Medicare B CONNECTION

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

November 2016

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MLN Connects® Provider eNews – Special Edition

Wednesday, November 2, 2016

2017 Physician fee schedule final rule

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

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

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

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

The 2017 payment rule will also:

- Finalize a data collection strategy for global services with significantly reduced burden for practitioners compared to the proposal
- Finalize a change that will more accurately reflect local costs and significantly increase payments to practitioners in Puerto Rico
- Enhance program integrity and data transparency in the Medicare Advantage program.

For more information:

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

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

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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

About the 'Medicare B Connection'

The *Medicare B Connection* is a comprehensive publication developed by First Coast Service Options Inc. (First Coast) for Part B providers in Florida, Puerto Rico, and the U.S. Virgin Islands and is distributed on a monthly basis.

Important notifications that require communication in between publications will be posted to the First Coast Medicare provider education website at *http://medicare.fcso.com*. In some cases, additional unscheduled special issues may be posted.

Who receives the *Connection*

Anyone may view, print, or download the *Connection* from our provider education website(s). Providers who cannot obtain the *Connection* from the internet are required to register with us to receive a complimentary hardcopy.

Distribution of the *Connection* in hardcopy is limited to providers who have billed at least one Part B claim to First Coast Medicare during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, if a technical barrier exists that prevents them from obtaining it from the internet and they have returned a completed registration form to us.

Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription (see order form in the back of this issue). All issues published since 1997 may be downloaded from the internet, free of charge.

We use the same mailing address for all correspondence, and cannot designate that the *Connection* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare provider enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

Publication format

The *Connection* is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific CPT® and HCPCS procedure codes. It is arranged by categories (not specialties). For example, "Mental Health" would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.

- The section pertaining to **Electronic Data Interchange** (EDI) submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **Local Coverage Determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **General Information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.
- In addition to the above, other sections include:
- **Educational Resources**, and
- **Contact information** for Florida, Puerto Rico, and the U.S. Virgin Islands.

The *Medicare B Connection* represents formal notice of coverage policies

Articles included in each edition represent formal notice that specific coverage policies either have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Never miss an appeals deadline again

When it comes to submitting a claims appeal request, *timing is everything*. Don't worry – you won't need a desk calendar to count the days to your submission deadline. Try our *"time limit" calculators on our Appeals of claim decisions page*. Each calculator will *automatically calculate* when you must submit your request based upon the date of either the initial claim determination or the preceding appeal level.

Medicare Part B advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient.

For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). Section 50 of the *Medicare Claims Processing Manual* is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf#page=44*.

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found at *https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html*.

ABN modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier GA (waiver of liability statement on file) or GZ (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier GZ may be used in cases where a signed ABN is not obtained from the patient; however, when modifier GZ is billed, the provider assumes financial responsibility if the service or item is denied.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

GA modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier GA (waiver of liability statement on file).

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Nonassigned claims containing the modifier GA in which the patient has been found liable must have the patient's written consent for an appeal. Refer to the applicable contact section located at the end of this publication for the address in which to send written appeals requests.

Quarterly update to the correct coding initiative edits, version 23.0

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) 9847 instructs MACs of the normal update to the correct coding initiative (CCI) procedure to procedure (PTP) edits, effective January 1, 2017. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the national CCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The latest package of CCI PTP edits, version 23.0, effective January 1, 2017, will be available via the CMS data center. A test file will be available on or about November 2, 2016, and a final file will be available on or about November 17, 2016.

Version 23.0 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: column 1/column 2 correct coding edits and mutually exclusive code (MEC) edits. In order to simplify the use of CCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the column one/column two correct coding edit file. Separate consolidations have occurred for the two-practitioner NCCI edit files and the two NCCI edit files used for OCE. It will only be necessary to search the column one/column two correct coding edit file for active or previously deleted edits.

CMS no longer publishes a mutually exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single column one/column two correct coding edit file. The edits previously contained in the mutually exclusive edit file are **not** being deleted but are being moved to the column one/column two correct coding edit file. Refer to the CMS NCCI web page for additional information at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*.

