Medicare A Connection

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FIRST COAST SERVICE OPTIONS, INC.

A Newsletter for MAC Jurisdiction N Providers

November 2015

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Local coverage determinations and relevant ICD-10-CM codes

Updated local coverage determinations (LCD) to include ICD-10 diagnosis codes were posted to the Medicare coverage database (MCD) in April 2014.

Since the October 1, 2015, ICD-10 transition date, First Coast has received comments from physicians and allied providers suggesting changes and/or additions to the current ICD-10 LCD code sets.

First Coast appreciates input from the provider community and evaluates comments as they are received. If the evaluation results in a determination that additional ICD-10 diagnosis code(s) should be included in the applicable LCD, the LCD and associated editing will be updated and an article will be published.

First Coast is addressing all inquiries related to ICD-10 LCD codes as a priority. Please include the following information with your comments and submit to: *medical.policy@fcso.com*:

- The name of the LCD and corresponding L number
- The specific indication as stated in the LCD and relevant ICD-10 diagnosis codes recommended for addition in support of the indication
- If deletion of codes are recommended, please provide the rationale

As always, diagnosis codes are only a surrogate for the stated indications/limitations in the LCD and must be supported in the medical record.

Requests for new indications should be addressed per the normal LCD reconsideration process. For more information regarding this process, see: *http://medicare.fcso.com/Coverage_resources/138575.asp*

Note: If an LCD prior to the ICD-10 implementation date of October 1, 2015, did not include ICD-9 codes then the LCD after this date will not include diagnosis codes.

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

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

Internet-only manual updates to Pub. 100-01, 100-02 and 100-04 to correct errors and omissions

Provider types affected

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

Provider action needed

The purpose of change request (CR) 9336 is to update the Medicare manuals to correct various minor technical errors and omissions. These changes are intended only to clarify the existing content and no policy, processing, or system changes are anticipated.

Background

CR 9336 revises the following Medicare manuals:

- *Medicare General Information, Eligibility, and Entitlement Manual* (Publication 100-01);
- *Medicare Benefit Policy Manual* (Publication 100-02); and
- "*Medicare Claims Processing Manual*" (Publication 100-04).

Medicare general information, eligibility, and entitlement manual revision summary

Chapter 1: General overview

In Section 10.1, the final paragraph's discussion about tracking the utilization of Part A benefit days (as added previously by CR 8044) is clarified by removing the inappropriate reference to utilization of home health services, which is actually measured in terms of visits rather than benefit days.

Chapter 4: Physician certification and recertification of services

Section 10.6 is revised to explain more completely the reference to "alternate placement" days that CRs 8044 and 8669 had previously added to the fifth paragraph of Section 20.1 of the *Medicare Benefit Policy Manual*. The revised section now reads:

- "A physician who certifies or recertifies to the need for continued inpatient stay should use the same criteria that apply to the hospital's utilization review committee.

  These criteria include not only medical necessity, but also the availability of out-of-hospital facilities and services which will assume continuity of care. In accordance with the regulations at 42 CFR 424.13(c), a physician should certify or recertify need for continued hospitalization if the physician finds that the patient could receive treatment in a SNF but no bed is available in the participating SNF.

  Where the basis for the certification or recertification is the need for continued inpatient care because of the lack of SNF accommodations, the certification or recertification should so state.

  The physician is expected to continue efforts to place the patient in a participating SNF as soon as the bed becomes available. Coverage of these additional, 'alternate placement' days in the hospital can continue until the earliest of the following events occurs:

  - A bed becomes available in a participating SNF;
  - The beneficiary's care needs drop below SNF-level; or
  - The beneficiary has exhausted all of the available days of Part A inpatient hospital benefits in that benefit period."

'Medicare Benefit Policy Manual' revision summary

Chapter 8: Coverage of extended care (SNF) services under hospital insurance

In Section 20.1, the fourth paragraph's reference (as added previously by CR 8044) to the limitation of liability policy discussed in the *Medicare Claims Processing Manual*, Chapter 30, Section 130.2.A. is clarified to reflect the referenced policy more accurately.

Specifically, Chapter 8, Section 20.1 now clarifies that in some instances, the limitation of beneficiary liability for a hospital stay may apply to only a portion of the hospital stay, so that it would still be possible for the remainder of the hospital stay to count toward a "qualifying," medically necessary three-day stay for SNF benefit purposes.

'Medicare Claims Processing Manual' revision summary Chapter 6: Inpatient Part A billing and SNF consolidated billing

Sections 20.1.2 and 20.1.2.1 are each revised by removing a parenthetical reference to revenue codes (originally added in CR 3070) that has become obsolete. In Section 20.4 (Screening and Preventive Services), the description of screening services in the first paragraph (as added by CR 8044) is revised for greater clarity.

Also, for a phrase (under Part B) that appears near the end of the sixth paragraph of that section, the emphasized font that was inadvertently removed in the course of manualizing CR 8669 is now restored. The updated paragraph now reads as follows:

See **MANUAL**, next page

MANUAL

From previous page

Paragraph six: "Further, it is worth noting that unlike preventive services covered under Part B, those preventive vaccines covered under Part D are not subject to SNF CB, even when furnished to an SNF's Part A resident.

This is because Section 1862(a)(18) of the Act specifies that SNF CB applies to '. . . covered skilled nursing facility services described in Section 1888(e)(2)(A)(i) . . . .'

Section 1888(e)(2)(A)(i) of the Act, in turn, defines 'covered skilled nursing facility services' specifically in terms of (I) Part A SNF services, along with (II) those non-excluded services that (if not for the enactment of SNF CB) would be types of services '. . . for which payment may be made **under Part B** . . .'

Additional information

The official instruction, CR 9336, issued to your MAC regarding this change consists of three transmittals. Those are:

- *R3379CP*, which updates the "*Medicare Claims Processing Manual*;"
- *R211BP*, which updates the "*Medicare Benefit Policy Manual*;" and
- *R94GI*, which updates the "*Medicare General Information, Eligibility, and Entitlement Manual.*"

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

MLN Matters® Number: MM9336
Related Change Request (CR) #: CR 9336
Related CR Release Date: October 16, 2015
Effective Date: November 16, 2015
Related CR Transmittal #: R3379CP, R211BP, and R94GI
Implementation Date: November 16, 2015

Processing Issues

Deductible and coinsurance errors with skilled nursing facility claims

Issue

The Centers for Medicare & Medicaid Services (CMS) has determined the fiscal intermediary shared system (FISS) did not correctly apply deductible and coinsurance for specific skilled nursing facility claims with dates of service from January 1, 2015, through March 31, 2015.

Resolution

Medicare administrative contractors (MAC) will perform mass adjustments to all claims that meet the following criteria:

- Skilled nursing facility claims; type of bill 22x or 23x
- Service dates between January 1, 2015, through March 31, 2015
- Claims entered on or after April 6, 2015
- Healthcare procedure code system is one of the following: G0276, G0277, G0473, G6001, G6002, G6003, G6004, G6005, G6006, G6007, G6008, G6009, G6010, G6011, G6012, G6013, G6014, G6015, G6016, G6018, G6019, G6020, G6022, G6023, G6024, G6025, 20604, *20606*, *20611*, *20983*, *21811*, *21812*, *21813*, *22510*, *22511*, *22512*, *22513*, *22514*, *22515*, *22858*, *27279*, *33270*, *33271*, *33272*, *33273*, *33418*, *33419*, *33946*, *33947*, *33948*, *33949*, *33951*, *33952*, *33953*, *33954*, *33955*, *33956*, *33957*, *33958*, *33959*, *33962*, *33963*, *33964*, *33965*, *33966*, *33969*, *33984*, *33985*, *33986*, *33987*, *33988*, *33989*, *37218*, *43180*, *47383*, *52441*, *52442*, *62302*, *62303*, *62304*, *62305*, *64486*, *64487*, *64488*, *64489*, *66179*, *66184*, *76641*, *76642*, *77063*, *77085*, *77086*, *77306*, *77307*, *77316*, *77317*, *77318*, *88344*, *88364*, *88341*, *88366*, *88369*, *88373*, *88374*, *88377*, *91200*, *92145*, *93260*, *93261*, *93644*, *93702*, *96127*, *97610*, *99490*, *99184*

Status/date resolved

Open. MACs will perform mass adjustments on affected claims on or before December 31, 2015.

Provider action

No provider action is required.

Claims processing issue for vaccines

Provider types affected

The Centers for Medicare & Medicaid Services (CMS) discovered a system error when vaccine services other than pneumococcal and influenza are reported without condition code A6 for dates of service on or after October 1, 2015.

Condition code A6 is only required when reporting pneumococcal and influenza vaccines. Your Medicare administrative contractor (MAC) will correct claims returned to you in error with reason code 32200.

Issue

Change request (CR) 9362 updates Chapter 3 of the *Medicare Claims Processing Manual* to clarify key components of IRF payment policies. These changes are intended only to clarify the existing policies and no system or processing changes are anticipated.

Resolution

Medicare administrative contractors (MAC) will correct claims with reason code 32200 returned in error.

Status/date resolved

Open

Provider action

No provider action is required.

Pap smear and PET scan claims editing incorrectly

CMS discovered systems errors affecting claims with pap smear services and positron emission tomography (PET) scans with dates of service on or after October 1, 2015. No provider action is required.

- Pap smear services are editing incorrectly. Your Medicare administrative contractor (MAC) will correct any claims returned to you in error with reason code 32252, 32277, or 32970.
- Certain PET scans for infection and inflammation are processing inappropriately when reported with incorrect diagnosis codes. Your MAC will mass adjust any claims that may be impacted by this issue.

Incorrect payment of FQHC claims

Issue

The fiscal intermediary shared system (FISS) identified incorrect payments resulting from implementation of change request (CR) 8743 (related *MLN Matters*® article MM8743).

Based on its review and analysis, FISS determined that changes were needed to correct the payment calculation for federally qualified health center (FQHC) claims billed with value code “Q9” and facility code is equal to “M.”

