periods): N/A (not the third or subsequent benefit period): Conducted by certifying physician: I confirm that I had a face-to-face encounter with Jane Smith 06/27/2016 (date) and that I used the clinical findings from that encounter in determining continued eligibility for hospice care.

Hospice medical director (printed name): Dr. Marcus Welby

Hospice medical director (signature): Dr. Marcus Welby

Date: 06/28/2016

Conducted by allowed provider type: I confirm that a face-to face encounter occurred with (beneficiary's name) on __/___/____ (date) and the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of six months or less, should the illness run its normal course.

Hospice physician/NP (printed name): Marcus Welby, M.D.

Hospice physician/NP (signature): Marcus Welby

Date: 06/28/2016

Additional information

CMS acknowledges that this article is based on a product created by the National Government Services.

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/*.

The *Medicare Benefit Policy Manual*, Chapter 9, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf*.

The *Medicare Program Integrity Manual*, Chapter 3, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf*.

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Exceptions for late hospice notices of election delayed by Medicare systems

Provider types affected

This *MLN Matters*® article is intended for hospices submitting notices of election to Medicare administrative contractors (MACs) for Medicare beneficiaries.

What you need to know

Hospices must file a notice of election (NOE) for each patient within five calendar days after the effective date of the election. When a hospice's NOE is not submitted and accepted within five calendar days after the effective date of election, Medicare will not cover and pay for days of hospice care from the effective date of election to the date of filing of the accepted NOE.

MACs will grant an exception for the late NOE if the hospice is able to provide the MAC with documentation showing:

1) When the original NOE was submitted
2) When the NOE was returned to the hospice for correction or was accepted and available for correction, and
3) When the hospice resubmitted the NOE.

Background

When an NOE is submitted within the five-day timely filing period, but the NOE contains inadvertent errors (such as transposed numbers in a beneficiary identifier), the error does not trigger the NOE to be immediately returned to the hospice for correction. In these instances, the hospice must wait until the incorrect information is fully processed by Medicare systems before the NOE is returned to the hospice for correction. There are other NOE errors, such as incorrect admission dates, that will not be returned for correction and instead must be finalized and posted by the Medicare systems before the hospice can correct the NOE. These delays occur because the submitted data appears valid to Medicare systems; only the hospice is aware of the error. Such delays in Medicare systems could cause the NOE to be late and thus the days between the effective dates of the election and when the NOE is corrected, resubmitted, and accepted to be non-covered.

Medicare has determined that timely-filed NOEs with inadvertent errors that cannot be immediately corrected due to Medicare system constraints (and thus returned to the provider for correction, causing late system acceptance of NOEs and non-covered days) are outside the control of the hospice and so qualify for an exception to the timely filing requirement in the circumstances described below. All current provider education about errors that can be fixed immediately remains in effect. MACs will grant an exception only for instances where timely-filed NOEs contained errors that could not be immediately corrected due to system constraints.

MACs will grant an exception for the late NOE if the hospice is able to provide the MAC with documentation showing:

1) When the original NOE was submitted
2) When the NOE was returned to the hospice for correction or was accepted and available for correction, and
3) When the hospice resubmitted the NOE.

MACs will grant the exception if all documentation is provided and the hospice took appropriate actions within two business days to make corrections. Once the NOE is returned for correction the hospice will have two business days to resubmit. When the NOE was posted to the common working file (CWF) and must be cancelled and resubmitted, they will have two business days to cancel the NOE and then two business days to submit the new NOE after the date that the cancellation NOE finalizes.

If the hospice provides sufficient information in the Remarks section of its claim to allow the MAC to research the case, then MACs will make a determination without requesting the additional supporting documentation described above. The provider's remarks must clearly indicate the circumstances and time frames in order to substitute for documentation providing the same information. If it does not, MACs will request documentation. Documentation should consist of printouts or screen images of any Medicare systems screens that contain the information shown above. In instances where the MAC suspects a hospice has such a volume of exceptions requests for inadvertent errors that suggests abuse, the MAC may request documentation for every exception request rather than allowing those hospices to utilize the Remarks section of their claim.

MACs have previously educated that hospices need not wait until an NOE is returned to correct many errors. In these instances, an exception will not be granted. It is not appropriate for hospices to submit a partial NOE to fulfill the timely-filing requirement. MACs will not grant exceptions in cases where it appears that the hospice is engaging in such practices.

MACs will also not grant exceptions in cases where hospices with multiple provider identifiers submit the identifier of a location that did not actually provide the service.

Additionally, hospices have reported cases of system delays beyond their control occurring when Medicare systems are not available ("dark days"). In the great majority of cases, the five-day timely filing period allows enough time to submit NOEs on a day when Medicare systems are available. Additionally, the receipt date is typically applied to the NOE immediately upon submission to Medicare systems, so subsequent dark days would not affect the determination of timeliness. However, hospices report cases in which an NOE is submitted on the day before a dark-day period and the NOE does not receive a receipt date until the day following the dark days. If the hospice can provide documentation showing this situation occurred, MACs will grant an exception to the timely

See **NOE**, next page

Inappropriate billing of QMBs for Medicare cost-sharing

***Note**: This article was revised November 18, 2016, to reflect the revised change request (CR) 9817 issued that same day. In the article, the effective date, CR release date, transmittal number, and the web address for CR 9817 are revised. The sample letters at the end of the article have slight wording changes to show that the Medicaid program also helps low-income beneficiaries pay their Medicare premiums. All other information remains the same. This information was previously published in the November 2016 Medicare A Connection, pages 3-4.*

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 Qualified Medicare Beneficiary 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. 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 "Document history" section of this article.

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filing requirement. The Centers for Medicare & Medicaid Services (CMS) expects these cases to be very rare.

Additional information

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

MLN Matters® Number: SE1633

Related Change Request (CR) #: N/A
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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/R1757OTN.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

- **November 18, 2016** – The effective date, CR release date, transmittal number, and the web address for CR 9817 are revised in the article due to a revised CR 9817. The sample letters at the end of the article have slight wording changes to show that the Medicaid program also helps low-income beneficiaries pay their Medicare premiums.
- **November 4, 2016** – Initial issuance

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 premiums and 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:

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 premiums and 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 *Revised*
Related Change Request (CR) #: CR 9817
Related CR Release Date: November 18, 2016
Effective Date: December 16, 2016
Related CR Transmittal #: R1757OTN
Implementation Date: March 8, 2017

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Provider enrollment requirements for writing prescriptions for Medicare Part D drugs

***Note**: The article was revised November 16, 2016, to show a phased approach to enforcement that will begin in the second calendar quarter of 2017 and end with full implementation and enforcement of the Part D prescriber enforcement requirement January 1, 2019. This information was previously published in the April 2016 Medicare A Connection, pages 3-6.*

Provider types affected

This *MLN Matters*® special edition article is intended for physicians, dentists, and other eligible professionals who write prescriptions for Medicare beneficiaries for Medicare Part D drugs. The article is also directed to Medicare Part D plan sponsors.

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) finalized CMS-4159-F, "Medicare Program: Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs" on May 23, 2014. CMS later published CMS-6107-IFC, "Medicare Program: Changes to the Requirements for Part D Prescribers," an interim final rule with comment ("IFC"), that made changes to the final rule (CMS-4159-F), May 6, 2015. Together, these rules require virtually all physicians and other eligible professionals, including dentists, who write prescriptions for Part D drugs to be enrolled in an approved status or to have a valid opt-out affidavit on file for their prescriptions to be coverable under Part D, except in very limited circumstances. To allow sufficient time for the prescribers to enroll in Medicare and the Part D sponsors and the pharmacy benefit managers (PBMs) to make the complex system enhancements needed to comply with the prescriber enrollment requirements, CMS announced a delay in enforcement of this rule until February 1, 2017.

While the full implementation date is January 2019, CMS encourages all providers who prescribe Part D drugs, but are not yet enrolled or validly opted out of Medicare, to enroll in the Medicare program. Enrollment information is available at *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Part-D-Prescriber-Enrollment-About.html*.

While CMS is committed to the implementation of the prescriber enrollment requirements, CMS also recognizes the need to minimize the impact on the beneficiary population and ensure beneficiaries have access to the care they need. To strike this balance, CMS will implement a multifaceted, phased approach which will align full enforcement of the Part D prescriber enrollment requirements with other ongoing CMS initiatives. Full enforcement of the Part D prescriber enrollment requirement is January 1, 2019.

In the lead-up to the January 1, 2019, full-implementation date, CMS will undertake the following incremental strategic actions designed to increase on-going prescriber enrollment, while protecting beneficiaries and the Medicare program.

- **Precluded providers** – Prescriptions will be denied at the point of sale from sanctioned providers including, but not limited to, providers that are currently excluded by the OIG, revoked by the Medicare program and non-enrolled providers with a felony conviction within the last 10 years. (Implementation in Second Quarter 2017)
- **Easy enroll application process** – CMS will make an easy enrollment application process to enable providers to quickly enroll in Medicare. This process will allow providers to review, update, electronically sign and submit a pre-populated enrollment application online. (Implementation in second quarter 2017)
- **Targeted risk-based prescriber outreach** – CMS will begin targeted, prioritized risk-based outreach and education. This prioritized approach will include direct mailings and coordination with the Part D plans to enroll these prescribers. (implementation in second quarter 2017)
- **Direct mailing to all non-enrolled providers** – CMS will target and send direct mailings via email and/or paper to all prescribers that are not enrolled in the program. In addition, direct mailing notifications will be triggered for unenrolled providers based on PDE events. (implementation in third quarter 2017)
- **Current education and outreach** – CMS will continue with the current education and outreach efforts including such activities as stakeholder meetings and conferences, assembly meetings, and presentations. (continuously on-going)

The purpose of these rules are to ensure that Part D drugs are prescribed only by physicians and eligible professionals who are qualified to do so under state law and under the requirements of the Medicare program and who do not pose a risk to patient safety. By implementing these rules, CMS is improving the integrity of the Part D prescription drug program by using additional tools to reduce fraud, waste, and abuse in the Medicare program. Prescribers who are determined to have a pattern or practice of prescribing Part D drugs that are abusive and represents a threat to the health and safety of Medicare enrollees or fails to meet Medicare requirements will have their billing privileges revoked under 42 USC 424.535 (a)(14).

Background

If you write prescriptions for covered Part D drugs and you are not already enrolled in Medicare in an approved status or have a valid record of opting out, you should submit an enrollment application or an opt-out affidavit to your Medicare administrative contractor (MAC) as soon as possible, so that the prescriptions you write for Part D beneficiaries are coverable as Medicare begins to enforce this requirement on February 1, 2017 with full

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implementation and enforcement slated for January 1, 2019.

To enroll in Medicare for the limited purpose of prescribing:

You may submit your enrollment application electronically using the internet-based Provider Enrollment, Chain, and Ownership System (PECOS) located at *https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/internetbasedpecos.html* or by completing the paper CMS-855O application, which is available at *https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855o.pdf*, which you must submit to the MAC that services your geographic area. Note that there is no application fee required for your application submission. For step-by-step instructions, refer to the PECOS how-to guide, available at *https://go.cms.gov/orderreferhowtoguide* or watch an instructional video at *https://go.cms.gov/videotutorial*.

The CMS-855O is a shorter, abbreviated form and takes minimal time to complete. While the CMS-855O form states it is for physicians and non-physician practitioners who want to order and certify, it is also appropriate for use by prescribers, who want to enroll to also prescribe Part D drugs. (CMS is in the process of updating the CMS-855O form). If you do not see your specialty listed on the application, please select the Undefined Physician/Non-Physician Type option and identify your specialty in the space provided.

Note: Dentists are recognized by Medicare as physicians and should select the "Part B Physician Specialties" option and specify General Dentist in the free form text box.

The average processing time for CMS-855O applications submitted online is 45 days versus paper submissions which is 60 days. However, your application could be processed sooner depending on the MAC's current workload.

To enroll to bill for services (and prescribe Part D drugs):

To enroll in Medicare to bill for your services, you may complete the CMS-855I application. The CMS-855R should also be completed if you wish to reassign your right to bill the Medicare program and receive Medicare payments for some or all of the services you render to Medicare beneficiaries. All actions can be completed via PECOS or the paper enrollment application. For more information on enrolling in Medicare to bill for services refer to *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf*.

If you are a physician or non-physician practitioner who wants to opt-out of Medicare, you must submit an opt-out affidavit to the MAC that services your geographic area. Physicians and non-physician practitioners should be aware that if they choose to opt-out of Medicare, they are not permitted to participate in a Medicare Advantage Plan. In addition, once a physician or non-physician practitioner has opted out they are **not** permitted to terminate their opt-out affidavit early. Section 1802(b)(3)(B)(ii) of the Act establishes the term of the opt-out affidavit. The Act does not provide for early termination of the opt-out term. Under CMS regulations, physicians and practitioners who have not previously submitted an opt-out affidavit under Section 1802(b)(3) of the Act, may choose to terminate their opt-out status within 90 days after the effective date of the opt-out affidavit, if the physician or practitioner satisfies the requirements of 42 CFR § 405.445(b). No other method of terminating opt-out status before the end of the two year opt-out term is available.

Prior to enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), physician/practitioner opt-out affidavits were only effective for two years. As a result of changes made by MACRA, valid opt-out affidavits signed on or after June 16, 2015, will automatically renew every two years. If physicians and practitioners that file affidavits effective on or after June 16, 2015, do not want their opt-out to automatically renew at the end of a two year opt-out period, they may cancel the renewal by notifying all MACs with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period. Valid opt-out affidavits signed before June 16, 2015 will expire two years after the effective date of the opt out. If physicians and practitioners that filed affidavits effective before June 16, 2015, want to extend their opt out, they must submit a renewal affidavit within 30 days after the current opt-out period expires to all MACs with which they would have filed claims absent the opt-out. For more information on the opt-out process, refer to *MLN Matters*® article SE1311, titled "Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries," which is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf* and *https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2015-06-25-eNews.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending&imagelink=y#_Toc422891549*.

CMS would like to highlight the following limitations that apply to billing and non-billing providers:

- A resident is defined in 42 CFR § 413.75 as an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board. Interns, residents, and fellows may enroll in Medicare to prescribe if the state licenses them. Licensure can include a provisional license or similarly-regulated credential. Un-licensed interns, residents, and fellows must specify the teaching physician who is enrolled in Medicare as the authorized prescriber on a prescription for a Part D drug (assuming this is consistent with state law). Licensed residents have the option to either enroll themselves or use the teaching

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physician's name on prescriptions for Part D drugs, unless state law specifies which name is to be used. CMS strongly encourages teaching physicians and facilities to ensure that the NPI of the lawful prescriber under state law is included on prescriptions to assist pharmacies in identifying the correct prescriber and avoid follow up from the pharmacies, which experience rejected claims from Medicare Part D plans due to missing or wrong prescriber NPIs on the claims.