Additional information

The official instruction, CR 9847, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3646CP.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: MM9847
Related Change Request (CR) #: CR 9847
Related CR Release Date: November 4, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3646CP
Implementation Date: January 3, 2017

Correct your claims on the 'SPOT'

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

Clinical Trials

Investigational device exemption process for studies approved by CMS

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

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

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

Link to CMS approval process:

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

Link to First Coast Service Options Inc. (First Coast) cost and coding form:

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

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

The Centers for Medicare & Medicaid Services (CMS) covers transcatheter aortic valve replacement (TAVR) and transcatheter mitral valve repair (TMVR) under coverage with evidence development (CED) when specific conditions are met, as outlined in the *Medicare National Coverage Determination (NCD) Manual*, Chapter 1, Part 1, Section 20.32 for TAVR and NCD 20.33 for TMVR.

Therefore, Medicare administrative contractors (MACs) do not require study investigators to submit the same documentation for an additional review. However, it would be beneficial to both contractor and physician/facility if the cost and coding form for CMS-approved studies along with the CMS approval letter were sent to First Coast before claims are submitted. This will allow the contractor to make any necessary decisions and preparations for claims receipt especially if unlisted procedure codes are considered and/or applicable. This should not cause any delays in study participation and will help claim adjudication.

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

Drugs & Biologicals

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

Provider types affected

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

What you need to know

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

Background

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

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

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

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

Additional information

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

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

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

Radiology

Payment reduction for X-rays taken using film

Provider types affected

This *MLN Matters*® article is intended for physicians, other providers, and suppliers who submit Part B claims to Medicare administrative contractors (MACs) for X-ray imaging services provided to Medicare beneficiaries.

Provider action needed

Change request (CR) 9727 reduces the technical component (TC) (including the TC portion of a global service) of X-ray imaging services provided using film. Make sure that your billing staff are aware of these changes.

Background

The Consolidated Appropriations Act of 2016 (Section 502(a)(1)) is titled "Medicare Payment Incentive for the Transition from Traditional X-Ray Imaging to Digital Radiography and Other Medicare Imaging Payment Provision."

It amends the Social Security Act by reducing the payment amounts under the physician fee schedule (PFS) by 20 percent for the technical component (and the technical component of the global fee) of imaging services that are X-rays taken using film. This is effective for services provided on or January 1, 2017.

To implement this provision, the Centers for Medicare & Medicaid Services (CMS) has created modifier FX (X ray taken using film). Beginning in 2017, claims for X-rays using film must include modifier FX that will result in the applicable payment reduction for which payment is made under the Medicare physician fee schedule (MPFS).

The MPFS amount cannot be greater than the outpatient prospective payment system (OPPS) amount. MACs will compare the OPPS facility and non-facility payment fields to the MPFS facility and non-facility amounts and use the lower amount. The FX modifier will reduce whichever of these two amounts applies by 20 percent.

Beginning January 1, 2017, for claims in which the FX modifier reduction has been applied, MACs group code CO and the following messages:

- Claim adjustment reason code 237 – Legislated/ Regulatory Penalty. At least one remark code must be provided (may be comprised of either the NCPDP reject reason code, or remittance advice remark code that is not an ALERT.)
- Remittance advice remarks code N775 – Payment adjusted based on X-ray radiograph on film.

Note that the beneficiary is not liable for the FX modifier payment reduction.

Additional information

The official instruction, CR 9727, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3583CP.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: MM9727
Related Change Request (CR) #: CR 9727
Related CR Release Date: August 12, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3583CP
Implementation Date: January 3, 2017

Surgery

Comprehensive care for joint replacement model provider education

***Note**: This article was revised November 9, 2016, to correct a typo in the list of G-codes in the Billing and payment for telehealth services section. The original article mentioned code G9499 and it should have stated G9489. All other information remains the same. This information was previously published in the March 2016 Medicare B Connection, pages 21-24.*

Provider types affected

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

What you need to know

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

Background

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

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

Key points of CR 9533

CJR episodes of care

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

CJR participant hospitals

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

CJR model beneficiary inclusion criteria

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

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

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

CJR performance years

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

CJR model: Five performance years

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

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CJR

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Performance year	Date for episodes
Performance year four (2019)	Episodes that end between January 1, 2019, and December 31, 2019, inclusive
Performance year five (2020)	Episodes that end between January 1, 2020, and December 31, 2020, inclusive