Resolution

The issue was corrected August 24, 2015. Contractors have been directed to adjust claims that meet the following criteria:

- Finalized claims with a “P” status
- TOB 77x
- Provider = FQHC prospective payment system (PPS) provider with facility code = M
- Value code = Q9
- Rev code 0519
- HCPCS G0466, G0467, G0468, G0469, or G0470
- Claim processed on or after installation of CR 8743 (October 1, 2014), up through installation of system fix August 24, 2015.
- Option C HMO on claim page 12

Status/date resolved

Open

Provider action

No provider action is required.

Medicare advantage claims for FQHCs paying incorrectly

Issue

The Centers for Medicare & Medicaid Services (CMS) recently identified system errors whereby non-prospective payment system claims for services provided Medicare beneficiaries in federally qualified health centers are paying based on 80 percent of the supplemental rate rather than 100 percent.

Medicare administrative contractors will adjust claims for services provided in federally qualified health centers to Medicare beneficiaries covered by Medicare advantage plans. Affected claims meet the following criteria:

- Type of bill is 77x
- Claim status is P
- Revenue code is 0519
- Claim processed on or after April 6, 2015, through January 4, 2016.

Resolution

CMS installed a system fix August 24, 2015. MACs will adjust affected claims on or before January 19, 2016.

Status/date resolved

Open

Provider action

No provider action is required.

Update to NCD 210.3 colorectal cancer screening

Issue

Due to an increase in inappropriate denials, the Centers for Medicare & Medicaid Services (CMS) has expedited an update to national coverage determination (NCD) 210.3, colorectal cancer screening tests.

CMS is taking action to correct inappropriate denials of procedure code G0105 with ICD-10 code Z86.010 where they exist, and appropriate payment will be made for these procedures.

Resolution

No action is needed by providers. As outlined in change request (CR) 9252 for ICD-10 conversion/coding infrastructure revisions to NCDs published October 6, 2015,

Medicare will cover Z86.010 as well as a host of other codes for G0105 or G0120.

For more information, please refer to *MLN Matters* number MM9252: *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9252.pdf*.

Status/date resolved

Open.

Provider action

No action is needed by providers. CMS is taking action to correct inappropriate denials of procedure code G0105 with ICD-10 code Z86.010 where they exist, and appropriate payment will be made for these procedures.

Learn the secrets to billing Medicare correctly

Who has the power to improve your billing accuracy and efficiency?

You do – visit the *Tools to improve your billing* section where you'll discover the tools you need to learn how to consistently bill Medicare correctly – the first time.

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

CMS updates claim edits for prostate cancer screening tests

Issue

The Centers for Medicare & Medicaid Services (CMS) added procedure code G0103 to fiscal intermediary shared system (FISS) claim edits for the prostate cancer examination national coverage determination (NCD).

The code was inadvertently omitted on claims for services provided on or after October 1, 2015.

- Affected claims include claims that meet the following criteria:
- Claims processed from October 1, 2015, through October 26, 2015
- Type of bill is one of 12x, 13x, 14x, 22x, 23x, 71x, 75x, 77x, or 85x
- Date of service is on or after October 1, 2015
- Healthcare Common Procedure Coding System (HCPCS) is G0103
- Diagnosis (DX) is other than Z125; and,
- Covered charges are greater than 0.00

Resolution

Your Medicare administrative contractor (MAC) will mass adjust affected claims on or before December 30, 2015.

Status/date resolved

Open

Provider action

No provider action is required.

Erythropoiesis stimulating agents (J0881 and J0885) claims may have been denied in error

Issue

Claims for procedure code J0881 (Injection, darbepoetin alfa, 1 microgram [non-ESRD use]) and J0885 (Injection, darbepoetin alfa, 1 microgram [for ESRD on dialysis]) may have been denied in error with the following message: “These are non-covered services because this is not deemed a “medical necessity’ by the payer.”

Resolution

The error was corrected October 15, 2015. Claims processed on or after October 15, 2015, were adjudicated correctly. First Coast Service Options Inc. will perform a mass adjustment to correct impacted claims.

Status

Open

Provider action

None. Providers whose claims were incorrectly denied due to this error do not need to take any action.

Correction of mammography claims

Issue

The Centers for Medicare & Medicaid Services (CMS) discovered a system error with reason code 32016 assigning on mammography services with diagnosis code Z1231 for dates of service on or after October 1, 2015.

Resolution

Medicare administrative contractors (MAC) will correct claims with reason code 32016 returned in error.

Status/date resolved

Open

Provider action

No provider action is required.

Compliance tips for laboratory services

The Centers for Medicare & Medicaid Services (CMS) implemented the comprehensive error rate testing (CERT) program to measure improper payments in the Medicare fee-for-service (FFS) program. CERT selects a random sampling of claim types, including clinical laboratory services, to request and review medical documentation to determine if the services were paid appropriately.

If the criteria for coverage are not met or the provider fails to submit medical documentation to support the claim, the payment is recouped from the provider and an error is assessed to the contractor for that paid claim. First Coast is receiving errors for clinical laboratory services at both the national and contractor level in the CERT program.

Clinical laboratory tests had a national improper payment rate of 36 percent during the 2014 reporting period for the CERT program. Insufficient documentation caused more than 93 percent of the CERT review contractor identified improper payments. Insufficient documentation could be a missing order and/or documentation that support the intent to order the laboratory test(s), which are the highest errors in this category.

Tips for responding to documentation requests

If you receive a documentation request from a Medicare review contactor, you will need, at a minimum, to check for the following in your documentation and submit it to the requesting review contractor:

- Procure all pertinent documentation from the ordering provider, if necessary, and ensure all documentation (including the order) is authenticated according to Medicare requirements
    - If the documentation is not authenticated in compliance with Medicare's legibility rules, obtain a signature attestation, signature log or any other documentation to authenticate the ordering provider
- Confirm authenticated order or documentation showing intent to order is submitted
    - If you cannot provide a copy of the order, contact the ordering practitioner and request that they send you a copy of the order
    - If the ordering practitioner cannot provide a copy of the order, request they send the progress notes, plan of care or another medical record entry prior to the lab tests, such as medical history or physical examination, documenting the intent to order the test(s) or why the test is needed
- Audit documentation prior to submission to ensure all requirements are met and requested documents are included in response
- Certify the documentation submitted supports medical necessity for services billed
    - Refer to all available local coverage determinations (LCDs) for guidance on services being rendered and billed

Note: A best practice suggestion was received from a Florida laboratory. Their suggestion is to include information to support medical necessity for tests in the remarks section of the requisition or order that is received by the laboratory from the ordering/referring provider.

This suggestion may not be sufficient in supplying medical necessity for **all** laboratory tests. Please review medical necessity guidelines for the laboratory test being rendered to evaluate the effectiveness of this suggestion.

Sources: *Clinical Laboratory Specialty Web page*
Medical Documentation Web page
Medicare Coverage Database
MLN Matters® MM6698 Signature Guidelines for Medical Review Purposes
IOM Pub. 100-08, Chapter 3 Verifying Potential Errors and Taking Corrective Actions

National coverage determination for single chamber and dual chamber permanent cardiac pacemakers

***Note**: This article was revised on October 28, 2015 to reflect the revised change request (CR) 9078 issued on October 26. The CR was revised to direct the MACs to implement the NCD at the local level until Medicare system instructions are revised and Medicare system changes are implemented. All other information remains unchanged. This article was previously published in the March 2015 edition of Medicare A Connection, Pages 10-13.*

Provider types affected

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

Provider action needed

CR 9078 informs MACs that the Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) and concluded that implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Make sure that your billing staffs are aware of these changes.

Background

Permanent cardiac pacemakers refer to a group of self-contained, battery-operated, implanted devices that send electrical stimulation to the heart through one or more implanted leads. Single chamber pacemakers typically target either the right atrium or right ventricle.

Dual chamber pacemakers stimulate both the right atrium and the right ventricle.

On August 13, 2013, CMS issued an NCD, in which CMS concluded that implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible, symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block.

Symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example, syncope, seizures, congestive heart failure, dizziness, or confusion).

The following indications are covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Documented non-reversible symptomatic bradycardia due to sinus node dysfunction.
2. Documented non-reversible symptomatic bradycardia due to second degree and/or third degree atrioventricular block.

The following indications are non-covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Reversible causes of bradycardia such as electrolyte abnormalities, medications or drugs, and hypothermia.
2. Asymptomatic first degree atrioventricular block. *(exception)
3. Asymptomatic sinus bradycardia.
4. Asymptomatic sino-atrial block or asymptomatic sinus arrest. *(exception)
5. Ineffective atrial contractions (for example, chronic atrial fibrillation or flutter, or giant left atrium) without symptomatic bradycardia. *(exception)
6. Asymptomatic second degree atrioventricular block of Mobitz Type I unless the QRS complexes are prolonged or electrophysiological studies have demonstrated that the block is at or beyond the level of the his bundle (a component of the electrical conduction system of the heart).
7. Syncope of undetermined cause. *(exception)
8. Bradycardia during sleep.
9. Right bundle branch block with left axis deviation (and other forms of fascicular or bundle branch block) without syncope or other symptoms of intermittent atrioventricular block. *(exception)
10. Asymptomatic bradycardia in post-myocardial infarction patients about to initiate long-term beta-blocker drug therapy.

See **NCD**, next page

NCD

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11. Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of tachycardia. *(exception)

12. A clinical condition in which pacing takes place only intermittently and briefly, and which is not associated with a reasonable likelihood that pacing needs will become prolonged.

MACs will determine coverage under section 1862(a)(1)(A) of the Social Security Act for any other indications for the implantation and use of single chamber or dual chamber cardiac pacemakers that are not specifically addressed in this NCD.

Notes: MACs shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the practitioner and/or provider of the service that documentation is on file verifying the patient has non-reversible symptomatic bradycardia (symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example, syncope, seizures, congestive heart failure, dizziness, or confusion)).

Note: The final decision memorandum addresses Medicare policy specific to implanted permanent cardiac pacemakers, single chamber or dual chamber, for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block.