- The prescriber enrollment requirements also apply to physicians and non-physician practitioners who write prescriptions for Part D drugs and are employed by a Part A institutional provider (e.g., hospital, federally qualified health center (FQHC), rural health center (RHC)). Since Part A institutional providers may bill for services provided by an employed physician or non-physician practitioner, the physician or non-physician practitioner may not have separately enrolled, unless he or she is also billing for Part B services. Therefore, if the physician or non-physician practitioner prescribes Part D drugs as an employee of the institutional provider, he or she must be enrolled in an approved status for their prescriptions to be coverable under Part D beginning June 1, 2016.
- "Other authorized prescribers" are exempt from the Medicare Part D prescriber enrollment requirement. In other words, prescriptions written by "other authorized prescribers are still coverable under Part D, even if the prescriber is not enrolled in or opted out of Medicare. For purposes of the Part D prescriber enrollment requirement only, "other authorized prescribers" are defined as individuals other than physicians and eligible professionals who are authorized under state or other applicable law to write prescriptions but are not in a provider category that is permitted to enroll in or opt-out of Medicare under the applicable statutory language. CMS believes "other authorized prescribers" are largely pharmacists who are permitted to prescribe certain drugs in certain states, but based on the applicable statute, pharmacists are not able to enroll in or opt-out of Medicare.

If you believe you are an "other authorized prescriber" and are not a pharmacist, please contact *providerenrollment@cms.hhs.gov*. In addition, CMS strongly recommends that pharmacists in particular make sure that their primary taxonomy associated with their NPI in the National Plan & Provider Enumeration System (NPPES) reflects that they are a pharmacist. To review and update your NPPES information, please go to the National Plan & Provider Enumeration System web page at *https://nppes.cms.hhs.gov/NPPES/Welcome.do*. Upon enforcement of the regulation, Part D plans will need to be able to determine if the prescriber is a pharmacist in order to properly adjudicate the pharmacy claim at point-of-sale.

In an effort to prepare the prescribers and Part D sponsors for the first phase February 1, 2017, enforcement date, CMS has made available an enrollment file that identifies physician and eligible professional who are enrolled in Medicare in an approved or opt-out status. However, the file does not specify if a particular prescriber is eligible to prescribe, as prescribing authority is largely determined by state law. The enrollment file is available at *https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx*. The file contains production data but is considered a test file since the Part D prescriber enrollment requirement is not yet applicable. An updated enrollment file will be generated every two weeks, with a purposeful goal of providing updates twice a week by the date of enforcement.

The file displays physician and eligible professional eligibility on and after November 1, 2014, (that is, currently enrolled, new approvals, or changes from opt-out to enrolled as of November 1, 2014). Any periods, prior to November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will not be displayed on the enrollment file. However, any gaps in enrollment after November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will be reflected on the file with its respective effective and end dates for that given provider. For opted-out providers, the opt-out flag will display a Y/N (yes/no) value to indicate the periods the provider was opted out of Medicare. The file will include the provider's:

- (NPI)
- First and last names
- Effective and end dates
- Opt-out flag

Example 1 – Dr. John Smith's effective date of enrollment is January 1, 2014. Since he was enrolled prior to the generation of the test file, his effective date will display as November 1, 2014. Dr. Smith submits an enrollment application to voluntarily withdraw from Medicare effective December 15, 2014. Dr. Smith will appear on the applicable file as:

NPI	First name	Last name	Eff date	End date	Opt-out flag
123456789	John	Smith	11/1/14	12/15/14	N

Example 2 – Dr. Mary Jones submits an affidavit to opt-out of Medicare, effective December 1, 2014. Since she has opted out after the generation of the test file, her effective date will display as December 1, 2014. After the two year opt-out period expires, Dr. Jones decides she wants to enroll in Medicare to bill, order, and certify, or to write prescriptions. The enrollment application is received January 31, 2017, and the effective date issued is January 1, 2017. Dr. Jones will display on the applicable file as:

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NPI	First name	Last name	Eff date	End date	Opt-out flag
987654321	Mary	Jones	12/1/14	12/1/16	Y
987654321	Mary	Jones	1/1/17		N

After the enforcement date of February 1, 2017, the applicable effective dates on the file will be adjusted to February 1, 2017, and it will no longer be considered a test file. All inactive periods prior to February 1, 2017, will be removed from the file and it will only contain active and inactive enrollment or opt-out periods as of February 1, 2017, and after. The file will continue to be generated every two weeks, with a purposeful goal of providing updates twice a week by the date of enforcement. Part D sponsors may utilize the file to determine a prescriber's Medicare enrollment or opt-out status when processing Part D pharmacy claims. The file will not validate the provider's ability to prescribe under applicable laws. Please submit questions or issues encountered in accessing the file to *providerenrollment@cms.hhs.gov*.

Additional information

For more information on the enrollment requirements, visit *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/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/*.

For a list of frequency asked questions (FAQs) refer to *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/CMS-4159_FAQs.pdf*.

Document history

Date of change	Description
11/16/16	The article was revised to show a phased approach to enforcement that will begin in the second calendar quarter of 2017 and end with full implementation and enforcement of the Part D prescriber enforcement requirement on January 1, 2019.

Date of change	Description
4/18/16	The article was revised to amend additional dates in the article to reflect the delayed enforcement date of February 1, 2017.
4/7/16	The article was revised to communicate changes to and the delayed enforcement of the Part D prescriber enrollment requirement until February 1, 2017, and to provide clarifying information regarding the enrollment process.
12/5/14	The article was revised to add language to emphasize that form CMS-855O is appropriate for use by prescribers.
10/20/15	The article was revised to communicate changes to and the delayed enforcement of the Part D prescriber enrollment requirement until June 1, 2016, and to provide clarifying information regarding the enrollment process.

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Summary of policies in the 2017 MPFS final rule and the telehealth originating site facility fee payment

Provider types affected

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

Provider action needed

Change request (CR) 9844 provides a summary of policies in the 2017 Medicare physician fee schedule final rule and announces the telehealth originating site facility fee payment amount. Make sure that your billing staffs are aware of these updates.

Background

Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary of Health and Human Services to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) issued a final rule November 2, 2016, that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) that are paid under the MPFS in 2017.

The final rule (*CMS-1654-F*) also addresses public comments on Medicare payment policies proposed earlier in 2016. The proposed rule, "Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for 2017," was published in the *Federal Register* July 15, 2016.

The key changes are as follows:

CT modifier reduction changes from 5 percent to 15 percent

As required by Medicare law, effective January 1, 2016, a payment reduction of 5 percent applies to computed tomography (CT) services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the MPFS. The payment reduction increases to 15 percent in 2017 and subsequent years. See *MLN Matters*® article MM9250 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9250.pdf* for more details.

Multiple procedure payment reduction (MPPR) on the professional component (PC) of certain diagnostic imaging procedures

As required by Medicare law, CMS revised the MPPR of the PC of the second and subsequent procedures from 25 percent to 5 percent of the physician fee schedule amount. The MPPR on the technical component (TC) of imaging remains at 50 percent.

Currently, CMS makes full payment for the PC of the highest-priced procedure and payment at 75 percent for the PC of each additional procedure, when furnished by the same physician (or physician in the same group practice) to the same patient, in the same session on the same day. See *MLN Matters*® article MM9647 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9647.pdf* for more details.

Telehealth origination site facility fee payment amount update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare economic index (MEI) as defined in Section 1842(i)(3) of the Act. The MEI increase for 2017 is 1.2 percent. Therefore, for 2017, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $25.40. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

Access to telehealth services

CMS is adding the following services to the list of those that can be furnished to Medicare beneficiaries under the telehealth benefit:

- ESRD-related services CPT® codes 90967 through 90970
- Advance care planning CPT® codes 99497 through 99498
- Telehealth consultation HCPCS codes G0508 through G0509

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

New place of service (POS) code for telehealth

The new POS is 02 with a description of the location where health services and health related services are provided or received, through telecommunication technology.

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X-ray reduction for film

As required by Medicare law, Medicare reduces payment amounts under the MPFS by 20 percent for the TC (and the TC of the global fee) of imaging services that are X-rays taken using film, effective January 1, 2017, and after.

To implement this provision, CMS has created modifier FX (X-ray taken using film). Beginning in 2017, claims for X-rays using film must include modifier FX, which will result in the applicable payment reduction. See *MLN Matters*® article MM9727 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9727.pdf* for more details.

Primary care, care management, and cognitive services

CMS is finalizing the following coding and payment changes for 2017 to improve payment for various primary care, care management, and cognitive services. Each of these codes is included in the 2017 HCPCS update and payment information is included in the routine annual update files:

- Separate payment for existing codes describing prolonged Evaluation and Management (E/M) services without direct patient contact by the physician (or other billing practitioner) (CPT® codes 99358, 99359), and increased payment for prolonged E/M services with direct patient contact by the physician (or other billing practitioner) (CPT® code 99354) adopting the RUC-recommended values. CPT® codes 99358 and 99359 are listed in the *Medicare Claims Processing Manual* as non-payable (Chapter 12, Section 30.6.15.2). As of January 1, 2017, these codes are separately payable under the MPFS and changes to the manual are forthcoming.
- The MPFS includes new coding and payment for behavioral health integration (BHI) services including substance use disorder treatment, specifically three new codes to describe services furnished using the psychiatric collaborative care model (CoCM) (HCPCS codes G0502, G0503, G0504) and one new code to describe services furnished using other BHI care models (HCPCS code G0507).
- Separate payment for complex chronic care management (CCM) services (CPT® codes 99487, 99489), reduced administrative burden for CCM (CPT® codes 99487, 99489, 99490), and a new add-on code to the CCM initiating visit to account for the work of the billing practitioner in assessing the beneficiary and establishing the CCM care plan (HCPCS code G0506).
- A new code for cognition and functional assessment and care planning for treatment of cognitive impairment (HCPCS code G0505).

Implementation of alternative Medicare physician fee schedule (PFS) locality configuration for California

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA 2014) was signed into law and Section 220(h) of the legislation adds Section 1848(e) (6) of the Act, which now requires, for services furnished on or after January 1, 2017, that the locality definitions for California be based on the metropolitan statistical area (MSA) delineations as defined by the Office of Management and Budget (OMB). The resulting modifications to California's locality structure increases its number of localities from nine under the current locality structure to 27 under the MSA based locality structure. However, both the current localities and the MSA based localities are comprised of various component counties, and in some localities only some of the component counties are subject to the blended phase-in and hold harmless provisions required by Section 1848(e)(6)(B) and (C) of the Act. Although the modifications to California's locality structure increase the number of localities from nine under the current locality structure, to 27 under the MSA-based locality structure, for purposes of payment, the actual number of localities under the MSA based locality structure would be 32 to account for instances where unique locality numbers are needed.

Additionally, for some of these new localities, PAMA requires that the geographic practice cost index GPCI values that would be realized under the new MSA based locality structure are gradually phased in (in one-sixth increments) over a period of six years.

Update to the methodology for calculating GPCIs in the U.S. territories

CMS is revising the methodology used to calculate GPCIs in the U.S. territories, whereby Puerto Rico will be assigned the national average of 1.0 to each GPCI, as is currently done in the Virgin Islands in an effort to provide greater consistency in the calculation of the territories' GPCIs. This change is included in the routine PFS update files.

Data collection required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to accurately value global packages

CMS finalized a data collection strategy to gather information needed to value global surgical services. Practitioners in Florida, Kentucky, Louisiana, Nevada, New

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Jersey, North Dakota, Ohio, Oregon, and Rhode Island are required, beginning July 1, 2017, to report claims showing that a visit occurred during the post-operative period for select global services. Practitioners who only practice in settings of fewer than 10 practitioners are not required to report, but may do so voluntarily. Such visits will be reported using CPT® code 99024. The requirement to report will only apply to specified high-volume/high-cost services. The list of services for which reporting is required will be available on the CMS website. Practitioners who are not required to report are able to report voluntarily and encouraged to do so. If reporting voluntarily, reporting should be done for all visits relating to all codes on the list of applicable codes.

In addition a survey of practitioners will be conducted to gather data on service furnished in the post-operative period.

To the extent that these data result in proposals to revalue any global packages, that revaluation will be done through notice and comment rulemaking at a future time.

CPT® code 99024 is currently included on the PFS with a procedure status indicator of "B."

Valuing services that include moderate sedation as an inherent part of furnishing the procedure

The CPT® editorial panel created CPT® codes for separately reporting moderate sedation services, which corresponded to elimination of Appendix G from the *CPT® Manual*, effective January 1, 2017. Appendix G of the *CPT® Manual* identified services where moderate sedation was considered an inherent part of the procedural service. The MPFS final rule established valuations for the new moderate sedation CPT® codes and revaluation of certain procedural services previously identified in Appendix G. These coding and payment changes provide for payment for moderate sedation services only in cases where moderate sedation services are furnished.

Additional information

The official instruction, CR 9844, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3676CP.pdf*.

The final 2017 MPFS rule is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-f.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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Update to editing of therapy services to reflect coding changes

Provider types affected

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

Provider action needed

Change request (CR) 9698 instructs the MACs to apply certain coding edits to the new *Current Procedural Terminology*® (CPT®) codes that are used to report physical and occupational therapy evaluations and re-evaluations, effective January 1, 2017. Make sure your billing staffs are aware of these coding changes.

Background

Original Medicare claim processing systems contain edits to ensure claims for the evaluative procedures furnished by rehabilitative therapy clinicians – including physical therapists, occupational therapists and speech-language pathologists – are coded correctly. These edits ensure that when the codes for evaluative services are submitted, the therapy modifier (GP, GO or GN) that reports the type of therapy plan of care is consistent with the discipline described by the evaluation or re-evaluation code. The edits also ensure that Functional Reporting occurs, that is, that functional G-codes, along with severity modifiers, always accompany codes for therapy evaluative services.

For 2017, eight new CPT® codes (97161-97168) were created to replace existing codes 97001-97004) to report physical therapy (PT) and occupational therapy (OT) evaluations and reevaluations. The new CPT® code descriptors include specific components that are required for reporting as well as the typical face-to-face times. In another recent issuance, CR 9782, the Centers for Medicare & Medicaid Services (CMS) described the new PT and OT code sets, each comprised of three new codes for evaluation – stratified by low, moderate, and high complexity – and one code for re-evaluation. CR 9782 designated all eight new codes as "always therapy" (always require a therapy modifier) and added them to the 2017 therapy code list located at *https://www.cms.gov/Medicare/Billing/TherapyServices/index.html*. For a complete listing of the new codes, their CPT® long descriptors, and related policies, see the article related to CR 9782 at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9782.pdf*.

CR 9698 applies the coding requirements for certain evaluative procedures that are currently outlined in the *Medicare Claims Processing Manual*, Chapter 5 to the new codes for PT and OT evaluations and re-evaluations. These coding requirements include the payment policies for evaluative procedures that (a) require the application of discipline-specific therapy modifiers and (b) necessitate functional reporting using G-codes and severity modifiers. The new codes are also added to the list of evaluation codes that CMS will except from the caps after the therapy caps are reached when an evaluation is necessary, for example, to determine if the current status of the beneficiary requires therapy services.

This notification implements the following payment policies related to claims for therapy services for the new codes for physical therapy (PT) and occupational therapy (OT) evaluative procedures – claims without the required information will be returned as unprocessable:

Therapy modifiers: The new PT and OT codes are added to the current list of evaluative procedures that require a specific therapy modifier to identify the plan of care under which the services are delivered to be on the claim for therapy services. Therapy modifiers GP, GO or GN are required to report the type of therapy plan of care – PT, OT, or speech language pathology (SLP), respectively. This payment policy requires that each new PT evaluative procedure code – 97161, 97162, 97163, or 97164 – to be accompanied by the GP modifier; and, (b) each new code for an OT evaluative procedure – 97165, 97166, 97167, or 97168 – be reported with the GO modifier.