CJR episode reconciliation activities

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

Identifying CJR claims

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

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

Waivers and amendments of Medicare program rules

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

Post-discharge home visits

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

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

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

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

As described in the *Medicare Claims Processing Manual*, *Chapter 12*, Sections 40-40.4, Medicare policy generally does not allow for separate billing and payment for a postoperative visit furnished during the global period of a surgery when it is related to recovery from the surgery. However, for CJR, CMS will allow the surgeon or other

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practitioners to bill and be paid separately for a post-discharge home visit that was furnished in accordance with these conditions. All other Medicare rules for global surgery billing during the 90 day post-operative period continue to apply.

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

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

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

Billing and payment for telehealth services

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

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

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

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

Although CMS is associating the demonstration code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-code. Additional information on billing and payment for the

See **CJR**, next page

Therapy Services

Therapy services cap values for 2017

Provider types affected

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

Provider action needed

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

Background

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

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

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

Additional information

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

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

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

CJR

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telehealth home visit HCPCS g-codes will be available in the April 2016 release of the MPFS recurring update. Future updates to the RVUs and payment for these HCPCS codes will be included in the MPFS final rules and recurring updates each year.

Additional information

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

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

Document history

- November 9, 2016 - article revised to correct typo and to show correct code of G9489 on page 6.
- February 22, 2016 - initial issuance

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Related Change Request (CR) #: CR 9533
Related CR Release Date: February 19, 2016
Effective Date: April 1, 2016
Implementation Date: April 4, 2016
Related CR Transmittal #: R140DEMO

2017 annual update to the therapy code list

Provider types affected

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

What you need to know

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

Background

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

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

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

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

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

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

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

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

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

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

Additional information

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

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

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

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Implementation: January 3, 2017

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Manual updates to correct remittance advice messages

Provider types affected

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

What you need to know

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

Background

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

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

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

Additional information

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

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

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Implementation Date: February 10, 2017

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Learn the secrets to billing Medicare correctly

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

CMS issues guidance for reducing cross over claims

Provider types affected

This *MLN Matters*® special edition (SE) article is intended for physician/practitioner and supplier billing offices mailing CMS-1500 claim forms to Medicare administrative contractors (MACs) and durable medical equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider action needed

This article instructs physician/practitioner and supplier billing offices to correctly submit CMS-1500 claim forms to reduce the number of claims that are not "crossed over," or transferred electronically to the destination supplemental payer. Make sure your billing staff is aware of this guidance.

Background

Currently, when physician/practitioner and supplier billing offices mail CMS-1500 claim forms to their MAC or DME MAC, the MAC or DME MAC's shared system uses the resulting adjudication data in the creation of outbound Medicare crossover claims. More specifically, Medicare uses the results from the processing of the incoming hardcopy claims to create outbound Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12-N 837 professional Coordination of Benefits (COB) claims.

After the incoming hard-copy claims have met their Medicare payment floor requirements, MACs and DME MACs then transfer these claims to the Centers for Medicare & Medicaid Services (CMS) Benefits Coordination & Recovery Center (BCRC). The BCRC administers CMS' Medicare claim crossover process.

Upon receipt at the BCRC, the claims are edited for HIPAA ASC X12-N 837 claims compliance. Claims that pass compliance are "crossed over," or transferred electronically, to the destination supplemental payer. Claims that fail HIPAA compliance are not crossed over. Instead, the BCRC submits an electronic report to the associated MAC or DME MAC advising why the claims were not crossed over. MACs and DME MACs then create a notification letter that is mailed to the physician/practitioner or supplier's correspondence address of record, which is on file with the MAC or DME MAC. It is within the context of this process that CMS is creating SE1629.

Diagnosis coding on claims and processing and editing of those claims

Beginning in October 2015, billing vendors for physicians and medical practitioners and suppliers in the healthcare industry have been including International Classification of Diseases, Clinical Modifications, version 10 (ICD-CM-10), on healthcare claims submitted to Medicare in association with specified service-from date requirements.

- **Example**: If a claim's service-from date is October 15, 2015, physicians/practitioners and suppliers are to bill the claim to Medicare using an ICD-10, rather than ICD-9, diagnosis code.