Medicare coverage of removal/replacement of implanted permanent cardiac pacemakers, single chamber or dual chamber, for the above-noted indications, were not addressed in the final decision. Therefore, it is expected that MACs will continue to apply the reasonable and necessary standard in determining local coverage within their respective jurisdictions for removal/replacement of implanted permanent cardiac pacemakers, single chamber or dual chamber.

Cardiac pacemaker Healthcare Common Procedure Coding System (HCPCS) and *Current Procedural Terminology* (*CPT*®) codes

Professional claims

Effective for claims with dates of service on or after August 13, 2013, MACs shall pay for implanted permanent cardiac pacemakers, single chamber or dual chamber, for one of the following *CPT*® codes if the claim contains at least one of the designated diagnosis codes in addition to the – KX modifier:

33206 - Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial;

33207 - Insertion or replacement of permanent pacemaker

with transvenous electrode(s) – ventricular; or

33208 - Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial and ventricular.

Institutional claims

Effective for claims with dates of service on or after August 13, 2013, MACs shall pay for implanted permanent cardiac pacemakers, single chamber or dual chamber, for the following HCPCS codes if the claim contains at least one of the designated *CPT*® codes, and at least one of the designated diagnosis codes, in addition to the –KX modifier:

- C1785 – Pacemaker, dual chamber, rate-responsive (implantable);
- C1786 – Pacemaker, single chamber, rate-responsive (implantable);
- C2619 – Pacemaker, dual chamber, nonrate-responsive (implantable);
- C2620 – Pacemaker, single chamber, nonrate-responsive (implantable);
- *33206* – Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial
- *33207* – Insertion or replacement of permanent pacemaker with transvenous electrode(s) – ventricular
- *33208* – Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial and ventricular

MACs have discretion to cover or not cover the following *CPT*® codes:

- *33227* – Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system; or
- *33228* – Removal of permanent pacemaker pulse

See **NCD**, next page

NCD

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generator with replacement of pacemaker pulse generator; dual lead system.

Cardiac pacemaker ICD-9/ICD-10 diagnosis codes

Professional claims

Claims with dates of service on and after August 13, 2013, for implanted permanent cardiac pacemakers, single chamber or dual chamber, are covered if submitted with one of the following *CPT*® codes: *33206*, *33207*, or *33208*, and that contain at least one of the following ICD-9/ICD-10 diagnosis codes (upon ICD-10 implementation) listed below in addition to the –KX modifier:

- 426.0 Atrioventricular block, complete/ I44.2 Atrioventricular block, complete;
- 426.12 Mobitz (type) II atrioventricular block/ I44.1 Atrioventricular block, second degree;
- 426.13 Other second degree atrioventricular block/ I44.1 Atrioventricular block, second degree;
- 427.81 Sinoatrial node dysfunction/ I49.5 Sick sinus syndrome; or
- 746.86 Congenital heart block/ Q24.6 – Congenital heart block.

The following diagnosis codes can be covered at your MACs discretion if submitted with at least one of the *CPT*® codes and diagnosis codes listed above in addition to the –KX modifier:

- 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block;
- 426.11 First degree atrioventricular block/ I44.0 Atrioventricular block first degree;
- 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block/ I45.19 Other right bundle-branch block;
- 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia;
- 427.31 Atrial fibrillation/ I48.1 Persistent atrial fibrillation/ I48.91, Unspecified atrial fibrillation;
- 427.32 Atrial flutter/ I48.3 Typical atrial flutter/ I48.4 Atypical atrial flutter or I48.91 Unspecified atrial fibrillation; or
- 780.2 Syncope and collapse/R55 Syncope and collapse (R55 is the ICD-10 dx code but is not payable upon implementation of ICD-10 and is only included here for information purposes).

Institutional claims

For coverage of claims with dates of service on and after August 13, 2013, for implanted permanent cardiac pacemakers, single chamber or dual chamber, using HCPCS codes: C1785, C1786, C2619, C2620, *33206, 33207*, or *33208*, the claim must contain at least one of the following procedure codes:

- 37.81 Initial insertion of single chamber device, not specified as rate responsive
- 37.82 Initial insertion of single chamber device, rate responsive
- 37.83 Initial insertion of single chamber device and at least one of the following diagnosis codes in addition to the –KX modifier:
- 426.0 Atrioventricular block, complete;
- 426.12 Mobitz (type) II atrioventricular block;
- 426.13 Other second degree atrioventricular block;
- 427.81 Sinoatrial node dysfunction; or
- 746.86 Congenital heart block.

The following diagnosis codes can be covered, at the MAC's discretion, if submitted with at least one of the diagnosis codes listed above in addition to the –KX modifier:

- 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block;
- 426.11 First degree atrioventricular block/ I44.0 Atrioventricular block first degree;
- 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block/ I45.19 Other right bundle-branch block;
- 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia;

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- 427.31 Atrial fibrillation/ I48.1 Persistent atrial fibrillation/ I48.91, Unspecified atrial fibrillation;
- 427.32 Atrial flutter/ I48.3 Typical atrial flutter/ I48.4 Atypical atrial flutter or I48.91 Unspecified atrial fibrillation; or
- 780.2 Syncope and collapse/R55 Syncope and collapse (R55 is the ICD-10 dx code but is not payable upon implementation of ICD-10 and is only included here for information purposes).

Professional claims

MACs shall return claims lines for implanted permanent cardiac pacemakers, single chamber or dual chamber, containing one of the following *CPT*® codes: *33206*, *33207*, or *33208*, as unprocessable when the -KX modifier is not present.

When returning such claims, MACs shall use the following messages:

- Claim adjustment reason code (CARC) 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.
- Remittance advice remarks code (RARC) N517 - Resubmit a new claim with the requested information.

MACs shall return to providers claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, when any of the following are not present on the claim: At least one HCPCS code: C1785, C1786, C2619, or C2620, at least one *CPT*® code: *33206, 33207, 33208, 33227, 33228*, at least one diagnosis code: 426.0/I44.2, 426.12/I44.1, 426.13/I44.1, 427.81/I49.5, 746.86/Q24.6, at least one procedure code: 37.81/0JH604Z, 0JH634Z, 0JH804Z, 0JH834Z, 37.82/0JH605Z, 0JH635Z, 0JH805Z, 0JH835Z, 38.83/0JH606Z, 0JH636Z, 0JH806Z, 0JH836Z, and the -KX modifier is not present on the claim.

Cardiac pacemaker non-covered ICD-10 diagnosis code

For claims with dates of service on or after implementation of ICD-10, for implanted permanent cardiac pacemakers, single chamber or dual chamber, using one of the following HCPCS and/or *CPT*® codes: C1785, C1786, C2619, C2620, *33206, 33207*, or *33208*, ICD-10 diagnosis code R55 is not covered even if the claim contains one of the valid diagnosis codes listed above.

MACs will use the following messages when denying claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, containing one of the following HCPCS and/or *CPT*® codes: C1785, C1786, C2619, C2620, *33206, 33207*, or *33208*, and ICD-10 diagnosis code R55 with the following messages:

- CARC 96: Non-covered charge(s).
- RARC N569: Not covered when performed for the reported diagnosis.
- Group code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed advance beneficiary notice (ABN) is on file.
- Group code PR assigning financial liability to the beneficiary, if a claim is received with occurrence code 32 indicating a signed ABN is on file, or occurrence code 32 is present with modifier GA.

Additional information

The official instruction, CR 9078, was issued to your MAC via two transmittals. The first transmittal updates the *Medicare Claims Processing Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3384CP.pdf* .

The second updates the Medicare *National Coverage Determination Manual* and it is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R186NCD.pdf*.

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

Document history

- This article was revised May 26, 2015, to add a reference to *MLN Matters® article MM8525* which allows payment for nationally covered implanted permanent cardiac pacemakers, single chamber or dual chamber, for the indications outlined in the Medicare *National Coverage Determinations Manual*.
- This article was revised October 28, 2015 to reflect the revised CR 9078 issued October 26. The CR was revised to direct the MACs to implement the NCD at the local level until Medicare system instructions are revised and Medicare system changes are implemented.

MLN Matters® Number: MM9078
Related Change Request (CR) #: CR 9078
Related CR Release Date: October 26, 2015
Effective Date: August 13, 2015
Related CR Transmittal #: R3384CP and R186NCD
Implementation Date: July 6, 2015

New values for incomplete colonoscopies billed with modifier 53

Provider types affected

This *MLN Matters*® article is intended for providers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries related to incomplete colonoscopies billed with modifier *53*.

Provider action needed

Stop – impact to you

Change request (CR) 9317, from which this article is taken, revises the method for calculating payment for discontinued procedures. New payment rates will apply when modifier *53* (discontinued procedure) is appended to codes *44388*, *45378*, G0105, and G0121.

Caution – what you need to know

Effective for services performed on or after January 1, 2016, the Medicare physician fee schedule (MPFS) database will have specific values for *Current Procedural Terminology* (*CPT*®) codes *44388-53*; *45378-53*; G0105-*53*; and G0121-*53*.

Go – what you need to do

Make sure that your billing staffs are aware of these revisions for calculating payments for discontinued procedures using modifier *53*. Incomplete colonoscopies are reported with modifier *53*. Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes.

Background

According to *CPT*® instruction, prior to 2015, an incomplete colonoscopy was defined as a colonoscopy that did not evaluate the colon past the splenic flexure (the distal third of the colon). Physicians were previously instructed to report an incomplete colonoscopy with *45378* and append modifier *53* (discontinued procedure), which is paid at the same rate as a sigmoidoscopy.

In 2015, the *CPT*® instruction changed the definition of an incomplete colonoscopy to a colonoscopy that does not evaluate the entire colon. The 2015 *CPT*® manual states:

"When performing a diagnostic or screening endoscopic procedure on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, report *45378* (colonoscopy) or *44388* (colonoscopy through stoma) with modifier *53* and provide appropriate documentation."

Therefore, in accordance with the change in *CPT*® manual language, the Centers for Medicare & Medicaid Services (CMS) has applied specified values in the MPFS database for the following codes:

- *44388-53* (colonoscopy through stoma);
- *45378-53* (colonoscopy);
- G0105-*53* (colorectal cancer screening; colonoscopy on individual at high risk; and
- G0121-*53* (colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk).