Functional reporting: In addition to other functional reporting requirements, current payment policy requires functional reporting, using G-codes and severity modifiers, when an evaluative procedure is furnished and billed. CR 9698 adds the eight new codes for PT and OT evaluations and reevaluations – 97161, 97162, 97163, 97164, 97165, 97166, 97167, and 97168 – to the procedure code list of evaluative procedures that necessitate functional reporting. A severity modifier (CH – CN) is required to accompany each functional G-code (G8978-G8999, G9158-G9176, and G9186) on the same line of service.

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For each evaluative procedure code, functional reporting requires either two or three functional G-codes and related severity modifiers be on the same claim. Two G-codes are typically reported on specified claims throughout the therapy episode. However, when an evaluative service is furnished that represents a one-time therapy visit, the therapy clinician reports all three G-codes in the functional limitation set – G-codes for current status, goal status and discharge status.

For the documentation requirements related to functional reporting, please refer to the *Medicare Benefits Policy Manual*, Chapter 15, Section 220.4.

CMS coding requirements for functional reporting applied through CR 9698 ensure that at least two G-codes in a functional set and their corresponding severity modifiers are present on the same claim with any one of the codes on this evaluative procedure code list. The required reporting of G-codes includes: (a) G-codes for current status and goal status; or, (b) G-codes for discharge status and goal status. Remember that your MAC will return to the provider (RTP):

1. Claims you submit for the new therapy evaluative procedures, HCPCS codes 97161-97168, without including one of the following pairs of G-codes/severity modifiers required for functional reporting: (a) A current status G-code/severity modifier paired with a goal status G-code/severity modifier; or, (b) A goal status G-code/severity modifier paired with a discharge status G-code/severity modifier.
2. Institutional outpatient claims reporting HCPCS codes 97161, 97162, 97163, and 97164 that you submit without including modifier GP.
3. Institutional outpatient claims reporting HCPCS codes 97165, 97166, 97167, and 97168, that you submit without including modifier GO.

Additional information

The official instruction, CR 9698, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3670CP.pdf*.

The updated *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Sections 10.3.2 (Exceptions Process), 10.6 (Functional Reporting), and 20.2 (Reporting of Service Units with HCPCS) is attached to CR 9698.

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: MM9698
Related Change Request (CR) #: CR 9698
Related CR Release Date: December 1, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3670CP
Implementation Date: April 3, 2017

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Fee schedule amounts for group three power wheelchair accessories and cushions

Section 16005 of the 21st Century Cures Act

Under Section 2 of the Patient Access and Medicare Protection Act (PAMPA), 2016 Medicare fee schedule amounts for group 3 power wheelchair accessories and cushions could not be adjusted based on information from the competitive bidding programs. Section 16005 of the 21st Century Cures Act extends the use of these unadjusted Medicare fee schedule amounts for group three power wheelchair accessories and cushions through June 30, 2017. Suppliers should continue to use the KU modifier when billing for wheelchair accessories and cushions furnished in connection with group three complex rehabilitative power wheelchairs for dates of service from January 1, 2017, through June 30, 2017. Information on this change is now available on the durable medical equipment center web page (*http://go.usa.gov/x9xy4*).

Prolonged services without direct face-to-face patient contact – manual update

Provider types affected

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

Provider action needed

Change request (CR) 9905 provides that the Centers for Medicare & Medicaid Services (CMS) revises Chapter 12, Section 30.6.15.2 of the *Medicare Claims Processing Manual* to indicate that beginning 2017, *Current Procedural Terminology* (CPT®) codes 99358 and 99359 (prolonged services without face-to-face contact) are separately payable under the Medicare physician fee schedule. Make sure your billing staffs are aware of these CPT® code changes.

Background

Prior to 2017, CPT® codes 99358 and 99359 (prolonged services without face-to-face contact) were not separately payable, and were included for payment under the related face-to-face evaluation and management (E/M) service code. Practitioners were not permitted to bill the patient for services described by these codes, since they are Medicare covered services and payment was included in the payment for other billable services.

The CPT® prefatory language and reporting rules apply for the Medicare billing of these codes, for example, CPT® codes 99358 and 99359:

- Cannot be reported during the same service period as complex chronic care management (CCM) services or transitional care management services
- Are not reported for time spent in non-face-to-face care described by more specific codes having no upper time limit in the CPT® code set

CMS has posted a file at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html* that notes the times assumed to be typical, for purposes of physician fee schedule (PFS) rate-setting. While these typical times are not required to bill the displayed codes, CMS would expect that only time spent in excess of these times would be reported under CPT® codes 99358 and 99359.

Further, CMS notes: 1) that these codes can only be used to report extended qualifying time of the billing physician or other practitioner (not clinical staff); and 2) Prolonged services cannot be reported in association with a companion E/M code that also qualifies as the initiating visit for CCM services. Practitioners should instead report the add-on code for CCM initiation, if applicable.

Additional information

The official instruction, CR 9905, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3678CP.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: MM9905
Related Change Request (CR) #: CR 9905
Related CR Release Date: December 16, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3678CP
Implementation Date: January 3, 2017

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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.

January 2017 update to the laboratory national coverage determination edit software

***Note**: This article was revised November 17, 2016, to reflect the revised CR issued November 16. In the article, the implementation date is now December 5, 2016. Also, the CR release date, transmittal number and the web address for accessing the CR are revised. All other information remains the same. This information was previously published in the October 2016 Medicare A Connection, page 6.*

Provider types affected

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

Provider action needed

Change request (CR) 9806 announces changes that will be included in the January 2017 quarterly release of the edit module for clinical diagnosis laboratory services. Make sure your billing staffs are aware of these changes to ensure proper billing to Medicare.

Background

The national coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published November 23, 2001. Medicare developed nationally uniform software that was incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (Publication 100-03, Sections 190.12-190.34) were processed uniformly throughout the United States effective April 1, 2003.

CR 9806 communicates requirements to Medicare system maintainers and the MACs regarding changes to the NCD code lists used for laboratory claims edit software for January 2017. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the ICD-10-CM codes. Please see Section II (business requirements table) of CR 9806 for the lengthy list of codes added or deleted. Note that where codes are deleted, the effective date of deletion is September 30, 2016, and the effective date for codes added is October 1, 2016.

Additional information

The official instruction, CR 9806 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3656CP.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*.

Document history

- **November 16, 2016** - Article revised to show a revised implementation date of December 5, 2016
- **September 23, 2016** - initial issuance

MLN Matters® Number: MM9806
Revised Related Change Request (CR) #: CR 9806
Related CR Release Date: November 16, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3656CP
Implementation Date: December 5, 2016

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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*.

Coding revisions to national coverage determination

***Note**: This article was revised November 17, 2016, to reflect the revised change request (CR) 9571 issued on the same day. CR 9571 was revised to change the NCD 180.1 effective date in spreadsheet history to 1/1/16, in NCD 160.18, remove reactivation of MCS 012L from spreadsheet history and business requirement, and in NCD 220.6.20 to remove reference to 'primary diagnosis' regarding diagnosis code Z00.6 in spreadsheet, and reference FISS new RC for value code D4 in spreadsheet history. In the article, the CR release date, transmittal number and the web address for CR 9571 are revised. All other information remains the same. This information was previously published in the September 2016 Medicare A Connection, page 8.*

Provider types affected

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

Provider action needed

Change request (CR) 9751 is the 9th maintenance update of International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR 7818, CR 8109, CR 8197, CR 8691, CR 9087, CR 9252, CR 9540, and CR 9631; while others are the result of revisions required to other NCD-related CRs released separately. *MLN Matters*® articles *MM7818*, *MM8109*, *MM8197*, *MM8691*, *MM9087*, *MM9252*, *MM9540*,and *MM9631* contain information pertaining to these CR's.

Background

The translations from ICD-9 to ICD-10 are not consistent 1-1 matches, nor are all ICD-10 codes appearing in a complete general equivalence mappings (GEMS) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of the NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable as of October 1, 2015.

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

CR 9751 makes adjustments to the following NCDs:

- NCD 20.7 Percutaneous transluminal angioplasty (PTA)

- NCD 20.19 Ambulatory blood pressure monitoring (ABPM)
- NCD 20.33 Transcatheter mitral valve repair (TMVR) therapy
- NCD 40.1 Diabetes self-management training (DSMT)
- NCD 160.18 Vagus nerve stimulation (VNS)
- NCD 180.1 Medical nutrition therapy (MNT)
- NCD 190.3 Cytogenetic studies
- NCD 220.6.17 FDG PET for solid tumors
- NCD 220.6.20 PET beta amyloid in dementia/ neurological/disorders
- NCD 230.18 Sacral nerve stimulation (SNS) for urinary incontinence
- NCD 260.1 Adult liver transplants

The spreadsheets for the above NCDs are available at *https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9751.zip*.

Remember that coding and payment are areas of the Medicare program that are separate and distinct from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

Your MACs will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate:

- Remittance advice remark codes (RARC)
  - N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered; with
- Claim adjustment reason codes (CARC)

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- 50 - These are non-covered services because this is not deemed a “medical necessity” by the payer;
- 96 - Non-covered charge(s); or
- 119 Benefit maximum for this time period has been reached.

Group code PR (patient responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed advance beneficiary notice (ABN) is on file). Group code CO (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Additional information

The official instruction, CR 9751, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1753OTN.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*.

Document history

- **November 17, 2016** – This article was revised to reflect the revised CR 9571 issued on the same day. CR 9571 was revised to change the NCD 180.1 effective date in spreadsheet history to 1/1/16, in NCD 160.18, remove reactivation of MCS 012L from spreadsheet history, and in NCD 220.6.20 to remove reference to ‘primary diagnosis’ regarding diagnosis code Z00.6 in spreadsheet, and reference FISS new RC for value code D4 in spreadsheet history. In the article, the CR release date, transmittal number and the web address for CR 9571 are revised. All other information remains the same.
- **August 19, 2016** – Initial issuance

MLN Matters® Number: MM9751 *Revised*
Related Change Request (CR) #: CR 9751
Related CR Release Date: November 17, 2016
Effective Date: January 1, 2017 - Unless otherwise noted
Related CR Transmittal #: R1753OTN
Implementation Date: January 3, 2017

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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.

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 *https://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

Non-invasive extracranial arterial studies – revision to the Part A and Part B LCD

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

The local coverage determination (LCD) for non-invasive extracranial arterial studies was revised based on an LCD reconsideration request. This LCD was revised to include ICD-10-CM code Z01.810 under the "ICD-10 Codes that Support Medical Necessity" section of the LCD for Current Procedural Terminology® (CPT®) codes 93880 and 93882.

Effective date

This LCD revision is effective for claims processed **on or after December 13, 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, *click here*.

Viscosupplementation therapy for knee – revision to the Part A and Part B LCD

LCD ID number: L33767 (Florida, Puerto Rico/ U.S. Virgin Islands)

The local coverage determination (LCD) for viscosupplementation therapy for knee was revised to include HCPCS code J3590 for Hymovis® in the "CPT®/ HCPCS Codes/Group 2 Paragraph: Part B", "ICD-10 Codes that Support Medical Necessity/Group 2 Paragraph:" and "Utilization Guidelines" sections of the LCD.

Also, the "Weekly Dosage/Injections per week" column was revised to read "24 mg/2" for Hymovis® in the "Utilization Guidelines" section of the LCD.

In addition, the "Weekly Dosage/Injections per week" column was revised to read "10 mg/1" for GenVisc® and "16.8mg/1" for Gel-Syn™ and the "Total Dosage" column was revised to read "50mg" for GenVisc® and "50.4mg" for Gel-Syn™ in the "Utilization Guidelines" section of the LCD. Additionally, the "Sources of Information and Basis for Decision" section of the LCD was updated.

Effective date

The LCD revision related to the addition of HCPCS code J3590 for Hymovis® is effective for claims processed **on or after December 20, 2016**, for dates of service **on or after August 28, 2015**.

The LCD revision related to GenVisc® and Gel-Syn™ is effective for claims processed **on or after January 17, 2017**, for dates of service **on or after January 1, 2016**.

LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

Articles 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*.

2017 HCPCS Part A and Part B local coverage determination changes

First Coast Service Options Inc. has revised local coverage determinations (LCDs) impacted by the 2017 Healthcare Common Procedure Coding System (HCPCS) annual update. Procedure codes have been added, revised, replaced and deleted. The following is a list of the impacted LCDs.

Part A/B Combined LCDs

L33268 - Bendamustine hydrochloride (Treanda®, Bendeka ™)

L36393 - Controlled Substance Monitoring and Drugs of Abuse Testing

L36276 - Erythropoiesis Stimulating Agents

L33997 - Fluorescein Angiography

L33684 - Hemophilia Clotting Factors

L33704 - Infliximab (Remicade™)

L36773 - Intensity Modulated Radiation Therapy (IMRT) (Coding Guidelines only)

L34006 - Interspinous Process Decompression

L33727 - Irinotecan

L33382 - Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions

L33594 - Manipulation Under Anesthesia (MUA)

L34519 - Molecular Pathology Procedures

L33595 - Monitored Anesthesia Care (MAC) for Certain Interventional Pain Management Services

L33777 - Noncovered Services

L33693 - Non-Invasive Evaluation of Extremity Veins

L33695 - Non-invasive Extracranial Arterial Studies

L33252 - Psychiatric Diagnostic Evaluation and Psychotherapy Services

L33745 - Respiratory Therapeutic Services (Coding Guidelines only)

L36342 - Screening and Diagnostic Mammography

L33413 - Therapy and Rehabilitation Services

L33762 - Treatment of varicose veins of the lower extremity

L33767 - Viscosupplementation Therapy For Knee

L33566 - Wound Debridement Services (Coding Guidelines only)

Part A only LCD

L33972 - Psychiatric Partial Hospitalization Program

Part B only LCDS

L33903 - Diagnostic Laryngoscopy

L33906 - Epidural

L33834 - Health and Behavior Assessment/Intervention

L33910 - Independent Diagnostic Testing Facility (IDTF) (Coding Guideline only)

L33911 - Indocyanine - Green Angiography

L33919 - Macugen (pegaptanib sodium injection) (Coding Guidelines only)

Effective date

This LCD revision is effective for services rendered **on or after April 11, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Coding article for positron emission tomography (PET) scans used for oncological indications

The Centers for Medicare & Medicaid Services (CMS) determined that local Medicare administrative contractors (MACs) may determine coverage within their respective jurisdictions for positron emission tomography (PET) using radiopharmaceuticals for their Food & Drug Administration (FDA)-approved labeled indications **for oncologic imaging**. Unless there is a specific NCD to the contrary, local Medicare administrative contractors (MACs) may determine coverage or noncoverage for positron emission tomography (PET) using new proprietary radiopharmaceuticals for their FDA-approved labeled indications for oncologic imaging only. This is effective for dates of service on or after March 7, 2013, and includes those radiopharmaceuticals that may be approved by the FDA in the future. This decision does not change coverage for any uses of PET using the following four radiopharmaceuticals: FDG (2-deoxy-2-[F-18] fluoro-D-Glucose (fluorodeoxyglucose)); NaF-18 (fluorine-18 labeled sodium fluoride); ammonia N-13; or rubidium-82 (Rb-82)). In addition, this decision does not prevent CMS from determining national coverage for any uses of any radiopharmaceuticals in the future, and if such determinations are made, a future determination would supersede local MAC determination(s).

Please refer to the following CMS references for full, detailed information regarding the coverage of positron emission tomography (PET) scans used for oncologic conditions: CMS internet-Only Manual (IOM) Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 4, Section 220.6 and CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 13, Section 60.