CMS MACs and DME MACs have either a front-end contractor common edits module (CCEM) or common electronic data interchange (CEDI) module that activates when ICD diagnosis code versions are incorrectly used for claim service dates. Additionally, the MAC and DME MAC CCEM and CEDI have logic that activates when incoming electronically- submitted claims contain duplicate ICD-10 diagnosis codes, as well as duplicate diagnosis code pointers.

MACs and DME MACs currently do not have established claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) that may be used through Medicare's unprocessable claims procedure to advise physician/practitioners or suppliers that they have either incorrectly:

1. Included a duplicate ICD-10 diagnosis code on an incoming CMS-1500 Claim; or
2. Included a diagnosis code pointer reference more than once (for example, "1, 1") on such claims.

CMS is providing the informational guidance to physicians/practitioners and medical suppliers in the hopes that they will have fewer issues with Medicare crossing their claims over to supplemental payers.

BCRC editing and claims failing to cross over

Prior to and after the implementation of ICD-10 diagnosis reporting in October 2015, representatives from the Medicare supplemental payer community informed CMS and its BCRC that **the *ICD-10-CM, Version 5010 Manual*** provides direction to users regarding the inappropriateness of reporting ICD-10-CM diagnosis codes more than once. The guidance is as follows:

Within Section B, *General Coding Guidelines, number 12, page 19*, the manual states:

"***12. Reporting Same Diagnosis Code More Than Once****: Each unique ICD-10-CM diagnosis code may be reported only once per encounter. This also applies to bilateral conditions when there are no distinct codes identifying laterally or two different conditions classified to the same ICD-10-CM diagnosis code.*"

CMS has determined that the above guidance has influenced many healthcare plans, payers, and clearinghouses to create edits that will activate if the same ICD-10 diagnosis code is duplicated on claims. The BCRC, at the discretion of CMS, has also done so, to ensure that supplemental payers will not reject Medicare crossover claims with this characteristic upon receipt. Therefore, any claims that MACs and DME MACs transmit to the BCRC that contain duplicate ICD-10 diagnosis codes are encountering the following error:

- H54271 – "ICD-10 codes cannot be duplicated."

Since MACs and DME MACs have duplicate diagnosis code editing included in their CCEM or CEDI front-end editing routines, incoming electronic HIPAA ASC X12-N 837 claims with these characteristics are being rejected through Medicare's 277-CA process. This means it is

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primarily incoming hardcopy (CMS-1500) claims that are now encountering the H54271 edit rejection.

Additionally, guidance in the HIPAA technical report version 3 (TR-3) guide governing 837 professional claims transactions makes reference to use of distinct diagnosis pointers to differentiate among multiple diagnosis codes when included on healthcare claims. It appears Medicare's CCEM or CEDI routines catch situations where diagnosis code pointer references are used more than once. However, there is no available CARC or RARC that can be used to identify this situation as part of Medicare's unprocessable claim procedure. Because of this, claims where a diagnosis pointer reference is duplicated, such as "1, 1," are encountering the following error at the BCRC:

- H25670 – "Diagnosis code pointers should not be duplicated."

Next steps to remediate this issue

CMS recognizes it is possible for a physician/practitioner or supplier to reference a given reported diagnosis code, through a diagnosis code pointer, more than once when billing Medicare for multiple services on the same claim. However, vendors or physician/practitioner and supplier offices that create CMS-1500 claims can obtain better Medicare claim crossover results if they:

- Cease reporting the same ICD-9 or ICD-10 diagnosis more than once and
- Cease reporting a diagnosis code pointer reference more than once (for example, 1, 1, or 2, 2)

Additional information

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

Document history

Date	Description
November 8, 2016	Initial issuance

MLN Matters® Number: SE1629
Related Change Request (CR) #: N/A
Article Release Date: November 8, 2016
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Implementation Date: N/A

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*.