Effective for services performed on or after January 1, 2016, the MPFS database will have specific values for the codes listed above. Given that the new *CPT*® definition of an incomplete colonoscopy also include colonoscopies where the colonoscope is advanced past the splenic flexure but not to the cecum, CMS has established new values for incomplete diagnostic and screening colonoscopies performed on or after January 1, 2016.

Incomplete colonoscopies are reported with modifier *53*. Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes.

Note: Chapters 12, Section 30.1 and Chapter 18, Section 60.2 of the *Medicare Claims Processing Manual* have been revised to reflect the information contained in CR 9317.

Additional information

The official instruction, CR 9317 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3368CP.pdf*.

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

MLN Matters® Number: MM9317
Related Change Request (CR) #: CR 9317
Related CR Release Date: October 9, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3368CP
Implementation Date: January 1, 2016

Update to the list of compendia used off-label in an anti-cancer chemotherapeutic regimen

Provider types affected

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

What you need to know

This article is based on change request (CR) 9386 which announces that effective for services on or after August 12, 2015, the Centers for Medicare & Medicaid Services (CMS) is adding Wolters Kluwer Lexi-Drugs® to the list of authoritative compendia for use in the determination of a medically-accepted indication of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen.

Background

The Social Security Act (Section 1861(t)(2)(B)(ii)(I); as amended by the Deficit Reduction Act of 2005 (Pub. Law 109-171; Section 6001(f)(1)), recognized the following three compendia as authoritative sources for use in the determination of a "medically accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

1. American Medical Association Drug Evaluations (AMA-DE);
2. United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication; and
3. American Hospital Formulary Service-Drug Information (AHFS-DI).

These authoritative sources could be used in the determination of a "medically-accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen, unless:

- The Secretary of Health and Human Services (HHS) determined that the use is not medically appropriate; or
- The use is identified as not indicated in one or more such compendia.

This provision was implemented through instructions to the MACs in the *Medicare Benefit Policy Manual* (Chapter 15, Section 50.4.5).

Due to changes in the pharmaceutical reference industry:

- The AHFS-DI was the only remaining statutorily-named compendia available for CMS reference;
- The AMA-DE and USP-DI are no longer published;

- Thomson Micromedex designated drug points was the successor to USP-DI; but
- Drug points has since been deleted from the list of recognized compendia.

In January 2008, CMS established, via the physician fee schedule final rule for 2008:

- A process for revising the list of compendia, as authorized under the Social Security Act (Section 1861(t)(2)), and
- A definition for "compendium."

This sub-regulatory process for revising the list of compendia is described in the *Medicare Benefit Policy Manual* (Chapter 15, Section 50.4.5.1).

Based on this process, CMS updated the list in 2008 to include the following four compendia:

1. **Existing** – American Hospital Formulary Service-Drug Information (AHFS-DI),
2. **Effective June 5, 2008** – National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium,
3. **Effective June 10, 2008** – Truven Health Analytics Micromedex DrugDex, and
4. **Effective July 2, 2008** – Elsevier/Gold Standard Clinical Pharmacology.

On August 12, 2015, CMS announced the addition of Wolters Kluwer Lexi-Drugs® to the above list of four compendia used by the Medicare program in the determination of a "medically-accepted indication" for off-label drugs and biologics used in an anticancer chemotherapeutic treatment regimen. This is effective for services on or after August 12, 2015.

See **CHEMOTHERAPY**, next page

Reporting of type of bill 014x for billing screening of Hepatitis C virus in adults

Provider types affected

This *MLN Matters*® article is intended for providers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries related to screening of Hepatitis C virus (HCV) in adults.

Provider action needed

This article is based on change request (CR) 9360, which adds type of bill (TOB) 014x (Hospital Other Part B) as an applicable TOB for the screening of HCV when submitted for non-patient laboratory specimen (HCPCS Code G0472).

Transmittal 3215, CR 8871, titled, "Screening for Hepatitis C Virus (HCV) in Adults," omitted TOB 014x from the list of applicable TOBs for HCV screening. Payment for these services submitted on TOB 014x will be based on the laboratory fee schedule. Make sure your billing personnel are aware of this change.

Background

As a result of CR 9360, appropriate TOBs for the screening of HCV other than non-patient laboratory specimen include:

- 013x;
- 014x;
- 071x;
- 077x; and
- 085x.

Note that MACs will not search for claims with G0472, submitted under TOB 014x with dates of service on or after June 2, 2014, but received before April 4, 2016, but the MACs may adjust claims that are brought to their attention. In addition, MACs will apply the same logic for G0472 on TOB 14x as described in *MLN Matters*® articles MM8871 and MM9200.

Additional information

The official instruction, CR 9360 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3393CP.pdf*.

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

MLN Matters® Number: MM9360
Related Change Request (CR) #: CR 9360
Related CR Release Date: November 5, 2015
Effective Date: June 2, 2014
Related CR Transmittal #: R3393CP
Implementation Date: April 4, 2016

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Further details on this issue are in the revised Chapter 15, Section 50.4.5.1 of the *Medicare Benefit Policy Manual*, which is an attachment to CR 9386.

Additional information

The official instruction, CR 9386, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R212BP.pdf*.

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

MLN Matters® Number: MM9386
Related Change Request (CR) #: CR 9386
Related CR Release Date: November 6, 2015
Effective Date: August 12, 2015
Related CR Transmittal #: R212BP
Implementation Date: February 10, 2016

January 2016 changes to the laboratory NCD edit software

***Note**: This article was revised November 6, 2015, to reflect the revised change request (CR) 9352 issued November 5, 2015. The CR was revised to change the effective date. In addition, the transmittal number, CR release date, and the Web address for accessing CR 9352 are revised. All other information remains the same. This information was previously published October 2015 Medicare A Connection, Page 18.*

Provider types affected

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

Provider action needed

CR 9352 informs MACs about the changes that will be included in the January 2016 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

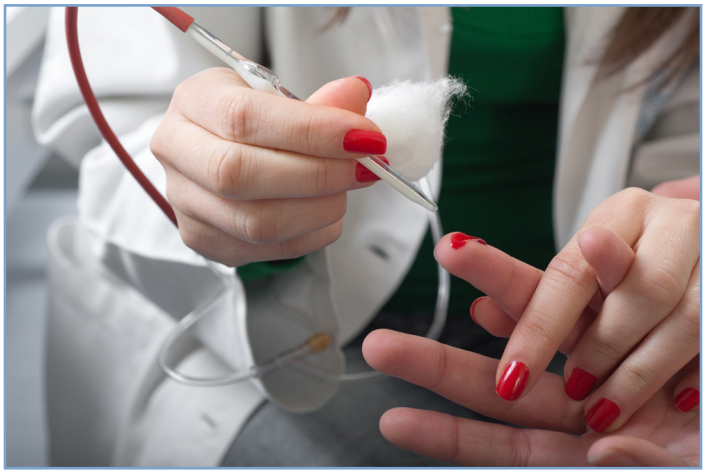
Background

The national coverage determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published November 23, 2001. Nationally uniform software was developed and incorporated in Medicare's claim processing systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective April 1, 2003.

CR 9352 communicates requirements to Medicare's shared system maintainers (SSMs) and MACs notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for January 2016. Changes are being made to the NCD code lists as follows:

- Add ICD-10-CM codes N131 and N132 to the list of ICD-10-CM codes that are covered by Medicare for the urine culture, bacterial (190.12) NCD.
- Add ICD-10-CM code I481 to the list of ICD-10-CM codes that are covered by Medicare for the partial thromboplastin time (PTT) (190.16) NCD.
- Add ICD-10-CM code S069X0A to the list of ICD-10-CM codes that are covered by Medicare for the prothrombin time (PT) (190.17) NCD.
- Add ICD-10- ICD-10-CM code I481 to the list of ICD-10-CM codes that are covered by Medicare for the thyroid testing (190.22) NCD.

These changes are effective for services furnished on or after October 1, 2015.



Additional information

The official instruction, CR 9352, issued to your MAC regarding this change, is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3396CP.pdf*.

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

Document history

Date	Description
November 6, 2015	This article was revised November 6, 2015, to reflect the revised CR 9352 issued November 5, 2015. The CR was revised to change the effective date. In addition, the transmittal number, CR release date, and the Web address for accessing CR 9352 are revised.

MLN Matters® Number: MM9352 *Revised*
Related Change Request (CR) #: CR 9352
Related CR Release Date: November 5, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3396CP
Implementation Date: January 4, 2016

ICD-10-CM diagnosis codes for bone mass measurement

Provider types affected

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

Provider action needed

The Centers for Medicare & Medicaid Services (CMS) will implement change request (CR) 9252 on January 4, 2016, effective October 1, 2015. (See related *MLN Matters*® article MM9252.) This CR establishes the list of covered conditions and corresponding ICD-10-CM diagnosis codes approved for bone mass measurement studies according to the requirements set forth in national coverage determination (NCD) 150.3. CR 9252 and accompanying spreadsheet inadvertently omitted the condition of osteopenia and the ICD-10-CM codes that describe it which are classified to subcategory M85.8 - Other specified disorders of bone density and structure.

The codes and conditions identified within this subcategory are considered covered indications for bone mass measurement under NCD 150.3 and providers should report these appropriately according to medical documentation. Additional guidance and education as to the updated complete list of covered indications will be forthcoming as CMS continues to review this issue and the system updates required.

Background

Under ICD-9-CM, the term "Osteopenia" was indexed to ICD-9-CM diagnosis code 733.90 (Disorder of bone and cartilage). This code was listed as a covered condition under the business requirement 5521.1.1 for CR 5521/ NCD 150.3, dated May 11, 2007, when reported with *CPT*® code *77080*®. (See related *MLN Matters*® article MM5521.)

The accompanying *Benefit Policy Manual*, Publication 100-02, Chapter 15, Section 80.5.6, Beneficiaries Who May Be Covered, includes: 2. An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia, or vertebral fracture.