Healthcare common procedure coding system (HCPCS) code J3490 (Unclassified drugs) is applicable to all new diagnostic radiopharmaceuticals used in non-beta-amyloid PET imaging. Effective for services after January 1, 2017, HCPCS code A9588 is applicable for fluciclovine F18; HCPCS code A9587 is applicable for Gallium ga-68, dotatate; and HCPCS code A9515 is applicable for Choline c-11.

Beginning with services performed on or after June 11, 2013, contractors shall pay for up to three (3) FDG PET scans when used to guide subsequent management of anti-tumor treatment strategy (modifier PS) after completion of initial anti-cancer therapy (modifier PI) for the exact same cancer diagnosis. Coverage of any additional FDG PET scans (that is, beyond three) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-tumor therapy for the same cancer diagnosis will be determined by the A/B MACs (A or B). Claims will include the KX modifier indicating the coverage criteria is met for coverage of four or more FDG PET scans for subsequent treatment strategy for the same cancer diagnosis. A different cancer diagnosis whether submitted with a PI or a PS modifier will begin the count of one initial and three subsequent FDG PET scans not requiring the KX modifier and four or more FDG PET scans for subsequent treatment strategy for the same cancer diagnosis requiring the KX modifier.

Note: Fluciclovine F18 and Choline c-11 are FDA-approved for suspected prostate cancer recurrence. It is expected that the PS modifier is appended to indicate a subsequent FDG PET scan; the use of the PI modifier for initial treatment of prostate cancer is not covered.

Coverage indications and limitations, including nationally non-covered conditions (e.g., the use of FDG PET imaging to determine initial treatment strategy in patients with adenocarcinoma of the prostate), are described within the IOM sections referenced above. Effective for claims with dates of service on and after June 11, 2013, the chart below summarizes national FDG PET coverage for oncologic conditions, which summarizes coverage and non-coverage for initial and subsequent treatment strategies for FDG PET. When applicable the contractor will apply the same coverage and non-coverage summarized on the chart below to new proprietary radiopharmaceuticals used for FDA-approved labeled indications for positron emission tomography (PET) oncologic imaging.

FDG PET coverage for oncologic conditions:

Tumor type	Initial treatment strategy	Subsequent treatment strategy
Colorectal	Cover	Cover
Esophagus	Cover	Cover
Head & neck (not thyroid CNS)	Cover	Cover
Lymphoma	Cover	Cover

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Tumor type	Initial treatment strategy	Subsequent treatment strategy
Non-small cell lung	Cover	Cover
Ovary	Cover	Cover
Brain	Cover	Cover
Cervix	Cover w/ exception*	Cover
Small cell lung	Cover	Cover
Soft tissue sarcoma	Cover	Cover
Pancreas	Cover	Cover
Testes	Cover	Cover
Breast (female and male)	Cover w/ exception*	Cover
Melanoma	Cover w/ exception*	Cover
Prostate	Noncover	Cover
Thyroid	Cover	Cover
All other solid tumors	Cover	Cover
Myeloma	Cover	Cover
All other cancers not listed herein	Cover	Cover

*__Cervix__: nationally non-covered for the initial diagnosis of cervical cancer related to initial anti-tumor treatment strategy; all other indications for initial anti-tumor treatment strategy for cervical cancer are nationally covered.

*__Breast__: nationally non-covered for initial diagnosis and/or staging of axillary lymph nodes; nationally covered for initial staging of metastatic disease. All other indications for initial anti-tumor treatment strategy for breast cancer are nationally covered.

*__Melanoma__: nationally non-covered for initial staging of regional lymph nodes; all other indications for initial anti-tumor treatment strategy for melanoma are nationally covered.

Providers should refer to the following link for a list of appropriate diagnosis codes: *NCD 220.6.17 PET for Solid Tumors Oncologic Diagnosis Codes*. Please note, however, that the ICD-10-CM diagnosis code, as always, is only one piece of information in support of the medical necessity of the service. All requirements must be met, and the clinical documentation in the medical record must support all of the requirements.

Medicare billing certificate programs

The programs are designed to provide education on Part A and Part B of the Medicare program. They each include required web-based training courses, readings, and a list of helpful resources. Upon successful completion of each of the programs, you will receive a certificate in Medicare billing from CMS.

To participate in either the Part A or Part B provider type program, visit *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html* and select “web-based training (WBT) courses.”

Please visit the Learning Management and Product Ordering System (LM/POS), at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/LMPOS-HowTo-Fact-Sheet-ICN909190.pdf* to learn how to create an account and log on to the LM/POS.

The MLN LM/POS gives you free, immediate access to MLN educational products and web-based training (WBT) courses, many of which provide continuing education credits! You must have a registered account and log on to the system in order to view and order educational products and enroll in WBT courses.

January 2017 integrated outpatient code editor specifications version 18.0

Provider types affected

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

What you need to know

Change request (CR) 9892 provides instructions and specifications for the integrated outpatient code editor (I/OCE) used for outpatient prospective payment system (OPPS) and non-OPPS claims. This is for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the home health prospective payment system (PPS) or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes. The I/OCE specifications will be posted at *https://www.cms.gov/OutpatientCodeEdit/*. These specifications contain the appendices mentioned in the table below.

Key I/OCE changes for January 2017

The following table summarizes the modifications of the IOCE for the January 2017 v18.0 release. Note that some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the 'Effective date' column.

Effective date	Edits affected	Modification
1/1/2017		Implement new program logic for the community mental health center (CMHC) outlier limitation (see OPPS processing logic and Appendix E). Apply new payment method flag 6 to all OPPS payable lines if condition code 66 is present for claims with bill type 76x.
1/1/2017		Implement new program logic to include negative pressure wound therapy (NPWT) procedure codes 97607 and 97608 to the list of codes reportable for home health claims with bill type 34x that are payable under OPPS (see OPPS special processing logic and Appendix F-(a)).
8/1/2016	67	Implement mid-quarter Food and Drug Administration (FDA) approval edit for 90674.
1/1/2017	100	Implement new edit: Claim for hematopoietic stem cell transplantation (HSCT) allogeneic transplantation lacks required revenue code line for donor acquisition services (claim is returned to provider (RTP)). Edit criteria: A claim reporting HSCT allogeneic transplantation (procedure code 38240) is reported and there is no additional line on the claim reporting revenue code 815 for donor acquisition services (see Table 4).
1/1/2017	41	Add new revenue code 815 (Allogeneic stem cell acquisition services) to the valid revenue code list.
1/1/2017		Implement updated program logic to process conditional ambulatory payment classification (APC)/packaging, critical care ancillary packaging and advance care planning across the claim rather than by day (see OPPS processing logic).
1/1/2017		Implement updated program logic for processing terminated device-intensive procedure offset determinations by HCPCS code, not by APC. **Note**: This also includes table changes for the quarterly data file reports.
1/1/2017		Implement new program logic for payment adjustment of film x-ray HCPCS codes. Film x-ray HCPCS codes with modifier FX reported are assigned new payment adjustment flag 21 (see OPPS processing logic, Table 7 and Appendix G).

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Effective date	Edits affected	Modification
1/1/2017	22	Add new modifiers FX (X-ray taken using film), PN (Non-excepted off-campus svc), 95 (Synchronous telemedicine service) and V1, V2, V3 (Demonstration modifiers 1, 2, 3) to the valid modifier list.
1/1/2017		Implement new status indicator (SI) value E1, to replace former SI E for non-covered services (see Table 7). **Note**: Edits 9, 28 and 50 applied formerly for HCPCS with SI = E are now applied to HCPCS with SI = E1.
1/1/2017		Implement new SI value E2 (Items and services for which pricing information and claims data are not available) (see Table 7).
1/1/2017	13	Reactivate edit 13: Separate payment for services is not provided by Medicare (LIR). Edit criteria: there is a line item HCPCS present with SI = E2 (see OPPS processing logic, Table 4, Table 7).
1/1/2014		Correction of program logic for extended assessment and management (EAM) composite APC 8009 to not consider conditional APC processing of sometimes therapy codes with SI = Q1 resulting in final SI = A as criteria for preventing assignment of the EAM composite APC. Also, units of service are not reduced to one under conditional APC processing for sometimes therapy codes resulting in final SI = A (see OPPS processing logic and Appendix K).
9/28/2016	68	Implement mid-quarter NCD coverage for G0499.
1/1/2016	99	Update the edit logic to include exceptions for certain blood clotting factor HCPCS codes that may be self-administered and do not require that an OPPS payable procedure is present. Also, program logic only is updated to apply edit 99 only to those OPPS bill types where APC information is returned (see Appendix F(a) for reference).
1/1/2016		Update the inpatient procedure processing when the patient expires to also include claims with discharge status codes indicating transfer to another hospital facility (see OPPS processing logic and Appendix L).
1/1/2016		Update the inpatient procedure processing when the patient expires to also include claims with discharge status codes indicating transfer to another hospital facility (see OPPS processing logic and Appendix L).
1/1/2017	70	Update the edit logic and description to include transfer discharge status: Edit description: CA modifier requires patient discharge status indicating expired or transferred.
1/1/2017		Update the edit logic and description to include transfer discharge status: Edit description: CA modifier requires patient discharge status indicating expired or transferred.
1/1/2017	101	Implement new edit 101: Item or service with modifier PN not allowed under PFS (RTP). Edit criteria: Modifier PN is reported for an item or service that is considered to be non-excepted for an off-campus provider-based hospital outpatient department under Section 603.

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Effective date	Edits affected	Modification
1/1/2016		Update the advance care planning logic to include add-on code 99498; change the SI to A if reported with 99497 and the annual wellness visit, otherwise package with SI = N.
1/1/2017		Update the program logic and flowcharts for partial hospitalization and daily mental health to refer to a single level per diem APC (level I/II APCs no longer applicable) (see OPPS processing logic and Appendix C ('a' and 'b'). Appendices are attached to CR 9892.
1/1/2017	87	Update the skin substitute product lists (Appendix O, List E: Lists A and B)
1/1/2017	22	Modifier L1, associated with the reporting of conditionally packaged laboratory procedures is deactivated (see OPPS processing logic).
1/1/2017		Update program logic for LDR brachytherapy composite APC primary code 55875 is assigned under comprehensive APCs if conditions are not met for composite APC 8001 assignment (see Appendix K).
1/1/2017		Add the following new payment method flags (see Table 7 and Appendix E): - 6 (CMHC Outlier limitation reached) - 7 (Section 603 service with no reduction in OPPS Pricer) - 8 (Section 603 service with PFS reduction applied in OPPS Pricer)
1/1/2017		Update the description for payment indicator value of 2: "Services not paid by OPPS Pricer; paid under fee schedule or other payment system (SIs A, G, K)" (see Table 7).

Effective date	Edits affected	Modification
1/1/2017		Add new payment adjustment flag 21 (CAA Section 502b reduction on film x-ray) (see Table 7 and Appendix G).
1/1/2017		Add new SI values E1 and E2 (Items and services for which pricing information and claims data are not available) (see Table 7).
1/1/2017		Update Appendix F (a) to include new edits 100 and 101.
1/1/2017		Add new Appendix Q: processing steps and criteria for non-excepted items and services under Section 603.
1/1/2017		Update Appendix L to include new SI values E1 and E2 in the list of SI's that are edited as usual under comprehensive APC processing.
1/1/2017		Update table 4 to add new columns noting versions and dates effective for edits.

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Effective date	Edits affected	Modification
1/1/2017		Update the following lists for the release (see quarterly data files): - Bilateral flag lists - Procedure and gender conflict lists (edit 8) - Comprehensive APC list - Complexity-adjusted comprehensive APC code pairs - Device and device-procedure lists (edit 92) - Terminated device offset (offset by HCPCS) - Pass-through device offset amounts - Film X-ray HCPCS (new logic) - Negative pressure wound therapy (new logic) - Section 603 override HCPCS (new logic) - Blood clotting factor HCPCS (edit 99 exclusion) - Skin substitutes (edit 87) - Pass-through radiopharmaceuticals - Pass-through radiopharmaceutical APC offset amounts - Pass-through contrast APC offset amounts - Pass-through skin substitutes - Pass-through skin substitute APC offset amounts - Deductible-coinsurance N/A list appendix O, List C) - Service not paid Medicare list (new SI = E2) - Not recognized Medicare list (edit 28) - Non-covered service list (edit 9) - Statutory exclusion list (edit 50) - Not recognized OPPS list (edit 62) - FQHC vaccines - FQHC code pairs

Effective date	Edits affected	Modification
1/1/2017		Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
1/1/2017	20, 40	Implement version **23.0** of the NCCI (as modified for applicable outpatient institutional providers).

Additional information

The official instruction, CR 9892, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3674CP.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: MM9892
Related Change Request (CR) #: CR 9892
Related CR Release Date: December 9, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3674CP
Implementation Date: January 3, 2017

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Annual update of HCPCS codes used for home health consolidated billing enforcement

Provider types affected

This *MLN Matters*® article is intended for home health agencies (HHAs) and other providers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

Provider action needed

Change request (CR) 9771 provides the 2017 annual update to the list of HCPCS codes used by Medicare systems to enforce consolidated billing of home health services. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the home health prospective payment system (HH PPS).

With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, K codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency.

The HCPCS codes in the table below are being added to the HH consolidated billing therapy code list, effective for services on or after January 1, 2017. These codes replace HCPCS codes: 97001, 97002, 97003, 97004.

HCPCS code	Descriptor
97161	PT EVAL LOW COMPLEX 20 MIN
97162	PT EVAL MOD COMPLEX 30 MIN
97163	PT EVAL HIGH COMPLEX 45 MIN
97164	PT RE-EVAL EST PLAN CARE
97165	OT EVAL LOW COMPLEX 30 MIN
97166	OT EVAL MOD COMPLEX 45 MIN
97177	OT EVAL HIGH COMPLEX 60 MIN
97168	OT RE-EVAL EST PLAN CARE

G0279 and G0280 are deleted from the HH consolidated billing therapy code list. These codes were replaced with 0019T and should have been removed from the list in earlier updates. Effective January 1, 2015, these codes were redefined for another purpose. MACs will adjust claims denied due to HH consolidated billing with HCPCS codes G0279 and G0280 and line item dates of service on or after January 1, 2015, if brought to their attention.

Additional information

The official instruction, CR 9771, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3618CP.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: MM9771
Related Change Request (CR) #: CR 9771
Related CR Release Date: October 7, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3618CP
Implementation Date: January 3, 2017

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July 2016 ASP Medicare Part B drug pricing files and revisions to prior pricing files

Provider types affected

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

Provider action needed

Change request (CR) 9612 informs MACs to download and implement the July 2016 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the April 2016, January 2016, October 2016, and July 2015, 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 July 5, 2016, with dates of service July 1, 2016, through September 30, 2016. Make sure that 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 OPPS are incorporated into the outpatient code editor (OCE) through separate instructions that can be located in the *Medicare Claims Processing Manual* (*Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)*, Section 50 (Outpatient PRICER)).

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

Files	Effective dates of service
July 2016 ASP and ASP NOC	July 1, 2016, through September 30, 2016
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
October 2015 ASP and ASP NOC	October 1, 2015, through December 31, 2015
July 2015 ASP and ASP NOC	July 1, 2015, through September 30, 2015

Additional information

The official instruction, CR 9612, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3494CP.pdf*.

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

MLN Matters® Number: MM9612
Related Change Request (CR) #: CR 9612
Related CR Release Date: April 22, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3494CP
Implementation Date: July 5, 2016

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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 *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf*.