Processing Issues

Application of skin substitute grafts for treatment of DFU and VLU of lower extremities — overpayments

Issue

First Coast Service Options Inc. has identified an internal processing issue that resulted in overpayments related to the application of skin substitute grafts for treatment of diabetic foot ulcers (DFU) and venous leg ulcers (VLU) of lower extremities based on the coverage criteria addressed in local coverage determination (LCD) L36377. The LCD addresses the reasonable and necessary (R&N) threshold for coverage of skin replacement surgery, specifically the indications for the application of skin substitute grafts for DFU and VLU. Evaluation of the clinical literature indicates that studies comparing the efficacy of skin substitute grafts as an adjunct to chronic wound care are limited in number, apply mainly to generally healthy patients, and examine only a small portion of the skin substitute products available in the United States. Therefore, no individual product can be considered for coverage unless the applicable skin replacement surgery code meets the requirements of this LCD.

Resolution

This processing issue was corrected effective for claims processed on or after April 12, 2016, for services rendered on or after September 6, 2015. Procedure codes 15271, 15272, 15273, 15274, 15275, 15276, 15277, and 15278 (application of skin substitutes) will be denied if procedure codes Q4100-Q4165 (skin substitute products) are not billed on the same date of service. Additionally, if procedure codes Q4100-Q4165 are denied, procedure codes 15271, 15272, 15273, 15274, 15275, 15276, 15277, and 15278 will also be denied when billed on the same date of service.

Status/date resolved

Open/April 12, 2016

Provider action

Providers who received payment in error will receive a demand letter requesting the monies back. Providers do not need to contact customer service; they should follow the instructions in their demand letters.

Current processing issues

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

Computerized corneal topography – claims may have been denied in error

Issue

Claims submitted for computerized corneal topography (procedure code 92025) between October 1, 2015 and August 7, 2016, may have been denied in error when billed with diagnosis codes H11.811-H11-819, H18.51, H18.52, H18.53, H18.54, and H18.55.

Resolution

This error was corrected August 8, 2016. Claims processed on or after August 8, 2016, were adjudicated correctly. First Coast Service Options Inc. will perform adjustments to correct the errors on all the affected claims.

Status/date resolved

Closed/August 8, 2016

Provider action

No action is required by the provider.

Current processing issues

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

Controlled substance monitoring and drugs of abuse testing - overpayments

Issue

First Coast Service Options Inc. has identified an internal processing issue that resulted in overpayments related to specimen validity testing (SVT). SVT is an internal laboratory procedure to determine whether the urine specimen has been diluted or adulterated that also assures and protects the laboratory from reporting invalid test results to the ordering physician. SVT must be performed on every specimen by the laboratory. SVT testing relates to specimen integrity and accuracy, and not for direct patient management. SVT results provide information about the integrity of the urine specimen and does not define/establish criteria for a physician to prescribe/non-prescribe pain medication or dismiss a patient, and as such, is not a separately reimbursable Medicare service.

Resolution

Current Procedural Terminology (CPT®) code 81003 (routine urinalysis) and CPT® code 82570 (urine creatinine), will both be denied when performed on the same date of service as the qualitative drug test (Healthcare Common Procedure Coding System [HCPCS] codes G6030-G6057 [which were deleted effective January 1, 2016] and G0477-G0483 [effective on and after January 1, 2016]).

Status/date resolved

Open/June 30, 2016.

Provider action

Providers who received payment in error will receive a demand letter requesting the monies back. Providers do not need to contact customer service; they should follow the instructions in the demand letters.

Current processing issues

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

General Information

New physician specialty code for hospitalist

Provider types affected

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

Provider action needed

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

Background

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

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

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

Additional information

The official instruction, CR 9716, issued to your MAC regarding this change consists of two transmittals. The first updates the *Medicare Claims Processing Manual* and it is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3637CP.pdf*. The second updates the *Medicare Financial Management Manual* at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R274FM.pdf*.

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

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

Inappropriate billing of QMBs for Medicare cost-sharing

Provider types affected

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

Provider action needed

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

Background

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

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

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

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

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

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

In September 2016, all Medicare beneficiaries received "Medicare & You 2017," which contains new language to advise QMB individuals about their billing protections.

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

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

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

Additional information

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

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

Example of cover letter for affected QMB individuals sent by MAC

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

Dear [Beneficiary Name]:

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

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

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

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.

See **QMBs**, next page

QMBs

previous page

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

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

Example of compliance letter sent to provider by the MAC

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

Dear [Provider/Supplier Name]:

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

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

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

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

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

Sincerely,

[Name]
[Title]
[MAC name]

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

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

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.