Under ICD-10-CM, the term "Osteopenia" is indexed to ICD-10-CM subcategory M85.8 - Other specified disorders of bone density and structure, within the ICD-10-CM alphabetic index. The codes within this subcategory were inadvertently omitted from the CMS spreadsheet that accompanied CR 9252 containing the list of covered conditions and corresponding diagnosis codes. These are considered covered for NCD 150.3 indications.

Below is the list of ICD-10-CM diagnosis codes within subcategory M85.8- that providers may report as covered indications in addition to the current list provided in CR 9252 and its accompanying CMS spreadsheet.

- M85.80 Other specified disorders of bone density and structure, unspecified site
- M85.811 Other specified disorders of bone density and structure, right shoulder
- M85.812 Other specified disorders of bone density and structure, left shoulder
- M85.821 Other specified disorders of bone density and structure, right upper arm
- M85.822 Other specified disorders of bone density and structure, left upper arm
- M85.831 Other specified disorders of bone density and structure, right forearm
- M85.832 Other specified disorders of bone density and structure, left forearm
- M85.841 Other specified disorders of bone density and structure, right hand
- M85.842 Other specified disorders of bone density and structure, left hand
- M85.851 Other specified disorders of bone density and structure, right thigh
- M85.852 Other specified disorders of bone density and structure, left thigh
- M85.861 Other specified disorders of bone density and structure, right lower leg
- M85.862 Other specified disorders of bone density and structure, left lower leg
- M85.871 Other specified disorders of bone density and structure, right ankle and foot
- M85.872 Other specified disorders of bone density and structure, left ankle and foot
- M85.88 Other specified disorders of bone density and structure, other site
- M85.89 Other specified disorders of bone density and structure, multiple sites

Additional information

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

MLN Matters® Number: SE1525
Related Change Request (CR) #: CR 9252
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A

Implementation Date: N/A

Medicare coverage of screening for lung cancer with low-dose computed tomography

Provider types affected

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

Provider action needed

Change request (CR) 9246 informs MACs that Medicare covers lung cancer screening with low-dose computed tomography (LDCT) if all eligibility requirements listed in the national coverage determination (NCD) are met. Make sure that your billing staffs are aware of these changes.

Background

Section 1861(ddd)(1) of the *Social Security Act (the Act)* authorizes the Centers for Medicare & Medicaid Services (CMS) to add coverage of "additional preventive services" through the NCD process. The "additional preventive services" must meet all of the following criteria:

- Be reasonable and necessary for the prevention or early detection of illness or disability;
- Be recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
- Be appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the evidence for lung cancer screening with low dose computed tomography (LDCT) and determined that the criteria listed above were met, enabling CMS to cover this "additional preventive service" under Medicare Part B.

CMS issued NCD 210.14 on August 21, 2105, that provides for Medicare coverage of screening for lung cancer with LDCT. Effective for claims with dates of service on and after February 5, 2015, Medicare beneficiaries must meet all of the following criteria:

- Be 55–77 years of age
- Be asymptomatic (no signs or symptoms of lung cancer)
- Have a tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes)
- Be a current smoker or one who has quit smoking within the last 15 years
- Receive a written order for lung cancer screening with LDCT that meets the requirements described in the NCD

Written orders for lung cancer LDCT screenings must be appropriately documented in the beneficiary's medical record, and must contain the following information:

- Date of birth
- Actual pack–year smoking history (number)
- Current smoking status, and for former smokers, the number of years since quitting smoking
- A statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer)
- The national provider identifier (NPI) of the ordering practitioner

Counseling and shared decision-making visit

Before the first lung cancer LDCT screening occurs, the beneficiary must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision-making visit that includes the following elements and is appropriately documented in the beneficiary's medical records:

- Must be furnished by a physician (as defined in section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) as defined in Section 1861(aa)(5) of the Act); and
- Must include all of the following elements:
    - Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting;
    - Shared decision-making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
    - Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of co-morbidities, and ability or willingness to undergo diagnosis and treatment;
    - Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions; and,

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- If appropriate, the furnishing of a written order for lung cancer screening with LDCT.

Written orders for subsequent annual LDCT screens may be furnished during any appropriate visit with a physician or qualified non-physician practitioner (PA, NP, or CNS)

There is also specific criteria that the reading radiologist and radiology imaging facility must meet. The radiology imaging facility must collect and submit data to a CMS-approved registry for each LDCT lung cancer screening performed. The data collected and submitted to a CMS-approved registry must include specific elements. Information regarding CMS-approved registries is posted at: *http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Lung-Cancer-Screening-Registries.html*.

Coinsurance and deductibles

Medicare coinsurance and Part B deductible are waived for this preventive service.

Health care common procedure coding system (HCPCS) codes

Effective for claims with dates of service on and after February 5, 2015, the following HCPCS codes are used for lung cancer screening with LDCT:

- **G0296** – Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)
- **G0297** – Low dose CT scan (LDCT) for lung cancer screening

In addition to the HCPCS code, these services must be billed with ICD-10 diagnosis code Z87.891 (personal history of tobacco use/personal history of nicotine dependence), ICD-9 diagnosis code V15.82.

Note: **Contractors shall apply contractor-pricing to claims containing HCPCS G0296 and G0297 with dates of service February 5, 2015, through December 31, 2015.**

Institutional billing requirements

Effective for claims with dates of service on and after February 5, 2015, providers may use the following types of bill (TOBs) when submitting claims for lung cancer screening, HCPCS codes G0296 and G0297: 12x, 13x, 22x, 23x, 71x (G0296 only), 77x (G0296 only), and 85x.

Medicare will pay for these services as follows:

- **Outpatient hospital departments** – TOBs 12x and 13x - based on outpatient prospective payment system (OPPS)
- **Skilled nursing facilities (SNFs)** – TOBs 22x and 23x – based on the Medicare physician fee schedule (MPFS)
- **Critical access hospitals (CAHs)** – TOB 85x – based on reasonable cost
- **CAH Method II** – TOB 85x with revenue code 096x, 097x, or 098x based on the lesser of the actual charge or the MPFS (115 percent of the lesser of the fee schedule amount and submitted charge) for HCPCS G0296 only;
- **Rural health clinics (RHCs)** – TOB 71x – based on the all-inclusive rate for HCPCS G0296 only; and
- **Federally qualified health centers (FQHCs)** – TOB 77x – based on the PPS rate for HCPCS G0296 only.

Note: For outpatient hospital settings, as in any other setting, services covered under this NCD must be ordered by a primary care provider within the context of a primary care setting and performed by an eligible Medicare provider for these services.

Claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs), group codes

MACs will use the following CARCs, RARCs, and group codes when denying payment for LDCT lung cancer screening, HCPCS G0296 and G0297:

Submitted on a TOB other than 12x, 13x, 22x, 23x, 71x, 77x, or 85x:

- **CARC 170** – Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N95** – This provider type/provider specialty may not bill this service.
- **Group code CO** (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: For modifier GZ, MACs will use CARC 50.

For TOBs 71x and 77x when HCPCS G0296 is billed on the same date of service with another visit (this does not apply to initial preventive physical exams for 71x TOBs):

- **CARC 97** – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the

See **TOMOGRAPHY**, next page

TOMOGRAPHY

From previous page

835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- **RARC M15** – Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

Note: 77x TOBs will be processed through the integrated outpatient code editor under the current process.

- **Group code CO** assigning financial liability to the provider.

Where a previous HCPCS G0297 is paid in history in a 12-month period (at least 11 full months must elapse from the date of the last screening):

- **CARC 119** – Benefit maximum for this time period or occurrence has been reached.
- **RARC N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- **Group code CO** assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: For modifier GZ, MACs will use CARC 50.

Because the beneficiary is not between the ages of 55 and 77 at the time the service was rendered (line-level):

- **CARC 6**: – The procedure/revenue code is inconsistent with the patient's age. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **Group code CO** (contractual obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Note: For modifier GZ, MACs will use CARC 50.

Because the claim line was not billed with ICD-10 diagnosis Z87.891:

- **CARC 167** – This (these) diagnosis(es) is (are) not covered. **Note**: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- **RARC N386** – This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item

or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

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

Note: For modifier GZ, MACs will use CARC 50.

Additional information

The official instruction, CR 9246, consists of two transmittals:

1. *Transmittal R3374CP* updates the *Medicare Claims Processing Manual*
2. *Transmittal R185NCD* updates the *Medicare NCD Manual*

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

MLN Matters® Number: MM9246
Related Change Request (CR) #: 9246
Related CR Release Date: October 15, 2015
Effective Date: February 5, 2015
Related CR Transmittal #: R3374CP and R185NCD
Implementation Date: January 4, 2016

Local Coverage Determinations

This section of *Medicare A 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 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.

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

Advance beneficiary notice

- **Modifier GZ** must be used when providers, 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 providers, 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 (LCD) must append the billed service with **modifier GA or GZ.**

First Coast Service Options Inc provides current and draft local coverage determinations (LCDs), when they exist, for Medicare-covered procedure codes.

Not every procedure code is covered by an LCD. *Click here* **to look up current LCDs**

Revised LCDs

Azacitidine (Vidaza®) – revision to the LCD

LCD ID number: L33266 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for azacitidine (Vidaza®) was revised to add ICD-10-CM diagnosis C93.10-C93.12 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) **on or after November 5, 2015**.

Effective date

This LCD revision is effective for **claims processed on or after October 29, 2015**, for **services rendered on or after October 1, 2015**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://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*.

Bone mineral density studies – revision to the LCD

LCD ID number: L36356 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on direction from the Centers for Medicare & Medicaid Services (CMS), the local coverage determination (LCD) for bone mineral density studies was revised to add ICD-10-CM diagnosis codes M85.80*, M85.811*, M85.812*, M85.821*, M85.822*, M85.831*, M85.832*, M85.841*, M85.842*, M85.851*, M85.852*, M85.861*, M85.862*, M85.871*, M85.872*, M85.88*, and M85.89* to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (*CPT*) codes *77080* and *77085*.

The updated LCD will be available on the Medicare coverage database (MCD) **on or after November 12, 2015**.