October 2016 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) 9724 provides the October 2016 quarterly update and instructs MACs to download and implement the October 2016 ASP drug pricing files and, if released by CMS, the July 2016, April 2016, January 2016, and October 2015, 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 October 3, 2016, with dates of service October 1, 2016, through December 31, 2016. MACs will not search and adjust claims that have already been 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 the Centers for Medicare & Medicaid Services (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
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
April 2016 ASP and ASP NOC	April 1, 2016, through June 30, 2016

Files	Effective dates of service
January 2016 ASP and ASP NOC	January 1, 2016, through March 31, 2016
October 2015 ASP and ASP NOC	October 1, 2015, through December 31, 2015

Additional information

The official instruction, CR 9724, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3573CP.pdf*.

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

MLN Matters® Number: MM9724
Related Change Request (CR) #: CR 9724
Related CR Release Date: July 29, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3573CP
Implementation October 3, 2016

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2017 update for DMEPOS fee schedule

Provider types affected

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

What you need to know

Change request (CR) 9854 provides the 2017 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background

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

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

The Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME. The Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. The methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs are established in regulations at 42 CFR Section 414.210(g). Also, program instructions on these changes are available in Transmittal 3551, CR 9642 (*MLN Matters*® article *MM9642*), dated June 23, 2016, and Transmittal 3416, CR 9431 (*MM9431*), dated November 23, 2015.

The DMEPOS and PEN fee schedule files contain Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the adjusted fee schedule amounts as well as codes that are not subject to the fee schedule CBP adjustments. Fee schedule amounts that are adjusted using information from CBPs will not be subject to the annual DMEPOS covered item update, but will be updated pursuant to 42 CFR 414.210(g)(8) when information from the CBPs is updated. This update to the adjusted fees includes information from the CBPs that takes effect on January 1, 2017 (Round 1 2017). Pursuant to 42 CFR Section 414.210(g)(4), for items where the single payment amounts (SPAs) from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment would go into effect (for example, 2017 for this update) and for each subsequent year such as 2018 and 2019.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. ZIP codes for non-continental metropolitan statistical areas (MSA) are not included in the DMEPOS rural ZIP code file. The DMEPOS rural ZIP code file is updated on a quarterly basis as necessary. Regulations at Section 414.202 define rural areas to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any MSA. A rural area also includes any ZIP code within an MSA that is excluded from a competitive bidding area established for that MSA.

Policy: Fee schedule and rural zip code files

The DMEPOS fee schedule file contains fee schedule amounts for non-rural and rural areas. Also, the PEN fee schedule file includes state fee schedule amounts for both enteral nutrition items and national non-rural fee schedule amounts for parenteral nutrition items.

The DMEPOS and PEN fee schedules and the rural ZIP code public use files (PUFs) will be available for state Medicaid agencies, managed care organizations, and other interested parties on the CMS *DMEPOS fee schedule* website after November 18, 2016.

New codes added

The new codes are not to be used for billing purposes until they are effective on January 1, 2017. For gap-filling pricing purposes, deflation factors are applied before updating to the current year. The deflation factors for 2016 by payment category are below.

0.454 for oxygen

0.457 for capped rental

0.458 for prosthetics and orthotics

0.582 for surgical dressings

0.633 for parental and enteral nutrition

0.969 for splints and casts

0.952 for intraocular lenses

Codes deleted

Codes deleted from the DMEPOS fee schedule files effective January 1, 2017, are:

- B9000 - Enteral nutrition infusion pump - without alarm (Enter infusion pump w/o alrm)
- B9000MS - Enteral nutrition infusion pump - without alarm

See **DMEPOS**, next page

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- E0628 - Separate seat lift mechanism for use with patient owned furniture-electric (Seat lift for pt furn-electr)
- K0901 - Knee orthosis (ko), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf (Ko single upright pre ots)
- K0902 - Knee orthosis (ko), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf (Ko double upright pre ots)

Effective January 1, 2017, codes B9000 and E0628 will crosswalk to codes B9002 and E0627 respectively. Payment for necessary maintenance and servicing of B9000 pumps will also crosswalk to B9002MS.

Effective January 1, 2017, the fees for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier 'KU' are deleted from the DMEPOS fee schedule file.

The fee schedule amounts associated with the KU modifier were mandated by Section 2 of Patient Access and Medicare Protection Act (PAMPA) effective for dates of service January 1, 2016, through December 31, 2016. The list of HCPCS codes to which this statutory section applied is available in Transmittal 3535, CR 9520 *Transmittal 3535, CR 9520*, dated June 7, 2016.

Specific coding and pricing issues

Effective January 1, 2017, existing off-the-shelf orthotic (OTS) codes K0901 and K0902 are re-designated as codes L1851 and L1852 respectively. The fee schedule amounts for codes K0901 and K0902 will be applied to the corresponding new codes L1851 and L1852 as part of this update. Attachment B in CR 9854 updates the list of orthotic codes that are designated as OTS on the CMS *orthotics website* to reflect the addition of the two renumbered codes (L1851 and L1852).

As part of the this update, the adjusted fee schedule amounts for the following groups of similar items are adjusted in accordance with 42 CFR Section 414.210 (g)(6) to limit the single payment amounts (SPAs) for items without certain features to the weighted average of the SPAs for the items both with and without the features prior to using the SPAs in adjusting the fee schedule amounts:

1. Hospital beds (HCPCS codes E0250, E0251, E0255, E0256, E0260, E0261, E0290, E0291, E0292, E0293, E0294, E0295, E0301, E0302, E0303 and E0304)
2. Mattress and overlays (HCPCS codes E0277, E0371, E0372, and E0373)

3. Power wheelchairs (HCPCS codes K0813, K0814, K0815, K0816, K0820, K0821, K0822, and K0823)
4. Seat lift mechanisms (HCPCS codes E0627 and E0629)
5. TENS devices (HCPCS codes E0720 and E0730)
6. Walkers (HCPCS codes E0130, E0135, E0141 and E0143)

CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513).

To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of 2004.

For 2017, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the 2015. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2017.

Diabetic testing supplies

The fee schedule amounts for non-mail order diabetic testing supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in 2013 so that they are equal to the single payment amounts for mail order DTS established in implementing the national mail order CBP under Section 1847 of the Act.

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The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated. This can happen no less often than every time the mail order CBP contracts are re-competed. The CBP for mail order diabetic supplies is effective July 1, 2016, to December 31, 2018. The program instructions reviewing these changes are Transmittal 2709, CR 8325 (*MM8325*), dated May 17, 2013, and Transmittal 2661, CR 8204 (*MM8204*), dated February 22, 2013. Note that the mail order DTS (KL) fee schedule amounts for all states and territories were removed from the DMEPOS fee schedule file as part of the July 1, 2016, update.

2017 fee schedule update factor of 0.7 percent

For 2017, an update factor of 0.7 percent is applied to certain DMEPOS fee schedule amounts.

In accordance with the statutory Sections 1834(a)(14) of the Act, certain DMEPOS fee schedule amounts are updated for 2017 by the percentage increase in the consumer price index for all urban consumers (United States city average) or urban consumers (CPI- U) for the 12-month period ending with June of 2016, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP). The MFP adjustment is 0.3 percent and the CPI-U percentage increase is 1 percent. Therefore, the 1 percentage increase in the CPI-U is reduced by the 0.3 percentage increase in the MFP resulting in a net increase of 0.7 percent for the update factor.

2017 update to the labor payment rates

Included below and in Attachment A in CR 9854 are the 2017 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI- U for the twelve month period ending with June 30, 2016, is 1 percent, this change is applied to the 2016 labor payment amounts to update the rates for 2017. The 2017 labor payment amounts in Attachment A are effective for claims submitted using HCPCS codes K0739, L4205, and L7520 with dates of service from January 1, 2017, through December 31, 2017.

State	K0739	L4205	L7520
AK	$28.29	$32.23	$37.92
AL	$15.02	$22.38	$30.38
AR	$15.02	$22.38	$30.38
AZ	$18.57	$22.35	$37.38
CA	$23.04	$36.74	$42.81
CO	$15.02	$22.38	$30.38
CT	$25.08	$22.88	$30.38
DC	$15.02	$22.35	$30.38
DE	$27.65	$22.35	$30.38
FL	$15.02	$22.38	$30.38
GA	$15.02	$22.38	$30.38
HI	$18.57	$32.23	$37.92
IA	$15.02	$22.35	$36.37
ID	$15.02	$22.35	$30.38
IL	$15.02	$22.35	$30.38
IN	$15.02	$22.35	$30.38
KS	$15.02	$22.35	$37.92
KY	$15.02	$28.65	$38.85
LA	$15.02	$22.38	$30.38
MA	$25.08	$22.35	$30.38
MD	$15.02	$22.35	$30.38
ME	$25.08	$22.35	$30.38
MI	$15.02	$22.35	$30.38
MN	$15.02	$22.35	$30.38
MO	$15.02	$22.35	$30.38
MS	$15.02	$22.38	$30.38
MT	$15.02	$22.35	$37.92
NC	$15.02	$22.38	$30.38
ND	$18.72	$32.16	$37.92
NE	$15.02	$22.35	$42.36
NH	$16.13	$22.35	$30.38
NJ	$20.26	$22.35	$30.38
NM	$15.02	$22.38	$30.38
NV	$23.93	$22.35	$41.41
NY	$27.65	$22.38	$30.38
OH	$15.02	$22.35	$30.38
OK	$15.02	$22.38	$30.38
OR	$15.02	$22.35	$43.68
PA	$16.13	$23.02	$30.38
PR	$15.02	$22.38	$30.38
RI	$17.90	$23.04	$30.38
SC	$15.02	$22.38	$30.38
SD	$16.79	$22.35	$40.62
TN	$15.02	$22.38	$30.38
TX	$15.02	$22.38	$30.38
UT	$15.06	$22.35	$47.31
VA	$15.02	$22.35	$30.38
VI	$15.02	$22.38	$30.38
VT	$16.13	$22.35	$30.38
WA	$23.93	$32.79	$38.96
WI	$15.02	$22.35	$30.38
WV	$15.02	$22.35	$30.38
WY	$20.94	$29.83	$42.36

2017 national monthly fee schedule amounts for stationary oxygen equipment

As part of this update, CMS is implementing the 2017 monthly fee schedule payment amounts for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service from January 1, 2017, through December 31, 2017. As required

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by statute, the addition of the separate payment classes for oxygen generating portable equipment (OGPE) and stationary and portable oxygen contents must be annually budget neutral. Medicare expenditures must account for these separate oxygen payment classes. Therefore, the fee schedule amounts for stationary oxygen equipment are reduced by a certain percentage each year to balance the increase in payments made for the additional separate oxygen payment classes. For dates of service January 1, 2017, through December 31, 2017, the 2017 monthly fee schedule payment amounts for stationary oxygen equipment range from approximately $67 to $77, incorporating the budget neutrality adjustment factor.

When updating the stationary oxygen equipment amounts, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the payment amounts for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2017 maintenance and servicing payment amount for certain oxygen equipment

Also updated for 2017 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen, equipment was instructed in Transmittal 635, CR 6972 (*MM6972*), dated February 5, 2010, and Transmittal 717, CR 6990 (*MM6990*), dated June 8, 2010. To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every six months, beginning six months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for HCPCS codes E1390, E1391, E0433, or K0738, billed with the MS modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary for any six-month period.

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered

item update for DME as set forth in Section 1834(a)(14) of the Act. Therefore, the 2016 maintenance and servicing fee is adjusted by the 0.7 percent MFP-adjusted covered item update factor to yield 2017 maintenance and servicing fee of $69.97 for oxygen concentrators and transfilling equipment.

Additional information

The official instruction, CR 9854 issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3671CP.pdf*.

If you have any questions, please contact your MAC at their toll-free number. That number is available at *MAC Toll-Free Number* under - How Does It Work.

For more information regarding the competitive bidding implementation contractor (CIBC) website refer to the CBIC website.

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Related Change Request (CR) #: CR 9854
Related CR Release Date: December 5, 2016
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Implementation Date: January 3, 2017

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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.

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

Provider types affected

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

Provider action needed

Change request (CR) 9774 updates the remittance advice remark code (RARC) and claim adjustment reason code (CARC) lists and instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

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

CMS provides this CR as a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Shared system maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in this CR, contractors must implement on the date specified on the WPC website, which is at *http://wpc-edi.com/Reference/*.

A discrepancy between the dates may arise as the WPC website is only updated three times a year and may not match the CMS release schedule. For this recurring CR, the MACs and the SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update CR (CR 9695).

Additional information

The official instruction, CR 9774, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3660CP.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: MM9774
Related Change Request (CR) #: CR 9774
Related CR Release Date: November 18, 2016
Effective Date: April 1, 2017
Related CR Transmittal #: R3660CP
Implementation Date: April 3, 2017

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Claim status category and claim status codes update

Provider types affected

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

Provider action needed

Change request (CR) 9769 informs MACs about system changes to update, as needed, the claim status and claim status category codes used for the Accredited Standards Committee (ASC) X12 276/277 health care claim status request and response and ASC X12 277 health care claim acknowledgment transactions. Make sure that your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only claim status category codes and claim status codes approved by the National Code Maintenance Committee in the ASC X12 276/277 health care claim status request and response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry six months for implementation of newly added or changed codes. The codes sets are available on the Washington Publishing Company website at *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/* and *http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/*.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the January 2017 committee meeting shall be posted on these sites on or about February 1, 2017. Your MAC will complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes, by the implementation date of CR 9769.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR 9769.

Additional information

The official instruction, CR 9769, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3661CP.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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Implementation Date: April 3, 2017

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CMS updates the code list for CARC, RARC, and CAGC combinations

Provider types affected

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

Provider action needed

Change request (CR) 9767 informs MACs of the regular update in the Council for Affordable Quality Healthcare (CAQH) Committee on operating rules for information exchange (CORE) defined code combinations per operating rule 360 - uniform use of claim adjustment reason codes and remittance advice remark codes (835) rule. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE EFT & ERA operating rule set that was implemented on January 1, 2014, under the Patient Protection and Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

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

CR 9767 deals with the regular update in CAQH CORE defined code combinations per operating rule 360 - uniform use of claim adjustment reason codes and remittance advice remark codes (835) rule.

CAQH CORE will publish the next version of the code combination List on or about February 1, 2017. This update is based on the claim adjustment reason code (CARC), remittance advice remark code (RARC) updates as posted at the WPC website on or about November 1, 2016. This will also include updates based on market-based review (MBR) that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by health plans including Medicare as the industry needs them.

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

Note: Per Affordable Care Act mandate all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/group code for a minimum set of four business scenarios. Medicare can use any code combination if the business scenario is not one of the four CORE defined business scenarios. With the four CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional information

The official instruction, CR 9767, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3665CP.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: MM9767
Related Change Request (CR) #: CR 9767
Related CR Release Date: November 23, 2016
Effective Date: April 1, 2017
Related CR Transmittal #: R3665CP
Implementation Date: April 3, 2017

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Changes to the ESRD facility claim to accommodate dialysis for acute kidney injury

Provider types affected

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

What you need to know

Change request (CR) 9598 implements changes to the ESRD facility claim (type of bill 72x) to accommodate dialysis furnished to beneficiaries with acute kidney injury (AKI). This *MLN Matters*® special edition article summarizes these changes. Make sure that your billing staffs are aware of these changes.