Modifications to the national coordination of benefits agreement crossover process

Provider types affected

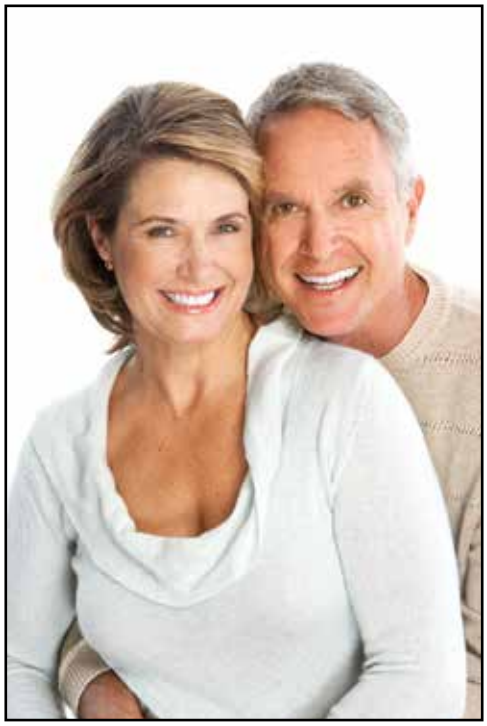
This *MLN Matters*® article is intended for providers, including hospices, submitting institutional claims to Medicare administrative contractors (MACs) requiring coordination of benefits (COB) for services provided to Medicare beneficiaries.

Provider action needed

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

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

Make sure your billing staff is aware of these changes.



Background

The Council for Affordable Quality Healthcare Committee for Operating Rules for Information Exchange (CAQH CORE) dictates which CARC and RARC combinations must be used by all covered entities in the healthcare industry. Medicare routinely reports CARCs and RARCs on Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Institute (ASC) 835 electronic remittance advice (ERA) transactions in accordance with HIPAA requirements. Medicare also includes CARCs and RARCs within HIPAA ASC 837-N claims transactions, including 837 coordination of benefits (COB) claims transactions. However, within 837 claims transactions, RARCs are referred to as "claim payment reason codes" and appear within the 2320 Medicare inpatient adjudication information (MIA) and Medicare outpatient adjudication information (MOA) segments.

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

The Part A system is producing instances of duplicated hospital day counts on outbound 837 institutional COB/crossover claims. CR 9681 remedies this situation. **Important**: Hospital billing staffs should avoid entering hospital day counts via direct data entry (DDE) screens.

Lastly, at present there is no editing with the Part A system to prevent the entry of a POA indicator on incoming outpatient facility claims. CR 9681 remedies this issue by returning to the provider (RTP) any outpatient claim (type of bill other than 11x, 18x, 21x, 41x, and 82x) that contains a POA indicator. **Important**: Billing vendors for hospitals should make it a practice to only include POA indicators on 11x, 18x, 21x, 41x, and 82x type of bill (TOB) claims submitted to Medicare.

Additional information

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

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

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

This section of *Medicare B Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction N (JN) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our LCDs/Medical Coverage web page at *http://medicare.fcso.com/Landing/139800.asp* for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic notification

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

More information

For more information, or, if you do not have internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048

Looking for LCDs?

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

Advance beneficiary notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

Before you file an appeal...

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

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

Revisions to LCDs

Hemophilia clotting factors – revision to the Part AB LCD

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

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

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

Effective date

This LCD revision is effective for services rendered **on or after October 1, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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

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

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

Effective date

This LCD revision is effective for claims processed **on or after November 18, 2016**, for services rendered **on or after October 1, 2016**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

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

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

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

Effective date

This LCD revision is effective for claims processed **on or after November 21, 2016**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx*.

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

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

Upcoming provider outreach and educational event

Topic: Psychotherapy services (B)

Date: Wednesday, January 18
Time: 11:30 a.m.-1:00 p.m.
Type of Event: Webcast
https://medicare.fcso.com/Events/0362844.asp

Note: Unless otherwise indicated, designated times for educational events are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands.