Effective date

This LCD revision is effective for **claims processed on or after November 2, 2015, for Part B** and **on or after November 4, 2015 for Part A**, for **services rendered on or after October 1, 2015**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://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*.

Cardiology-non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET– revision to the LCD

LCD ID number: L36209 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for cardiology-non-emergent outpatient testing: exercise stress test, stress echo, MPI SPECT, and cardiac PET was revised to add ICD-10-CM diagnosis codes I05.0- I05.9, I06.0- I06.9, I07.0- I07.9, I08.0- I08.9, I09.1, I09.81, I09.89, I09.9, I35.0- I35.9, I36.0- I36.9, and I37.0- I37.9 for *Current Procedural Terminology* (*CPT*) codes *93350*, *93351*, and *93352* to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) **on or after November 5, 2015**.

Effective date

This LCD revision is effective for **claims processed on or after November 2, 2015**, for **services rendered on or after October 1, 2015**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://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*.

3D interpretation and reporting of imaging studies – revision to the LCD

LCD ID number: L33256 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for 3D interpretation and reporting of imaging studies was revised to add ICD-10-CM diagnosis code R93.8 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) **on or after November 5, 2015**.

Effective date

This LCD revision is effective for **claims processed on or after November 2, 2015**, for **services rendered on or after October 1, 2015**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://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*.

Scanning computerized ophthalmic diagnostic imaging (SCODI) – revision to the LCD

LCD ID number: L33751 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for scanning computerized ophthalmic diagnostic imaging (SCODI) was revised to add ICD-10-CM diagnosis codes H43.00-H43.9 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (*CPT*) codes *92133* and *92134*.

In addition, ICD-10-CM diagnosis codes H59.031-H59.039 were added to the "Indications and Limitations of Coverage and/or Medical Necessity" and "ICD-10 Codes that Support Medical Necessity" sections of the LCD for *CPT* codes *92133* and *92134*.

The updated LCD reflecting ICD-10-CM diagnosis codes H43.00-H43.9 is available on the Medicare coverage database (MCD) **on or after November 5, 2015**.

The updated LCD reflecting ICD-10-CM diagnosis codes H59.031-H59.039 will be available on the Medicare coverage database (MCD) **on or after November 19, 2015**.

Effective date

The LCD revision related to the addition of ICD-10-CM diagnosis codes H43.00-H43.9 is effective for **claims processed on or after October 29, 2015**, for **services rendered on or after October 1, 2015**.

The LCD revision related to the addition of ICD-10-CM diagnosis codes H59.031-H59.039 is effective for **claims processed on or after November 19, 2015**, for **services rendered on or after October 1, 2015**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://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*.

Medicare signature requirements

The Medicare requirement to authenticate the medical record is to ensure the services rendered have been thoroughly documented and authenticated by the author of the medical record entry. *Click here* for information on Medicare's signature requirements and how adhering to these requirements can prevent impacts to your claims.

Fluorescein angiography – revision to the LCD

LCD ID number: L33997 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for fluorescein angiography was revised to add ICD-10-CM diagnosis codes H59.031-H59.039 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (*CPT*) code *92235*. The updated LCD will be available on the Medicare coverage database (MCD) **on or after November 19, 2015**.

Effective date

This LCD revision is effective for **claims processed on or after November 19, 2015**, **for services rendered on or after October 1, 2015**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://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*.

Gemcitabine (Gemzar®) – revision to the LCD

LCD ID number: L33726 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for gemcitabine (Gemzar®) was revised to add ICD-10-CM diagnosis codes C45.1 and C67.0-C67.9 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) **on or after November 19, 2015**.

Effective date

This LCD revision is effective for **claims processed on or after November 5, 2015**, for **services rendered on or after October 1, 2015**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://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*.

Noncovered services – revision to the LCD

LCD ID number: L33777 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for noncovered services was revised to remove *Current Procedural Terminology* (*CPT*®) code *0330T* from the "*CPT*/HCPCS Codes" section of the LCD under the subtitles "Procedures for Part A" and "Procedures for Part B."

CPT® code *0330T* (tear film imaging, unilateral or bilateral, with interpretation and report) will be added to the new LCD for diagnostic evaluation and medical management of moderate-severe dry eye disease (DED) (L36232) as a noncovered service.

The new LCD addresses both the diagnostic evaluation and medical management of moderate –severe DED.

Effective date

This LCD revision is effective for **services rendered on or after November 22, 2015**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://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*.

Ophthalmoscopy – revision to the LCD

LCD ID number: L34017 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for ophthalmoscopy was revised to add ICD-10-CM diagnosis codes H59.031-H59.039 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD for *Current Procedural Terminology* (*CPT*) codes *92225* and *92226*.

The updated LCD will be available on the Medicare coverage database (MCD) **on or after November 19, 2015**.

Effective date

This LCD revision is effective for **claims processed on or after November 19, 2015**, for **services rendered on or after October 1, 2015**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://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*.

Polysomnography and sleep testing – revision to the LCD

LCD ID number: L33405 (Florida, Puerto Rico/U.S. Virgin Islands)

The Local Coverage Determination (LCD) for polysomnography and sleep testing has been revised based on data analysis and claim review that identified repeat sleep study testing within a six month to one year period of time for both initial diagnostic testing and titration of positive airway pressure (PAP) therapy.

The indications/limitations and utilization for such testing was clarified.

Additionally, the LCD has been updated given the addition of new codes, as well as to add language related to the limited coverage of the titration of a covered oral appliance for the treatment of obstructive sleep apnea.

(The oral appliance must meet the requirements of the durable medical equipment Medicare administrative contractor (DME MAC) LCD.)

Effective date

This LCD is effective for **services rendered on or after December 21, 2015**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://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*.

Diagnostic colonoscopy – revision to the LCD

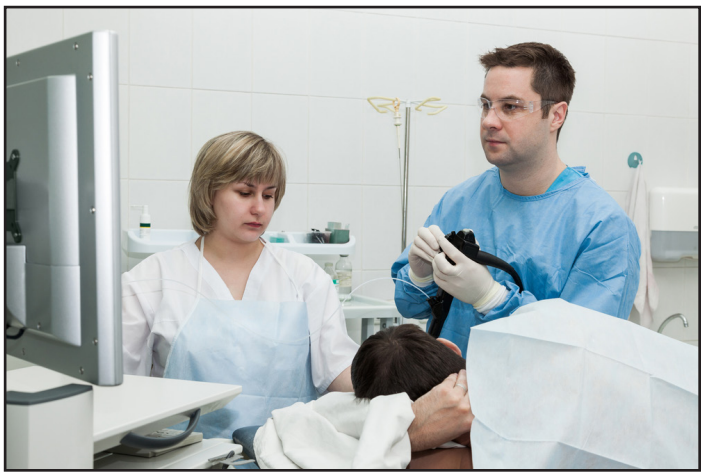
LCD ID number: L33671 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for diagnostic colonoscopy was revised to add ICD-10-CM diagnosis codes C45.9, C79.9, D13.2, D13.30, D13.39, D19.1, K57.00 – K57.01, K59.00 – K59.09, and K63.5 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD. In addition, the LCD was revised to expand the ulcerative colitis ICD-10-CM diagnosis range to K51.00 – K51.919.

The updated LCD will be available on the Medicare coverage database (MCD) November 12, 2015.

Effective date

This LCD revision is effective for claims processed **on or after November 6, 2015**, for services rendered **on or after October 1, 2015**. First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://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*.

Susceptibility studies – revision to the LCD

LCD ID number: L33755 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for susceptibility studies was revised to add ICD-10-CM diagnosis code range B96.0 - B96.89 to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

In addition, ICD-10 diagnosis code range M00.10 - M00.19 was removed from the "ICD-10 Codes that Support Medical Necessity" section of the LCD and ICD-10 diagnosis code range M00.00 - M00.89 was added to the "ICD-10 Codes that Support Medical Necessity" section of the LCD.

The updated LCD will be available on the Medicare coverage database (MCD) **on or after November 19, 2015**.

Effective date

This LCD revision is effective for **claims processed on or after November 12, 2015**, for **services rendered on or after October 1, 2015**.

First Coast Service Options Inc. LCDs are available through the CMS Medicare coverage database at *http://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*.

Claims processing guidance for implementing ICD-10 – A re-issue of MM7492

Note: This article was revised October 30, 2015, to add language to Table A regarding inpatient psychiatric facilities (IPFs) and long term care hospital (LTCH) PPS. All other information remains the same. This article was previously published in the August 2014 edition of Medicare A Connection, Pages 45-50.

Provider types affected

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

Provider action needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA.

The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2015. As a result of CR 7492 (and related *MLN Matters*® article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013, implementation date for ICD-10. **This article updates MM7492 to reflect the October 1, 2015, implementation date**. Make sure your billing and coding staffs are aware of these changes.

Key points of SE1408

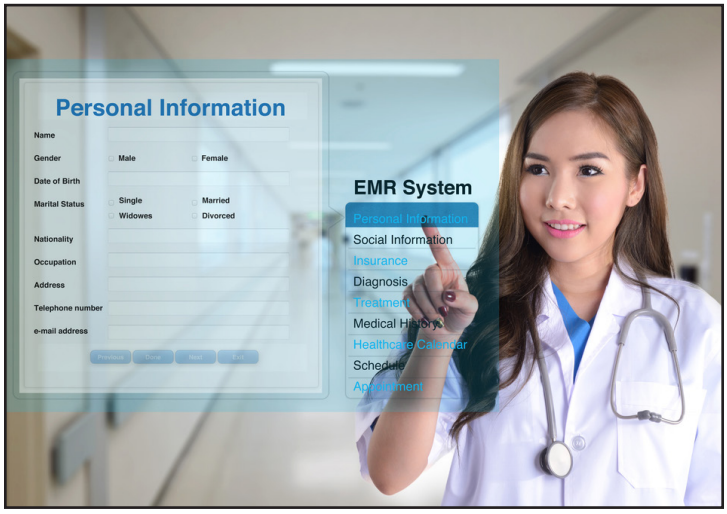
General reporting of ICD-10

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time.