Background

On June 29, 2015, The Trade Preferences Extension Act of 2015 was enacted in which Section 808 amended Section 1861(s)(2)(F) of the Social Security Act (42 U.S.C. 1395x(s)(2)(F)) by extending renal dialysis services paid under Section 1881(b)(14) to beneficiaries with AKI effective January 1, 2017.

Beginning January 1, 2017, ESRD facilities will be able to furnish dialysis to AKI patients. The AKI provision was signed into law on June 29, 2015. (See *Sec. 808 Public Law 114-27*)

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

Renal dialysis services as defined in 42 CFR 413.171, would be considered to be renal dialysis services for patients with AKI. 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.

Items and services furnished to beneficiaries with AKI that are not considered to be renal dialysis services as defined in 42 CFR 413.171, are separately payable. Specifically, drugs, biologicals, laboratory services, supplies, and other services that ESRD facilities are certified to furnish and that would otherwise get furnished to a beneficiary with AKI in a hospital outpatient setting will be paid separately using the applicable Part B fee schedule. This includes vaccines. ESRD facilities may provide vaccines to beneficiaries with AKI and seek reimbursement under the applicable CMS vaccination policies discussed in *Chapter 18 of the Medicare Claims Processing Manual*.

For payment under Medicare, ESRD facilities shall report all items and services furnished to beneficiaries with AKI by submitting the 72x type of bill 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 the 72x type of bill 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 are required to 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). Beneficiaries with AKI are able to receive either peritoneal dialysis or hemodialysis in an ESRD facility. Based on the level of care required for these beneficiaries, at this time, CMS is not extending the home dialysis benefit to beneficiaries with AKI.

AKI claims will not have limits on how many dialysis 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, the facility is paid based on the full base rate. An example includes medical emergencies such as rushing a dialysis patient to an emergency room mid-treatment. This is a rare occurrence and must be fully documented to your MAC's satisfaction.

Applicability of other ESRD and CMS adjustments

ESRD network fee

The ESRD network fee reduction is not applicable to claims for beneficiaries with AKI. The operationalization of this policy occurs via CR 9814 effective April 1, 2017, and claims submitted between January 1, 2017, and March 31, 2017, will be adjusted once the CR is implemented.

See **AKI**, next page

CMS implements changes in the end-stage renal disease prospective payment system

***Note**: This article was revised December 6, 2016, to add a link to MLN Matters® article MM9814 that details payment information for AKI services. All other information is unchanged. This was previously published in the November 2016 Medicare A Connection, pages 16-17.*

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 (Section1881(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*

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ESRD quality incentive program (QIP)

The ESRD QIP is not applicable for beneficiaries with AKI at this time.

Sequestration adjustments

The 2 percent sequestration adjustment is applicable to claims for beneficiaries with AKI. This is global CMS adjustments and applies to AKI claims.

ESRD conditions for coverage (CfCs)

The ESRD CfCs at 42 CFR Part 494 are health and safety standards that all Medicare-participating dialysis facilities must meet. These standards set baseline requirements for patient safety, infection control, care planning, staff qualifications, record keeping, and other matters to ensure that all patients, including ESRD and AKI patients, receive safe and appropriate care.

Low volume payment adjustment (LVPA)

AKI dialysis treatments count toward the LVPA threshold when determining total number of treatments provided when a facility prepares the low volume attestation to determine eligibility for the LVPA.

Additional information

The official instruction, CR 9598, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1759OTN.pdf*.

The official instruction, CR 9418, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1738OTN.pdf*.

42 CFR 413.171 is available at *http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=3233ff9c843c3f74275cab5dcbcf088c&mc=true&n=pt42.2.413&r=PART&ty=HTML#se42.2.413_1171*.

42 CFR 494 is available at *http://www.ecfr.gov/cgi-bin/text-idx?SID=0cf1f211399c42665d1bfb2ed9b6783a&mc=true&tpl=/ecfrbrowse/Title42/42cfr494_main_02.tpl*.

The Trade Preferences Extension Act of 2015 is available at *https://www.congress.gov/bill/114th-congress/house-bill/1295/text#toc-HEE69B51CC87340E2B2AB6A4FA73D2A82*.

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/*.

The 2017 proposed rule is available at *https://www.gpo.gov/fdsys/pkg/FR-2016-06-30/pdf/2016-15188.pdf*.

The 2017 final rule is available at *https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-26152.pdf*.

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Implementation Date: January 3, 2017

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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.

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 that is 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*.

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

***Note**: This article was revised December 7, 2016, to add a link to MLN Matters® article MM9807 that provides additional information on the implementation of AKI services. All other information is unchanged. This information was previously published in the November 2016 Medicare A Connection, pages 16-17.*

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 on June 29, 2015. The pertinent section is available online at *https://www.congress.gov/bill/114th-congress/house-bill/1295/text#toc-HEE69B51CC87340E2B2AB6A4FA73D2A82*.

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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-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
December 7, 2016	The article was revised to add a link to *MLN Matters*® article *MM9807* that provides additional information on the implementation of AKI services.
November 4, 2016	Initial issuance

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Hospital requirements for making an election for a particular fiscal period covered by CMS ruling 1498-R2

Effective date: January 19, 2017
*Unless otherwise specified, the effective date is the date of service.

Implementation date: January 19, 2017

I. General information

A. Background

On April 28, 2010, the administrator of the Centers for Medicare & Medicaid Services (CMS) issued CMS ruling 1498-R. The ruling addressed administrative appeals on three different issues related to Medicare disproportionate share hospital (DSH) payment:

1) The Medicare-supplemental security income (SSI) fraction data matching process issue, and the method for recalculating the hospital's Medicare-SSI fraction by matching Medicare and SSI-entitlement data;
2) The exclusion from the Medicare fraction and the numerator of the Medicaid fraction of non-covered inpatient hospital days for patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted; and
3) The exclusion from the DSH calculation of labor/delivery room (LDR) inpatient days. On April 22, 2015, the administrator of CMS issued CMS ruling 1498-R2, which effectively amended CMS ruling 1498-R. This modification and amendment of CMS ruling 1498-R affects a change only with respect to the relief that is available for revised Medicare-SSI fractions, and the interaction between Medicare-SSI fractions suitably revised to address the data matching process issue and the issue of Medicare Part A non-covered or exhausted benefit days ("dual-eligible non-covered days") for cost-reporting periods involving patient discharges before October 1, 2004.

B. Policy

Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 provides that for discharges occurring on or after May 1, 1986, an additional payment must be made to inpatient prospective payment system (IPPS) hospitals serving a disproportionate share of low income patients. The additional payment is determined by multiplying the federal portion of the diagnosis-related group (DRG) payment by the DSH-adjustment factor. (See 42 CFR 412.106).

Prior to the implementation of the fiscal year (FY) 2005 IPPS final rule, inpatient days were included in the numerator of the Medicare-SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits. Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. The FY 2005 IPPS final rule amended the DSH regulations by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the Medicare-SSI fraction and made clear that patient days were to be included in that fraction if the patient was entitled to Medicare Part A. See the FY 2005 IPPS final rule (69 FR 49246) (revising 42 CFR 412.106(b)(2)(i)). Under our revised policy, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's Medicare-SSI fraction (provided that the patient was also entitled to SSI at that time) and in the Medicare-SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. The FY 2005 IPPS final rule revision to the DSH regulations was effective for patient discharges occurring on or after October 1, 2004 (69 FR 49099).

The CMS issued ruling 1498-R2 April 22, 2015, and it can be found at: *https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings-Items/CMS1498-R2.html*.

The CMS ruling 1498-R2 provided notice of CMS' determination that CMS ruling 1498-R shall be amended regarding its remedy for recalculation of certain Medicare DSH payment adjustments. CMS ruling 1498-R required the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals to remand each qualifying appeal to the appropriate Medicare contractor. CMS ruling 1498-R further explained how CMS and Medicare contractors were to recalculate the provider's DSH adjustment resolving any of the three different DSH issues. CMS and the Medicare contractor also were to apply the provisions of CMS ruling 1498-R, on all three DSH issues, to each qualifying hospital cost-reporting period where the contractor had not yet final settled the provider's Medicare cost report. CMS ruling 1498-R2 is a modification and amendment of CMS ruling 1498-R, but only insofar as CMS ruling 1498-R2 requires an election with respect to the Medicare-SSI component of the DSH payment adjustment for cost reports that involve SSI ratios for federal fiscal year (FFY) 2004 and earlier, or SSI ratios for hospital cost-reporting periods, but only for those patient discharges occurring before October 1, 2004.

The CMS and the Medicare contractors will resolve each Medicare-SSI and dual-eligible non-covered day appeal remanded by the PRRB to the contractor, or open hospital cost-reporting period subject to CMS ruling 1498-R and the amendment in CMS ruling 1498-R2 by allowing hospitals to exercise an election. This election is available for hospital cost-reporting periods where the Medicare contractor has not yet final settled the provider's Medicare cost report, as well as appeals remanded to the contractor pursuant to CMS ruling 1498-R (assuming any such hospital cost-reporting period involves SSI ratios for FFY 2004 and earlier or SSI ratios for hospital cost-reporting periods, but only for those patient discharges occurring before October 1, 2004). The election is also available for hospital cost-reporting periods previously reopened

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specifically on the Medicare-SSI fraction issue – neither CMS ruling 1498-R nor the amendment in CMS ruling 1498-R2 required reopening. For a particular hospital cost-reporting period or, as applicable, the portion of a particular cost-reporting period prior to October 1, 2004, subject to CMS ruling 1498-R and the amendment in CMS ruling 1498-R2, hospitals may elect either to:

1. Include inpatient days of a person entitled to Medicare Part A in the numerator of the hospital's Medicare-SSI fraction (provided that the patient was also entitled to SSI) and in that fraction's denominator, even if the inpatient stay was not covered under Part A or the patient's Part A hospital benefits were exhausted (that is, elect to have applied a suitably revised Medicare-SSI fraction calculated on the basis of "total days"); or
2. Exclude such days where the patient's Part A hospital benefits were exhausted or otherwise were not in a covered Part A stay from both the numerator and denominator of the Medicare-SSI fraction (that is, elect to have applied a suitably revised Medicare-SSI fraction calculated on the basis of "covered days").

In summary, a provider may elect whether to receive a suitably revised Medicare-SSI fraction on the basis of "covered days" or "total days" for hospital cost-reporting periods that involve SSI ratios for FFY 2004 and earlier, or SSI ratios for hospital cost reporting periods, but only for those patient discharges occurring before October 1, 2004. CMS ruling 1498-R2 does not affect any change with respect to the Medicaid fraction of the Medicare DSH payment calculation. The amendment to CMS ruling 1498-R only allows providers to exercise a choice with respect to the Medicare-SSI fraction, and nothing in the amended ruling or these instructions shall be interpreted to affect a hospital's Medicaid fraction of its DSH payment calculation.

The CMS has published on its website suitably revised Medicare-SSI fractions that display Medicare-SSI fractions calculated on the basis of "covered days," as well as "total days." Before an initial notice of program reimbursement (NPR) or revised NPR pursuant to the amendment to CMS ruling 1498-R is issued by its Medicare contractor, a hospital's designated representative should submit to its Medicare contractor a written request that reflects the hospital's election of whether, for a particular fiscal period, the hospital's suitably revised Medicare-SSI fraction will be calculated on the basis of "total days" or "covered days." The written request must be received by the Medicare contractor within 180-calendar days of the date instructions are posted on the contractor's website. The request to the Medicare contractor must include the following information:

Provider number
Hospital name
PRRB case number and PRRB remand date (if applicable)
Case name, docket number (if applicable)
Hospital's designated representative (if applicable)
Cost report begin date (YYYYMMDD)

Cost report end date (YYYYMMDD)
FFY based on begin date (YYYY)
Provider election ("total" or "covered")
SSI ratio selected (Numerical value from CMS website)

If the hospital's request does not contain all of the required information or if the hospital does not make an election for a particular fiscal period covered by CMS ruling 1498-R (as modified by CMS ruling 1498-R2) in this time frame, the Medicare contractor shall contact the hospital via letter, using a method that tracks delivery and receipt, to obtain the required information and if the provider does not respond within 30 days of the date of the letter, the Medicare contractor shall recalculate the provider's DSH adjustment using the higher of the two revised Medicare-SSI fractions.

Realignment

The 42 CFR 412.106(b)(3) allows the hospital the opportunity to request to have their Medicare-SSI fraction realigned based on its cost-reporting period (as opposed to the FFY).

For cost-reporting periods subject to CMS ruling 1498-R and the amendment in CMS ruling 1498-R2, CMS will furnish (at the hospital's written request and at no cost to the hospital) patient-level data concerning the number of the hospital's "covered" and "total" Medicare-SSI days, and the number of the hospital's "covered" and "total" Medicare days. Hospitals with cost-reporting periods that ended before December 8, 2004, that did not receive an initial NPR, must appeal the issue of the calculation of their Medicare-SSI days to the PRRB subsequent to receipt of an initial NPR in order to receive their data at no cost. Such data will be provided on the FFY basis for the relevant cost reporting period, or, if the hospital does not report on the FFY basis, the two FFYs in which the hospital's cost-reporting period falls.

If a provider previously submitted a realignment request for an open cost report, or for a cost report with an SSI appeal or SSI remand that uses a FFY 2004 or earlier Medicare-SSI fraction, the contractor shall send a notice to the provider to inform them that the realignment request no longer applies since the provider will first receive a revised Medicare-SSI fraction. After receiving its revised Medicare-

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New revenue code 0815 for allogeneic stem cell acquisition services

Provider types affected

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

What you need to know

Medicare systems will accept revenue code 0815 (allogeneic stem cell acquisition/donor services), recently created by the National Uniform Billing Committee (NUBC), effective January 1, 2017, when submitted on hospital claims (types of bill (TOB) 011x, 012x, 013x, or 085x). Make sure that your billing staffs are aware of this change.

Background

Hematopoietic stem cell transplantation (HSCT) is a process that includes mobilization, harvesting, and transplant of stem cells and the administration of high dose chemotherapy and/or radiotherapy prior to the actual transplant. During the process stem cells are harvested from either the patient (autologous) or a donor (allogeneic) and subsequently administered by intravenous infusion to the patient. Payment for these acquisition services is included in the outpatient prospective payment system ambulatory payment classification (OPPS APC) payment for the allogeneic stem cell transplant when the transplant occurs in the hospital outpatient setting and in the Medicare severity-diagnosis related group (MS-DRG) payment for the allogeneic stem cell transplant when the transplant occurs in the inpatient setting. MACs do not make separate payments for these acquisition services, because hospitals may bill and receive payment only for services provided to the Medicare beneficiary who is the recipient of the stem cell transplant and whose illness is being treated with the stem cell transplant. Unlike the acquisition costs of solid organs for transplant (for example, hearts and kidneys), which are paid on a reasonable cost basis, acquisition costs for allogeneic stem cells are included in the prospective payment.

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself).

Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment. (See the *Medicare Claims Processing Manual*, *Chapter 3*, Section 90.3 and *Chapter 4*, Section 231, for information regarding billing for autologous stem cell transplants.)

Currently, when the allogeneic stem cell transplant occurs in the outpatient setting, the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately in FL 42 of Form CMS-1450 (or electronic equivalent) by using revenue code 0819 (other organ acquisition). Revenue code 0819 charges should include all services required to acquire stem cells from a donor, as defined above, and should be reported on the

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SSI fraction, the provider may request realignment, based on the revised Medicare-SSI fraction, within the normal timeframes.