Two easy ways to register

Online – Visit our provider training website at *http://www.fcsouniversity.com*, log on to your account and select the course you wish to register. Class materials are available under "My Courses" no later than one day before the event**.**

First-time User? Set up an account by completing *Request User Account Form* online. Providers who do not have yet a national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

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

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our website, *medicare.fcso.com*, for details and newly scheduled educational events (teleconferences, webcasts, etc.) or call the First Coast Provider Education Registration Hotline at 1-904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the First Coast Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.

CMS MLN Connects® Provider eNews

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

MLN Connects® Provider eNews for October 27, 2016

MLN Connects® Provider eNews for October 27, 2016

View this edition as a PDF

News & Announcements

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

Provider Compliance

- Duplicate Claims

Upcoming Events

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

- Quality Payment Program Final Rule Call – November 15

Medicare Learning Network® Publications & Multimedia

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

MLN Connects® Provider eNews for November 3, 2016

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

News & Announcements

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

Provider Compliance

- Chiropractic Services: High Part B Improper Payment Rate

Claims, Pricers & Codes

- Billing for Influenza: New CPT® Code 90674

Upcoming Events

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

Medicare Learning Network® Publications & Multimedia

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

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MLN Connects® Provider eNews for November 10, 2016

MLN Connects® Provider eNews for November 10, 2016
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News & Announcements

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

Provider Compliance

- Compliance Program Basics

Claims, Pricers & Codes

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

Upcoming Events

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

Medicare Learning Network® Publications & Multimedia

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

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MLN Connects® Provider eNews for November 17, 2016

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

News & Announcements

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

Provider Compliance

- False Claims Act

Claims, Pricers & Codes

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

Upcoming Events

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

Medicare Learning Network® Publications & Multimedia

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

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MLN Connects® Provider eNews – Special Edition

Tuesday, November 1, 2016

- *CMS finalizes hospital OPPS changes to better support hospitals and physicians and improve patient care*
- *Home health agencies: Final payment changes*
- *ESRD PPS: Policies and payment rates for end-stage renal disease*

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

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

Included in the rule:

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

For more information:

- *Final Rule*
- *Fact Sheet*

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

Home health agencies: Final payment changes

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

Payment policy provisions:

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

The final rule also includes:

- Home health quality reporting program
- Home health value-based purchasing model

See **SPECIAL**, next page

SPECIAL

previous page

For more information:

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

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

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

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

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

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

Changes to the ESRD PPS:

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

Changes to the DMEPOS competitive bidding program:

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

For more information:

- *Final Rule*

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

Take action to combat the flu

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

Phone numbers

Customer service

866-454-9007
877-660-1759 (speech and hearing impaired)

Education event registration hotline

904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)

888-670-0940

Electronic funds transfers (EFT) (CMS-588)

866-454-9007
877-660-1759 (TTY)

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

866-454-9007
877-660-1759 (TTY)

The SPOT help desk

855-416-4199
email: *FCSOSPOTHelp@FCSO.com*

Addresses

Claims

Medicare Part B Claims
P.O. Box 2525
Jacksonville, FL 32231-0019

Redeterminations

Medicare Part B Redetermination
P.O. Box 2360
Jacksonville, FL 32231-0018

Redetermination of overpayments

Overpayment Redetermination, Review Request
P.O Box 45248
Jacksonville, FL 32232-5248

Reconsiderations

C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

General inquiries

General inquiry request
P.O. Box 2360
Jacksonville, FL 32231-0018

Email**:** *FloridaB@fcso.com*
Online form: *http://medicare.fcso.com/Feedback/161670.asp*

Provider enrollment

Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

Medical policy

Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
Email: *medical.policy@fcso.com*

Medicare secondary payer

Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery
P.O. Box 44141
Jacksonville, FL 32231-4141

Medicare Education and Outreach

Medicare Education and Outreach
P.O. Box 45157
Jacksonville, FL 32232-5157

Fraud and abuse

Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA Florida
P.O. Box 45268
Jacksonville, FL 32232-5268

Overnight mail and/or special courier service

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Websites

Provider

First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor
http://medicare.fcso.com

Find your *other contractors* (e.g. DME, HHA, etc)

Centers for Medicare & Medicaid Services
https://www.cms.gov

First Coast University
http://www.fcsouniversity.com/

Beneficiaries

Centers for Medicare & Medicaid Services
https://www.medicare.gov

Phone numbers

Customer service
866-454-9007
877-660-1759 (speech and hearing impaired)