Please refer to *http://www.cms.gov/Medicare/Coding/ICD10/index.html* for more information on the format of ICD-10 codes. In addition, ICD-10 procedure codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

General claims submissions information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be returned to provider (RTP) as unprocessable.



Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2015, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes.

Medicare will RTP all claims that are billed with both ICD-9 and ICD-10 general claims submissions information **diagnosis codes** on the same claim. For dates of service **prior to** October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code.

For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code.

Likewise, Medicare will also RTP all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim. For claims with dates of service prior to October 1, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, submit with the appropriate ICD-10 procedure code.

Remember that ICD-10 codes may only be used for services provided on or after October 1, 2015. Institutional claims containing ICD-10 codes for services prior to October 1, 2015, will be returned to provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Will the Centers for Medicare & Medicaid Services (CMS) allow for dual processing of ICD-9 and ICD-10 codes (accept and process both ICD-9 and ICD-10 codes for dates of service on and after October 1, 2015)?

See **ICD-10**, next page

ICD-10

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No, CMS will not allow for dual processing of ICD-9 and ICD-10 codes after ICD-10 implementation on October 1, 2015. Many providers and payers, including Medicare have already coded their systems to only allow ICD-10 codes beginning October 1, 2015.

The scope of systems changes and testing needed to allow for dual processing would require significant resources and could not be accomplished by the October 1, 2015, implementation date.

Should CMS allow for dual processing, it would force all entities with which we share data, including our trading partners, to also allow for dual processing? In addition, having a mix of ICD-9 and ICD-10 codes in the same year would have major ramifications for CMS quality, demonstration, and risk adjustment programs.

Claims that span the ICD-10 implementation date

There may be times when a claim spans the ICD-10 implementation date for institutional, professional, and supplier claims. For example, the beneficiary is admitted as an inpatient in late September, 2015 and is discharged after October 1, 2015. Another example is a DME claim for monthly billing that spans between September and October, 2015 (that is, the monthly billing dates are September 15, 2015 – October 14, 2015). The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A – Institutional providers

Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
11x	Inpatient hospitals (including TEFRA hospitals, inpatient prospective payment system (PPS) hospitals and critical access hospitals (CAHs)	If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.	THROUGH
11x	Inpatient psychiatric facility and long term care hospital (LTCH) PPS	*__Note__: If the hospital claim has a discharge and/or through date on or after 10/1/15, and a benefits exhaust occurrence code with a September 2015 date does not exist, the entire claim is billed using ICD-10. If a benefits exhaust occurrence code with a September 2015 date exists, the provider must split bill the claim using the benefits exhaust occurrence code date as the through date on the first claim and bill with ICD-9 codes. The subsequent claim is billed as a no pay claim with appropriate ICD-10 coding.	*See note in claims processing requirement column

See **ICD-10**, next page

ICD-10

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Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
12x	Inpatient Part B hospital services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
13x	Outpatient hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
14x	Non-patient laboratory services	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
18x	Swing beds	If the [swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
21x	Skilled nursing (Inpatient Part A)	If the [swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.	THROUGH
22x	Skilled nursing facilities (Inpatient Part B)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

See **ICD-10**, next page

ICD-10

From previous page

Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
23x	Skilled nursing facilities (Outpatient)	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
32x	Home health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.	THROUGH
32x	Home health – request for anticipated payment (RAPs)*	*Note - RAPs can report either an ICD-9 code or anICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.	*See note in claims processing requirement column
34x	Home health – (Outpatient)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
71x	Rural health clinics	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
72x	End-stage renal disease (ESRD)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

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Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
73x	Federally qualified health clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	N/A
74x	Outpatient therapy	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
75x	Comprehensive outpatient rehab facilities	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
76x	Community mental health clinics	Split claims - require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
77x	Federally qualified health clinics (effective 4/4/10)	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
81x	Hospice-hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

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Bill type(s)	Facility type/ services	Claims processing requirement	Use FROM or THROUGH date
82x	Hospice – non hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM
83x	Hospice – hospital based	N/A	N/A
85x	Critical access hospital	Split claims - Require providers split the claim so all ICD-9 codes remain on one claim with dates of service (dos) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.	FROM

Table B - Special outpatient claims processing circumstances

Scenario	Claims processing requirement	Use FROM or THROUGH Date
Three-day /one-day payment window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2015, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

Table C – Professional claims

Type of claim	Claims processing requirement	Use FROM or THROUGH date
All anesthesia claims	Anesthesia procedures that begin on 9/30/2015 but end on 10/1/2015 are to be billed with ICD-9 diagnosis codes and use 9/30/2015 as both the FROM and THROUGH date.	FROM

Table D –Supplier claims

Supplier type	Claims processing requirement	Use FROM or THROUGH/TO Date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/2015 (i.e., the FROM date of service occurs prior to 10/1/2015 and the TO date of service occurs after 10/1/2015).	FROM

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Announcement of payment rate increase for rural health clinics for 2016

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9347, which informs MACs about instructions for 2016 payment rate increase for RHCs. Make sure that your billing staff are aware of these changes.

Background

CR 9347 provides instructions to the MACs for 2016 payment rate increases for RHCs. As authorized by Section 1833(f) of the Social Security Act (the Act) (see *http://www.ssa.gov/OP_Home/ssact/title18/1833.htm*), the RHC payment limit for a subsequent year will be increased in accordance with the rate of increase in the Medicare economic index.

Effective January 1, 2016, through December 31, 2016, the RHC payment limit per visit for 2016 is $81.32. The 2016 RHC rate reflects a 1.1 percent increase above the 2015 payment limit of $80.44.

The effective date of January 1, 2016, for the RHC payment rate increase is necessary in order to update the payment rates in accordance with the Act (Section 1833(f)). Your MAC will not retroactively adjust individual RHC bills paid at previous upper payment limits.

Additional information

The official instruction, CR 9347, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3375CP.pdf*.

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

MLN Matters® Number: MM9347
Related Change Request (CR) #: CR 9347
Related CR Release Date: October 16, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3375CP
Implementation Date: January 4, 2016

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Additional information

You may also want to review SE1239 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf*. SE1239 announces the revised ICD-10 implementation date of October 1, 2015.

You may also want to review SE1410 at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.pdf*.

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

MLN Matters® Number: SE1408 *(Revised)*
Revised Related Change Request (CR) #: 7492
Related CR Release Date: N/A
Effective Date: October 1, 2014
Related CR Transmittal #: N/A
Implementation Date: N/A

Document history

- This article was revised June 27, 2015, to clarify language on under "Claims that Span the ICD-10 Implementation Date."
- The article was revised October 30, 2015, to add information in Table A regarding inpatient psychiatric facilities (IPF) and long term care hospital (LTCH) PPS guidance.

Manual updates to clarify inpatient rehabilitation facility claims processing

Provider types affected

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

What you need to know

Change request (CR) 9362 updates Chapter 3 of the *Medicare Claims Processing Manual* to clarify key components of IRF payment policies. These changes are intended only to clarify the existing policies and no system or processing changes are anticipated.

Background

Compliance with the regulatory requirements for the arthritis conditions specified in Chapter 3, Section 140.1.1 B-D of the *Medicare Claims Processing Manual* cannot be determined by the presence of an impairment group code or diagnosis code alone, but can only be verified through review of the IRF medical record.

Thus, the Centers for Medicare & Medicaid Services (CMS) removed arthritis impairment group codes and diagnosis codes from the list of codes used to determine presumptive compliance for compliance review periods beginning on or after October 1, 2015.

However, beginning on or after October 1, 2015, CMS also provided for an additional item on the IRF patient assessment instrument (PAI) (item #24A) to enable IRFs to indicate whether the patient's arthritis condition(s) meets all of the relevant regulatory requirements specified in Chapter 3, Section 140.1.1 B-D of the *Medicare Claims Processing Manual*.

With CR 9362, CMS is adding a new subsection D to Section 140.1.3 of Chapter 3 to guide MACs in using the new item #24A on the IRF-PAI to verify that the arthritis codes meet the 60 percent rule requirements. The added provisions of Chapter 3 are attached to CR 9362.

Additional information

The official instruction, CR 9362, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3388CP.pdf*.

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

MLN Matters® Number: MM9362
Related Change Request (CR) #: CR 9362
Related CR Release Date: October 30, 2015
Effective Date: December 2, 2015
Related CR Transmittal #: R3388CP
Implementation Date: December 2, 2015

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.*

Save time – correct your claims online!

October 2015 physician fee schedule database update

This article was revised September 30, 2015, to reflect the revised change request (CR) 9266 issued September 29. In the article, additional codes (G0105 and G0121) are added in the "What you need to know" section listing RVU changes.

Also, a number of codes with a revised bilateral surgery indicator are listed in that same section. The CR release date, transmittal number, and the Web address for CR 9266 are also revised. This article was previously published in the October 2015 edition of Medicare A Connection, Page 27.

Provider types affected

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

What you need to know

Changes included in the October update to the 2015 MPFSDB are effective for dates of service on and after January 1 (unless otherwise stated).

The key change is to the malpractice relative value units (RVU) of the following *CPT*®/HCPCS codes: *33471, 33606, 33611, 33619, 33676, 33677, 33692, 33737, 33755, 33762, 33764, 33768, 33770, 33771, 33775, 33776, 33777, 33778, 33779, 33780, 33781, 33783, 33786, 33803, 33813, 33822, 33840*, and *33851*; and the Work RVUs for G0105 and G0121.

The RVU changes for these codes are retroactive to January 1, 2015. In addition, effective January 1, 2015, codes *76641*, *76641*-TC, *76641*-26, *76642*, *76642*-TC, *76642*-26, *95866*, *95866*-TC, and *95866*-26 have a revised bilateral surgery indicator = three.

Also, effective October 1, 2015, *CPT*®/HCPCS code Q9979 is assigned a procedure status indicator of E (Excluded from the PFS by regulation. These codes are for items and services that CMS has excluded from the PFS by regulation. No payment may be made under the PFS for these codes and generally, no RVUs are shown.).