The hospital must submit a written request to its contractor if it elects to receive the suitably revised Medicare-SSI fractions on the basis of its cost reporting period. The request must be on provider letterhead and signed by authorized hospital personnel. The request must specify whether the provider elects to have its realigned Medicare-SSI fraction generated on the basis of "total days" or "covered days." Hospitals requesting that CMS recalculate their SSI ratios on the basis of their cost-reporting period shall send their Medicare contractor the following information:

Provider number
Hospital name
PRRB case number and PRRB remand date (if applicable)
Case name, docket number (if applicable)
Hospital's designated representative (if applicable)
Cost report begin date (YYYYMMDD)
Cost report end date (YYYYMMDD)
FFY based on begin date (YYYY)
Provider election ("total" or "covered")

If the hospital's realignment request does not contain all of the required information, notably if the request does not contain an election of "total" or "covered" with regard to the SSI ratio, the Medicare contractor shall contact the hospital via letter, using a method that tracks delivery and receipt, to obtain the required information and if the provider does not respond within 30 days of the date of the letter, the Medicare contractor shall inform CMS that no election was provided. In this instance, CMS will provide a realigned Medicare SSI ratio using the higher of the two revised Medicare-SSI fractions for the hospital's cost reporting period.

If a provider submitted a realignment request within three years of the NPR where there is no SSI appeal or SSI remand, the provider will receive its requested realignment using the original SSI ratio.

Change request: 9896
Transmittal: 279
Effective date: January 19, 2017
Implementation date: January 19, 2017

Office of Inspector General report: Stem cell transplantation

Provider types affected

This article is intended for providers billing Medicare administrative contractors (MACs) for services related to stem cell transplantation.

Provider action needed

The Office of the Inspector General (OIG) recently completed a review of Medicare claims related to stem cell transplants. This article is intended to address issues of incorrect billing as a result of the *February 2016 OIG report* and to clarify coverage of stem cell transplantation. This article does not introduce any new policies. It is intended to clarify the billing for stem cell services.

Background

The Centers for Medicare & Medicaid Services (CMS) has a coverage policy for stem cell transplantation, and the *Medicare National Coverage Determination (NCD) Manual* (*Publication 100-03, Section 110.8*) states that stem cell transplantation is a process in which stem cells are harvested from either a patient's or donor's bone marrow or peripheral blood for intravenous infusion.

Types of stem cell transplants that are covered:

Medicare covers allogeneic and autologous transplants. Allogeneic and autologous stem cell transplants are covered under Medicare for specific diagnoses.

1. Allogeneic hematopoietic stem cell transplantation (HSCT)

Allogeneic stem cell transplantation is a procedure in which a portion of a healthy donor's stem cells is obtained and prepared for intravenous infusion to restore normal hematopoietic function in recipients having an inherited or acquired hematopoietic deficiency or defect.

Expenses incurred by a donor are a covered benefit to the recipient/beneficiary but, except for physician services, are not paid separately. Services to the donor include physician services, hospital care in connection with screening the stem cell, and ordinary follow-up care.

2. Autologous stem cell transplantation (AuSCT)

Autologous stem cell transplantation is a technique for restoring stem cells using the patient's own previously stored cells. Autologous stem cell transplants (AuSCT) must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (high-dose chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies.

Medicare policy as stated in *transmittal 1805* states that stem cell transplants are typically performed in the outpatient setting. Should complications occur, then the procedure would be performed on an inpatient basis. However, the OIG report suggests that an inpatient stay of just one or two days is more likely a miscoded claim as opposed to submitting an outpatient claim to cover stem cell transplantation.

In its *February 2016 OIG report*, the OIG determined that Medicare paid for many stem cell transplant procedures incorrectly. The main finding was that providers billed these procedures as inpatient when they should have been submitted as outpatient or outpatient with observation services. The key points in the report are as follows:

- **Stem cell transplants are typically performed in the outpatient setting**.
- Hospitals may have incorrectly thought that stem cell transplantation was on CMS's list of inpatient-only procedures.

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same date of service as the transplant procedure in order to be appropriately packaged for payment purposes.

Stakeholders have expressed concern that the acquisition costs are not being accurately reflected in the transplant procedure as revenue code 0819 maps to cost center code 086xx (Other organ acquisition where XX is "00" through "19") and is reported on line 112 (or applicable subscripts of line 112) of the Form CMS-2552-10 cost report.

The Centers for Medicare & Medicaid Services (CMS) requested and NUBC approved a new revenue code 0815 to be used when the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately.

Additional information

The official instruction, CR 9674, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3571CP.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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- Hospitals often billed these services using incorrect Medicare severity diagnosis related groups (MS-DRGs). Of critical importance, the OIG found that many claims contained an MS-DRG suggesting a geometric mean length of stay (GMLOS) in the hospital that should have been much longer than the claim actually showed. For example, the following table shows the length of stay one might expect for the given MS-DRGs. Yet, the submitted claims reflected a length of stay of just one or two days. This suggests the claims should have been billed as outpatient, which is what Medicare policy considers to be the norm for stem cell transplants.

MS-DRG	MS-DRG title	GMLOS	Arithmetic mean
014	Allogeneic bone marrow transplant	20.0	25.1
016	Autologous bone marrow transplant W CC/MCC	17.5	19.1
017	Autologous bone marrow transplant W/O CC/MCC	8.9	12.4

Extracted from *Table 5* acute inpatient FY 2015 final rule

The two-midnight rule

To assist providers in determining whether inpatient admission is reasonable and payable under Medicare Part A, CMS adopted the two-midnight rule for admissions beginning on or after October 1, 2013. This rule established Medicare payment policy regarding the benchmark criteria that should be used when determining whether an inpatient admission is reasonable and payable under Medicare Part A.

In general, the two-midnight rule states that:

- Inpatient admissions will generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation.
- Medicare Part A payment is generally not appropriate for hospital stays not expected to span at least two midnights.

The two-midnight rule also specified that all treatment decisions for beneficiaries were based on the medical judgment of physicians and other qualified practitioners. The two-midnight rule does not prevent the physician from providing any service at any hospital, regardless of the expected duration of the service.

For stays for which the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.

Additional information

The OIG report is available at *https://oig.hhs.gov/oas/reports/region9/91402037.pdf*.

Transmittal 1805 is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1805A3.pdf*.

Table 5 of the acute inpatient FY2015 final rule is available at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page-Items/FY2015-Final-Rule-Tables.html*.

The section of the *National Coverage Determinations Manual* that deals with stem cell transplants for treatment of certain conditions is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf*.

You may want to review the following *MLN Matters*® articles for further information:

- MM9620 - “Stem Cell Transplantation for Multiple Myeloma, Myelofibrosis, and Sickle Cell Disease, and Myelodysplastic Syndromes” is at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9620.pdf*.
- MM6416 - “April 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)” is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6416.pdf*.
- MM4173 - “Stem Cell Transplantation” is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM4173.pdf*.
- MM3797 - “Updated Requirements for Autologous Stem Cell Transplantation (AuSCT) for Amyloidosis” is available at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3797.pdf*.

There is a fact sheet on the two-midnight rule at *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-4.html*.

CMS provides further guidance on the two-midnight rule with responses to frequently asked questions at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/QAsforWebsitePosting_110413-v2-CLEAN.pdf*.

Additional information is in a transcript of an MLN Connects® conference call discussing the two-midnight rule, which is available at *https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2-27-14MidnightRuleTranscript.pdf*.

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SNFs affiliated with ACOs may by-pass three-day stay rules

***Note**: This article was revised December 16, 2016, due to a revised change request (CR) 9568 issued on that date. As a result, the transmittal number, CR release date, and link to the CR are revised in this article. All other information remains the same. This information was previously published in the July 2016 Medicare A Connection, page 22.*

Provider types affected

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

Provider action needed

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

Background

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

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

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

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

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

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

Additional information

The official instruction, CR 9568, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1763OTN.pdf*.

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

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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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https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html on the CMS website under - How Does It Work.

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

Document history

Date of change	Description
December 16, 2016	The article was revised December 16, 2016, due to a revised CR 9568 issued on that date. As a result, the transmittal number, CR release date, and link to the CR are revised in this article.
July 5, 2016	The article was revised due to an updated CR. That CR revised shared system maintainer (SSM) responsibility. The transmittal number, CR release date and link to the transmittal also changed.
May 11, 2016	Initial article release

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Reduce avoidable hospitalizations among nursing facility residents – payment reform

Provider types affected

This article is intended for nursing facilities and practitioners participating in this initiative. Those are selected nursing facilities and practitioners in Alabama, Colorado, Indiana, Missouri, Nevada, New York, and Pennsylvania. The article is informational for other nursing facilities and practitioners.

Background

"The Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents – Payment Reform" tests a new payment model for nursing facilities and practitioners to incent early identification of changes in condition, treatment of specific conditions in a nursing facility without a hospital transfer, and improved care planning.

The objectives of this model are to reduce avoidable hospital transfers, improve health outcomes, and to reduce combined Medicare-Medicaid costs for long-stay nursing facility residents enrolled in Medicare and Medicaid. The model includes the introduction of six new Medicare Part B payment codes billable by nursing facilities for treatment of specific conditions and two new Medicare Part B payment codes billable by practitioners for onsite treatment and for care coordination.

The eligible beneficiaries for this initiative are long-stay nursing facility residents who have resided in the facility for 101 cumulative days or more, who are enrolled in Medicare (Parts A and B fee-for-service), reside in a Medicare or Medicaid certified bed, and who have not opted out of participating in the initiative.

Note: Participation in this initiative is limited to selected nursing facility and practitioners in Alabama, Colorado, Indiana, Missouri, Nevada, New York, and Pennsylvania. At this time, all participating nursing facilities have been chosen and screened for their eligibility to participate. The Centers for Medicare & Medicaid Services (CMS) and its partners are not recruiting new facilities at this time.

What you need to know

The payment model has three components:

- Nursing facility payments for the treatment of qualifying conditions (for beneficiaries not on a Medicare Part A skilled nursing facility stay)
- Practitioner payment for the treatment of conditions onsite at the nursing facility
- Practitioner payment for care coordination and caregiver engagement

Nursing facility payments for treatment of qualifying conditions (onsite acute care)

The following six new HCPCS codes can **only be billed by participating nursing facilities when qualifying criteria has been met**. Nursing facilities participating in this initiative should have received specific qualifying clinical criteria information from their enhanced care and coordination provider (ECCP). Please reach out to your ECCP if you do not have this information. The six codes are:

- **G9679**: Pneumonia - This code is for onsite acute care treatment of a nursing facility resident with pneumonia.
- **G9680**: Congestive heart failure (CHF) - This code is for onsite acute care treatment of a nursing facility resident with CHF.
- **G9681**: Chronic obstructive pulmonary disease (COPD)/asthma - This code is for onsite acute care treatment of a resident with COPD or asthma.
- **G9682**: Skin infection - This code is for the onsite acute care treatment of a nursing facility resident with a skin infection.
- **G9683**: Fluid or electrolyte disorder or dehydration - This code is for the onsite acute care treatment of a nursing facility resident with fluid or electrolyte disorder or dehydration.
- **G9684**: Urinary tract infection (UTI) - This code is for the onsite acute care treatment of a nursing facility resident with a UTI.

Each of the six codes follows standard Medicare Part B billing requirements and should be billed on a 22x or a 23x type of bill. Nursing facilities, at a minimum, need to follow the billing rules from the National Uniform Billing Committee (NUBC). They maintain the allowable revenue codes for certain facilities. Within the rules set out by the NUBC, CMS did not limit which revenue codes could be used with the new codes and advises nursing facilities to select the revenue code most appropriate for their situation. More information on SNF Part B billing (including those revenue codes that cannot be billed on a 22x) is available at *https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c07.pdf*.

Participating nursing facilities will be paid a per diem rate of $218 for HCPCS codes G9679 through G9684. As a reminder, Medicare payments to providers for individual services under Medicare Parts A and B have been under sequestration for services beginning April 2013. This means that final payment to providers will be two percent less than the calculated payment amount.

Payment for these codes is limited to nursing facilities participating in the initiative. Beneficiary co-insurance and deductible will be waived for these codes. None of these codes may be billed more than once a day for a single beneficiary and only one of these codes may be billed in a day for a single beneficiary.

Practitioner payment for the treatment of acute changes in condition onsite at the nursing facility

New practitioner code G9685 (practitioner payment for the

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treatment of conditions onsite at nursing facility) is billable for the initial visit for the evaluation and management of a beneficiary's acute change in condition in a nursing facility. Payment for this code is limited to practitioners participating in the initiative when billing for services rendered at a participating nursing facility. This code may only be billed once per day per beneficiary. Beneficiary co-insurance and deductible will be waived for these codes. Practitioners are permitted to bill for these services while a beneficiary is receiving Medicare Part A skilled nursing facility benefits. The payment rate for HCPCS code G9685 is aligned with CPT® code 99223 (initial hospital care), to help equalize the practitioner payment across sites.

Key components required

Key components required to bill code G9685 are:

- A comprehensive review of the beneficiary's history
- A comprehensive examination
- Medical decision making of moderate to high complexity, and
- Counseling and/or coordinating care with nursing facility staff and other providers or suppliers consistent with the nature of the problem(s) and the beneficiary's and family's needs.

Practitioners should reach out to their ECCP for questions and education on how and when to bill this code.

Practitioner payment for care coordination and caregiver engagement

New practitioner code G9686 (Care coordination and caregiver engagement conference) is for the onsite nursing facility conference that is separate and distinct from an evaluation and management visit, including qualified practitioner and at least one member of the nursing facility inter-disciplinary care team and resident or their designated caregiver. Payment for this code is limited to practitioners participating in the initiative when billing for services rendered at a participating nursing facility. Beneficiary co-insurance and deductible will be waived for this code. The payment rate for HCPCS code

G9686 is aligned with CPT® code 99214 (office or other outpatient visit for established patient).

The code may only be billed once per year for a single beneficiary in the absence of a significant change in condition. The code can be billed with the –KX modifier within 14 days of a significant change in condition that increases the likelihood of a hospital admission. The change in condition must be documented in the beneficiary's medical chart and include an MDS assessment.

Key components required

In order to qualify for payment for code G9686, the practitioner must conduct the discussion:

- With the beneficiary and/or individual(s) authorized to make health care decisions for the beneficiary (as appropriate)
- In a conference for a minimum of 25 minutes
- Without performing a clinical examination of the beneficiary during the discussion (this should be conducted as needed through regular operations and this session is focused on a care planning discussion), and
- With at least one member of the nursing facility interdisciplinary team.

The practitioner must also document the conversation in the beneficiary's medical chart. The change in condition must be documented in the beneficiary's chart and include a minimum data set (MDS) assessment.

Additional Information

Nursing facilities and practitioners should reach out to their ECCP for questions and education on this initiative.

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CJR model: Skilled nursing facility three-day rule waiver

Provider types affected

This *MLN Matters*® article is intended for skilled nursing facilities (SNFs) submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries in the comprehensive care for joint replacement (CJR) model.

What you need to know

This purpose of this article is to inform SNFs of the policies surrounding use of the three-day stay waiver available for use under the CJR model and to provide instructions on using the demonstration code 75 on applicable CJR claims submitted on or after January 1, 2017. Make sure that your billing staffs are aware of these changes.