Education event registration hotline
904-791-8103 (NOT toll-free)

Electronic data interchange (EDI)
888-670-0940

Electronic funds transfers (EFT) (CMS-588)
866-454-9007
877-660-1759 (TTY)

Fax number (for general inquiries)
904-361-0696

Interactive voice response (IVR) system
877-847-4992

Provider enrollment
888-845-8614
877-660-1759 (TTY)

The SPOT help desk
855-416-4199
Email: *FCSOSPOTHelp@FCSO.com*

Addresses

Claims
Medicare Part B Claims
P.O. Box 45098
Jacksonville, FL 32232-5098

Redeterminations
Medicare Part B Redetermination
P.O. Box 45024
Jacksonville, FL 32232-5024

Redetermination of overpayments
First Coast Service Options Inc.
P.O Box 45091
Jacksonville, FL 32232-5091

Reconsiderations
C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

General inquiries
First Coast Service Options Inc.
P.O. Box 45098
Jacksonville, FL 32232-5098

Email: *askFloridaB@fcso.com*
Online form: *http://medicare.fcso.com/Feedback/161670.asp*

Provider enrollment
Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

Medical policy
Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
Email: *medical.policy@fcso.com*

Medicare secondary payer
Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)
Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments
Medicare Part B Debt Recovery
P.O. Box 44141
Jacksonville, FL 32231-4141

Medicare Education and Outreach
Medicare Education and Outreach
P.O. Box 45157
Jacksonville, FL 32232-5157

Fraud and abuse
Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests
FOIA USVI
P.O. Box 45073
Jacksonville, FL 32231-5073

Special courier service
First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Websites

Provider
First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor

http://medicare.fcso.com

Find your *other contractors* (e.g. DME, HHA, etc)

Centers for Medicare & Medicaid Services

https://www.cms.gov

First Coast University

http://www.fcsouniversity.com/

Beneficiaries
Centers for Medicare & Medicaid Services

https://www.medicare.gov

Phone numbers

Customer service

1-877-715-1921
1-888-216-8261 (speech and hearing impaired)

Education event registration hotline

904-791-8103 (NOT toll-free)
904-361-0407 (FAX)

Electronic data interchange (EDI)

888-875-9779

Electronic funds transfers (EFT) (CMS-588)

877-715-1921
877-660-1759 (TTY)

General inquiries

877-715-1921
888-216-8261 (TTY)

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

877-715-1921
877-660-1759 (TTY)

The SPOT help desk

855-416-4199
email: *FCSOSPOTHelp@FCSO.com*

Addresses

Claims

Medicare Part B Claims
P.O. Box 45036
Jacksonville, FL 32232-5036

Redeterminations

Medicare Part B Redetermination
P.O. Box 45056
Jacksonville, FL 32232-5056

Redetermination of overpayments

First Coast Service Options Inc.
P.O Box 45015
Jacksonville, FL 32232-5015

Reconsiderations

C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
P.O. Box 183092
Columbus, Ohio 43218-3092

General inquiries

First Coast Service Options Inc.
P.O. Box 45098
Jacksonville, FL 32232-5098

Email**:** *askFloridaB@fcso.com*
Online form: *http://medicare.fcso.com/Feedback/161670.asp*

Provider enrollment

Provider Enrollment
P.O. Box 44021
Jacksonville, FL 32231-4021

Medical policy

Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
Email: *medical.policy@fcso.com*

Medicare secondary payer

Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery
P.O. Box 45040
Jacksonville, FL 32231-5040

Medicare Education and Outreach

Medicare Education and Outreach
P.O. Box 45157
Jacksonville, FL 32232-5157

Fraud and abuse

Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA Puerto Rico
P.O. Box 45092
Jacksonville, FL 32232-5092,

Special courier service

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532 Riverside Avenue
Jacksonville, FL 32202-4914

Websites

Provider

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Find your *other contractors* (e.g. DME, HHA, etc)

Centers for Medicare & Medicaid Services
https://www.cms.gov

First Coast University
http://www.fcsouniversity.com/

Beneficiaries

Centers for Medicare & Medicaid Services
https://www.medicare.gov

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