Background

Section 1115A of the Social Security 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. In accordance with this statutory authority, in November 2015 CMS published a final rule for the creation and testing of a new bundled payment model called the CJR model. The CJR model tests bundled payments for lower extremity joint replacement (LEJR) episodes at acute care hospitals located in multiple geographic areas. The intent of the model is to promote quality and financial accountability for episodes of care surrounding a LEJR procedure, hereafter referred to as LEJR episodes. The CJR model will test whether bundled payments to acute care hospitals for LEJR episodes of care can reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. CMS is testing the CJR model over a period of five performance years. The CJR model, began April 1, 2016, and will run through December 31, 2020.

Key points

Under the CJR model, acute care hospitals in certain selected geographic areas take on quality and payment accountability for retrospectively calculated bundled payments for LEJR episodes. All related care within 90 days of hospital discharge from the LEJR procedure is included in the episode of care.

CJR episodes of care

Medicare currently pays for LEJR procedures under the inpatient prospective payment system (IPPS) through one of two Medicare severity diagnosis related groups (MS-DRGs): MS-DRG 469 (major joint replacement or reattachment of lower extremity with major complications or comorbidities (MCC)) or MS-DRG 470 (major joint replacement or reattachment of lower extremity without MCC). Under the CJR model, episodes begin with admission to an acute care hospital for an LEJR procedure that is assigned to MS-DRG 469 or 470 upon beneficiary discharge and paid under the IPPS. Episodes end 90 days after the date of discharge from the acute care hospital. The episode includes the LEJR procedure, inpatient stay, and all related care as defined under the model that is covered under Medicare Parts A and B within the 90 days after discharge, including hospital care, post-acute care, and physician services.

CJR participant hospitals

Participant hospitals are the episode initiators (that is, the entity where the episode begins) and bear quality and episode payment accountability under the CJR model. CMS requires all hospitals paid under the IPPS and located in selected geographic areas to participate in the CJR model, with limited exceptions for those hospitals currently participating in bundled payments for care improvement (BPCI) Models for the LEJR BPCI clinical episodes.

CJR model beneficiary inclusion criteria

Medicare beneficiaries whose care is 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 throughout the duration of the episode.
- 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.
- Medicare is the primary payer.

Skilled nursing facility three-day waiver

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 is 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.

In order to provide more comprehensive care across the post-acute spectrum and support the ability of participant hospitals to coordinate the care of beneficiaries, CMS will conditionally waive the three-day stay requirement for covered SNF services for beneficiaries in CJR episodes in performance years two through five of the CJR model (i.e. on or after January 1, 2017).

Under Medicare rules, in order for Medicare to pay for SNF services, a beneficiary must have a qualifying hospital stay of at least three consecutive days (counting the day of hospital admission but not the day of discharge). Additional information regarding the skilled nursing facility benefit is available in the *Medicare Benefit Manual* (Pub 100–02), *Chapter 8*.

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CMS waives the SNF three-day rule for coverage of a SNF stay for a CJR beneficiary following the anchor hospitalization, only if the SNF is identified on the applicable calendar quarter list of qualified SNFs at the time of CJR beneficiary admission to the SNF. CMS will determine all the qualified SNFs for each calendar quarter based on a review of the most recent rolling 12 months of overall star ratings on the five-star quality rating system for SNFs on the nursing home compare website. All other Medicare rules for coverage and payment of Part A-covered SNF services continue to apply. This will allow payment of claims for SNF services delivered to beneficiaries at eligible sites.

When submitting claims to Medicare that require a waiver of the three-day hospital stay requirement for Part A SNF coverage, SNF billing staff must enter a "75" in the treatment authorization code field. This allows MACs to appropriately pay SNFs treating beneficiaries during CJR model episodes. In order to determine if use of the demonstration code "75" is appropriate, the following circumstances must be met:

- The hospitalization does not meet the prerequisite hospital stay of at least three consecutive days for Part A coverage of "extended care" services in a SNF. If the hospital stay would lead to covered SNF services in the absence of the waiver, then the waiver is not necessary for the stay.
- The discharge is from a participant hospital in the CJR model. Participant hospitals are listed on the CMS website this list is shared with the MACs on a monthly basis.
- The beneficiary must have been discharged from the CJR model participant hospital for one of the two specified MS–DRGs (469 or 470) within 30 days prior to the initiation of SNF services.
- The beneficiary meets the criteria for inclusion in the CJR model at the time of SNF admission: That is, he or she is enrolled in Part A and Part B, eligibility is not on the basis of ESRD, is not enrolled in any managed care plan, is not covered under a United Mine Workers of American health plan, and Medicare is the primary payer.
- The waiver will apply if the SNF is qualified to admit CJR model beneficiaries under the waiver. A list of qualified SNFs will be sent to the MACs and Medicare shared systems maintainers via a quarterly list, developed by CMS and posted to the CMS website on a quarterly basis. The list will contain those SNFs with an overall star rating of three stars or better for at least seven of the preceding 12 months of the rolling data used to create the quarterly list.
- **The SNF must include demonstration code 75 in the treatment authorization field when submitting claims that qualify for the SNF waiver under the CJR model. Note:** The waiver is not valid for swing bed (TOB 18x) stays or critical access hospitals (CAHs).
- All other Medicare rules for coverage and payment of Part A-covered SNF services continue to apply.

Additional information

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

The *Medicare Benefit Policy Manual*, Chapter 8, on SNF services is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf*.

More information on the CJR model is available at *https://innovation.cms.gov/initiatives/CJR*. At this page, one can scroll down and open a list of the hospitals participating in this model.

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New place of service code for telehealth and distant site payment policy

Provider types affected

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

Provider action needed

CR 9726 updates the place of service (POS) code set by creating a new code (POS 02) for telehealth services, effective January 1, 2017. You should ensure that your billing staffs are aware of this new POS code.

Background

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards, and their implementation guides, adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction include a POS code from the POS code set that the Centers for Medicare & Medicaid Services (CMS) maintains. The POS code set provides setting information necessary to appropriately pay Medicare & Medicaid claims.

As a payer, Medicare must be able to recognize, as valid, any valid code from the POS code set that appears on the HIPAA standard claim transaction. Further, unless prohibited by national policy to the contrary, Medicare not only recognizes such codes, but also adjudicates claims that contain these codes.

At times, Medicaid has had a greater need for code specificity than has Medicare; and many of the new codes, over the past few years, have been developed to meet Medicaid's needs. While Medicare does not always need this greater specificity in order to appropriately pay claims, it nevertheless adjudicates claims with the new codes to ease coordination of benefits and to give Medicaid and other payers the setting information they require.

Effective January 1, 2017, CMS is creating a new POS code 02 for use by the physician or practitioner furnishing telehealth services from a distant site. CR 9726 updates the current POS code set by adding this new code (POS 02: Telehealth), with a descriptor of "The location where health services and health related services are provided or received, through telecommunication technology."

Medicare will pay for these services using the Medicare physician fee schedule (MPFS), including the use of the MPFS facility rate for method II critical access hospitals billing on type of bill 85x. This telehealth POS code would not apply to originating site facilities billing a facility fee.

Remember that under HIPAA, the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service.

Modifiers GT (via interactive audio and video telecommunications systems) and GQ (via an asynchronous telecommunications system) are still required when billing for Medicare telehealth services. If you bill for telehealth services with POS code 02, but without the GT or GQ modifier, your MAC will deny the service with the following messages:

- Group code CO
- Claim adjustment reason code (CARC) 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present)
- Remittance advice remarks code (RARC) MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information)

Conversely, if you bill for telehealth services with modifiers GT or GQ, but without POS code 02, your MAC will deny the service with the following messages:

- Group code CO
- CARC 5 (The procedure code/bill type is inconsistent with the place of service.

Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present)

- RARC M77 (Missing/incomplete/invalid/inappropriate place of service)

Additional information

The official instruction, CR 9726, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3586CP.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: MM9726
Related Change Request (CR) #: CR 9726
Effective Date: January 1, 2017 - Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service.
Related CR Release Date: August 12, 2016
Related CR Transmittal #: R3586CP
Implementation Date: January 3, 2017

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CMS MLN Connects® Provider eNews

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

MLN Connects® Provider eNews for November 23, 2016

MLN Connects® Provider eNews for November 23, 2016
View this edition as a PDF

News & Announcements

- CMS Launches New Online Tool to Make Quality Payment Program Easier for Clinicians
- 2017 PQRS Results: Submit an Informal Review by November 30
- Value Modifier: Informal Review Request Period Open through November 30
- IMPACT Act Cross-Setting Quality Measures: Comments Due
- Post-Acute Care QRP Data Submission Exceptions for Hurricane Matthew
- New Quality Payment Program Resources Available
- Each Office Visit is an Opportunity to Recommend Influenza Vaccination

Provider Compliance

- Enteral Infusion Pumps

Claims, Pricers & Codes

- Reprocessing of Some IPPS Claims

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
- IRF-PAI Therapy Information Data Collection Call — January 12

Medicare Learning Network® Publications & Multimedia

- Emergency Preparedness Video Presentation — New
- Inappropriate Billing of Qualified Medicare Beneficiaries for Medicare Cost-Sharing MLN Matters Article — Revised
- Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs MLN Matters Article — Revised
- Hospital-Acquired Conditions and POA Indicator Reporting Provision Fact Sheet — Reminder
- PAP Devices: Complying with Documentation & Coverage Requirements Fact Sheet — Revised
- Evaluation and Management Services Guide — Reminder
- DMEPOS Quality Standards Booklet—Revised
- Medicare Claim Review Programs Booklet — Revised
- Drug Diversion: Do You Know Where the Drugs Are Going? Web-Based Training Course—Revised
- Hospice Payment System Booklet – Reminder

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Verification of preventive services

Did you know that you can verify a patient's preventive service benefits through First Coast's online portal (SPOT)? This *SPOT FAQ* will show you some of the information available regarding preventive services, including professional and technical services, next eligible dates, 'missing' professional or technical dates, annual wellness visits, and categories returned to SPOT by HETS (the Centers for Medicare & Medicaid Services' (CMS) HIPAA Eligibility Transaction System).

If you aren't registered for SPOT, *this FAQ* will show you how.

As a reminder, CMS mandates providers use self-service tools instead of calling the provider contact center to obtain this type of information.

MLN Connects® Provider eNews for December 1, 2016

MLN Connects® Provider eNews for December 1, 2016
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News & Announcements

- CMS Finalizes Measures under Consideration List for Pre-rulemaking
- Working to Achieve Health Equity: The CMS Equity Plan for Medicare One Year Later
- Clinical Laboratories: Prepare Now to Report Lab Data January 1- March 31, 2017
- Value Modifier: Informal Review Request Period Extended to December 7
- World AIDS Day is December 1
- National Handwashing Awareness Week: December 4 through 10

Provider Compliance

- Billing For Stem Cell Transplants

Upcoming Events

- National Partnership to Improve Dementia Care and QAPI Call — December 6
- 2016 Hospital Appeals Settlement Update Call — December 12
- IRF-PAI Therapy Information Data Collection Call — January 12

Medicare Learning Network® Publications & Multimedia

- Documentation Requirements for the Hospice Physician Certification/Recertification *MLN Matters®* Article — New
- Sample Hospice Notice of Election Statement MLN Matters Article — New
- Quality Payment Program Call: Audio Recording and Transcript — New
- Hospital Appeals Settlement Call: Audio Recording and Transcript — New

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MLN Connects® Provider eNews for December 8, 2016

MLN Connects® Provider eNews for December 8, 2016
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News & Announcements

- Keeping Medicare's Promise with MACRA
- Submit Quality Payment Program Comments by December 19
- EHR Incentive Programs: Information on CY 2017 and Stage 3 Program Requirements
- National Influenza Vaccination Week: What Does Medicare Cover?

Provider Compliance

- Billing for Ambulance Transports

Upcoming Events

- 2016 Hospital Appeals Settlement Update Call — December 12
- MIPS Webinar — December 13
- IRF-PAI Therapy Information Data Collection Call — January 12

Medicare Learning Network® Publications & Multimedia

- Exceptions for Late Hospice Notices of Election Delayed by Medicare Systems MLN Matters Article — New
- SNF Quality Reporting Program Video Presentation — New
- Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants Booklet — Revised
- Vaccine and Vaccine Administration Payments under Medicare Part D Fact Sheet — Reminder

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MLN Connects® Provider eNews for December 15, 2016

MLN Connects® Provider eNews for December 15, 2016
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News & Announcements

- CMS Releases Person and Family Engagement Strategy
- Medicare Outpatient Observation Notice CMS-10611 Available
- Quality Payment Program Patient Relationship Categories List: Comment by January 6
- IRF and LTCH QRP Preview Reports Available: Review by January 10
- ICD-10 Code Updates: Impact on Medicare Quality Programs

Provider Compliance

- Compliance Programs and Fraud and Abuse Laws

Upcoming Events

- MACRA 101 Webinar Series – December 16, 20, and 21
- Quality Payment Program: Electing MIPS vs. APMs Webinar — December 19
- IRF-PAI Therapy Information Data Collection Call – January 12
- ESRD QIP: Payment Year 2020 Final Rule Call – January 17
- Hospice Quality Reporting Program Provider Training — January 18

Medicare Learning Network® Publications & Multimedia

- Comprehensive CJR Model: SNF 3-Day Rule Waiver MLN Matters® Article — New
- Medicare Diabetes Prevention Program Call: Audio Recording and Transcript – New
- IRF and LTCH Quality Reporting Program Call: Audio Recording and Transcript – New
- LTCH Prospective Payment System Booklet – Revised
- Mass Immunizers and Roster Billing Fact Sheet – Reminder

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MLN Connects® Provider eNews for December 22, 2016

Editor's Note

Happy holidays from the eNews staff! The next regular edition of the eNews will be released on Thursday, January 5, 2017.

MLN Connects® Provider eNews for December 22, 2016
View this edition as a PDF

News & Announcements

- Increased Transparency and Quality Information via New Compare Sites and Data Updates
- Additional Opportunities for Clinicians under the Quality Payment Program
- HHS Finalizes New Medicare Alternative Payment Models
- CMS Releases Second Year of Home Health Utilization and Payment Data
- Hospice Quality Measure Reports Available
- New ST PEPPER Available
- First Two DME Items Subject to Prior Authorization
- Part D Prescribers: Date Change and Phased Enforcement
- 2017 eCQM Logic Flows for Eligible Clinicians Available
- EHR Incentive Programs: Prepare for 2016 Attestation
- EHR Incentive Programs FAQs on 2017 OPPS/ASC Final Rule

Provider Compliance

- Office of Inspector General Exclusion Authorities

Claims, Pricers & Codes

- Pricing and Payment Changes for DME Infusion Drugs Effective January 1, 2017

Upcoming Events

- IRF-PAI Therapy Information Data Collection Call – January 12
- ESRD QIP: Payment Year 2020 Final Rule Call – January 17
- Home Health Groupings Model Technical Report Call – January 18
- Comparative Billing Report Webinar on Knee Orthoses – February 8

Medicare Learning Network® Publications & Multimedia

- Continuation of HH Probe and Educate Medical Review Strategy MLN Matters® article – New
- Dementia Care and QAPI Call: Audio Recording and Transcript – New
- ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT®, and HCPCS Code Sets Educational Tool — Revised
- Medicare Billing: 837P and Form CMS-1500 Fact Sheet — Revised
- DMEPOS Accreditation Fact Sheet — Reminder
- MREP Software Fact Sheet – Reminder
- Continuing Education Credits for Web-Based Training Courses

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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