Background

The Social Security Act (Section 1848(c)(4); see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) authorizes the Centers for Medicare & Medicaid Services (CMS) to establish ancillary policies necessary to implement relative values for physicians' services.

Payment files were issued to the MACs based upon the 2015 Medicare physician fee schedule (MPFS) final rule, published in the *Federal Register* December 19, 2014, to be effective for services furnished between January 1, 2015, and December 31, 2015.

Additional information

The official instruction, CR 9266 issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-andGuidance/Guidance/Transmittals/Downloads/R3364CP.pdf.

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

MLN Matters® Number: MM9266 *(Revised)*
Related Change Request (CR) #: CR 9266
Related CR Release Date: September 29, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R3364CP
Implementation Date: October 5, 2015

Update to the federally qualified health centers prospective payment system – recurring file updates

Provider types affected

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

Provider action needed

Change request (CR) 9348 updates the FQHC PPS base payment rate and the geographic adjustment factors (GAFs) for the FQHC pricer for 2016. Please ensure your billing staffs are aware of these changes.

Background

Section 10501(i)(3)(A) of the Affordable Care Act (Pub. L. 111-148 and Pub. L. 111-152) added Section 1834(o) of the Social Security Act (the Act) to establish a payment system for the costs of FQHC services under Medicare Part B based on prospectively set rates.

In compliance with the statutory requirements of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period to implement a methodology and payment rates for a PPS for FQHCs under Medicare Part B beginning on October 1, 2014.

Under the FQHC PPS, Medicare pays FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically necessary, face-to-face FQHC visit is furnished to a Medicare beneficiary.

As required by 1834(o)(2)(B)(ii) of the Act, the base payment rate for the first year after implementation shall be increased in accordance with the rate of increase in the Medicare economic index. From January 1, 2016, through December 31, 2016, the FQHC PPS base payment rate is $160.60.

The 2016 base payment rate reflects a 1.1 percent increase above the 2015 base payment rate of $158.85. In accordance with Section 1834(o)(1)(A) of the Act, the FQHC PPS base rate is adjusted for each FQHC by the FQHC geographic adjustment factor (GAF), based on the geographic practice cost indices (GPCIs) used to adjust payment under the Medicare physician fee schedule (MPFS).

The FQHC GAF is adapted from the work and practice expense GPCIs, and are updated when the work and practice expense GPCIs are updated for the MPFS. For 2016, the FQHC PPS GAFs have been updated in order to be consistent with the statutory requirements.

Additional information

The official instruction, CR 9348, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3369CP.pdf*.

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

MLN Matters® Number: MM9348
Related Change Request (CR) #: CR 9348
Related CR Release Date: October 9, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3369CP
Implementation Date: January 4, 2016

Billing of the transportation fee by portable X-ray suppliers

Provider types affected

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

Provider action needed

This article is based on change request (CR) 9354 which removes the word "Medicare" before "patient" in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 13, Section 90.3) and clarifies guidance when more than one patient is X-rayed at the same location. Make sure that your billing staff are aware of these changes.

Background

Portable X-ray suppliers receive a transportation fee for transporting portable X-ray equipment to the location where portable X-rays are taken.

If more than one patient at the same location is X-rayed, the portable X-ray transportation fee is allocated among the patients.

The Centers for Medicare & Medicaid Services (CMS) believes it would be more appropriate to allocate the transportation fee among all patients who receive portable X-ray services in a single trip. Medicare should not pay for more than its share of the transportation costs for portable X-ray services.

CMS has revised the *Medicare Claims Processing Manual* to remove the word "Medicare" before "patient" in Section 90.3. Also, CMS is clarifying the guidance for the billing of the transportation fee of portable X-ray suppliers. The revised part of Section 90.3 is as follows:

> **90.3 - Transportation Component (HCPCS Codes R0070 - R0076)**
>
> "This component represents the transportation of the equipment to the patient. Establish local RVUs for the transportation R codes based on Medicare administrative contractor (MAC) knowledge of the nature of the service furnished. The MACs shall allow only a single transportation payment for each trip the portable X-ray supplier makes to a particular location.
>
> When more than one patient is X-rayed at the same location, the single transportation payment under the physician fee schedule is to be prorated among all patients (Medicare Parts A and B, and non-Medicare) receiving portable X-ray services during that trip, regardless of their insurance status.
>
> For example, for portable X-ray services furnished at a SNF, the transportation fee should be allocated among all patients receiving portable X-ray services at the same location in a single trip irrespective of whether the patient is in a Part A stay, a Part B patient, or not a Medicare beneficiary at all. If the patient is in a Part A SNF stay, payment for the allocated portion of the transportation fee (and the X-ray) would be the SNF's responsibility.
>
> For a privately insured patient, it would be the responsibility of that patient's insurer. For a Medicare Part B patient, payment would be made under Part B for the share of the transportation fee attributable to that patient."…

Additional information

The official instruction, CR 9354, issued to your MAC regarding this change is available at *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3387CP.pdf*.

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

MLN Matters® Number: MM9354
Related Change Request (CR) #: CR 9354
Related CR Release Date: October 30, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3387CP
Implementation Date: January 1, 2016

2016 home health prospective payment system rate update

Provider types affected

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

Provider action needed

CR 9406 informs providers about updates to the 60-day national episode rates, the national per-visit amounts, low-utilization payment adjustment (LUPA) add-on amounts, and the non-routine medical supply payment amounts under the HH PPS for 2016. Make sure your billing staff is aware of this update.

The Affordable Care Act mandated several changes to Section 1895(b) of the Social Security Act (the Act) and hence the HH PPS Update for 2016. Section 3131(a) of the Affordable Care Act mandated that starting in 2014, the Secretary must apply an adjustment to the national, standardized 60-day episode payment rate and other amounts applicable under Section 1895(b)(3)(A)(i)(III) of the Act to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors.

In addition, Section 3131(a) of the Affordable Care Act mandates that this rebasing must be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the amount (or amounts), as of the date of enactment, applicable under Section 1895(b)(3)(A)(i)(III) of the Act, and be fully implemented by 2017.

Section 3401(e) of the ACA requires that the market basket percentage under the HH PPS be annually adjusted by changes in economy-wide productivity for 2015 and each subsequent calendar year.

In addition to the Affordable Care Act mandates, Section 421(a) of the Medicare Modernization Act (MMA), as amended by Section 210 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10), provides an increase of 3 percent of the payment amount otherwise made under Section 1895 of the Act for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2018.

The statute waives budget neutrality related to this provision, as the statute specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under Section 1895 of the Act applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

Market basket update

The 2016 HH market basket update is 2.3 percent which is then reduced by a multi-factor productivity (MFP) adjustment of 0.4 percentage points. The resulting HH payment update is equal to 1.9 percent. HHAs that do not report the required quality data will receive a 2 percentage point reduction to the HH payment update of 1.9 percent.

National standardized 60-day episode payment

As described in the 2016 final rule, to determine the 2016 national, standardized 60-day episode payment rate, CMS applies a wage index budget neutrality factor of 1.0011 and a case-mix budget neutrality factor of 1.0187 to the previous calendar year's national, standardized 60-day episode rate ($2,961.38).

In order to account for nominal case-mix growth from 2012 to 2013, CMS applies a payment reduction of 0.97 percent to the 2016 national, standardized 60-day episode payment rate. This reduction will also be applied to the 2017 and 2018 national, standardized 60-day episode payment rate.

CMS then applies an $80.95 reduction (which is 3.5 percent of the 2010 national, standardized 60-day episode rate of $2,312.94) to the national, standardized 60-day episode rate. Lastly, the national, standardized 60-day episode payment rate is updated by the 2016 HH payment update percentage of 1.9 percent for HHAs that submit the required quality data and by 1.9 percent minus 2 percentage points or -0.1 percent for HHAs that do not submit quality data.

These two episode payment rates are shown in Tables 1 and Table 2 on page 42. These payments are further adjusted by the individual episode's case-mix weight and by the wage index.

National per-visit rates

To calculate the 2016 national per-visit payment rates,

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CMS starts with the 2015 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0010 to ensure budget neutrality for LUPA per-visit payments after applying the 2016 wage index, and then applies the maximum rebasing adjustments to the per-visit rates for each discipline. The per-visit rates are then updated by the 2016 HH payment update of 1.9 percent for HHAs that submit the required quality data and by -0.1 percent for HHAs that do not submit quality data. The per-visit rates are shown in Tables 3 and 4 on page 42.

LUPA add-on payments

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. Beginning in 2014, CMS calculates the payment for the first visit in a LUPA episode by multiplying the per-visit rate by a LUPA add-on factor specific to the type of visit (skilled nursing, physical therapy, speech-language pathology).

The specific requirements for the new LUPA add-on calculation are described in *CR 8380, Transmittal 2828* dated November 27, 2013. The LUPA add-on adjustment factors are displayed in Table 5.

Table 5: 2016 LUPA add-on factors

HH discipline type	Add-on factor
Skilled nursing	1.8451
Physical therapy	1.6700
Speech-language pathology	1.6266

Non-routine supply payments

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by an NRS conversion factor. To determine the 2016 NRS conversion factors, CMS starts with the 2015 NRS conversion factor ($53.23) and applies a 2.82 percent rebasing adjustment as described in the 2016 final rule.

CMS then updates the conversion factor by the 2016 HH payment update of 1.9 percent for HHAs that submit the required quality data and by -0.1 percent for HHAs that do not submit quality data. CMS does not apply a standardization factor as the NRS payment amount calculated from the conversion factor is not wage or case-mix adjusted when the final payment amount is computed. The NRS conversion factor for 2016 payments for HHAs that do submit the required quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b.

Table 6a: 2016 NRS conversion factor for HHAs that do submit the required quality data

2015 NRS conversion factor	2016 rebasing adjustment	2016 HH payment update percentage	2016 NRS conversion factor
$53.23	X 0.9718	X 1.019	$52.71

Table 6b: 2016 relative weights and payment amounts for the 6-severity NRS system for HHAs that DO submit quality data

Severity level	Points (scoring)	Relative weight	2016 NRS payment amount
1	0	0.2698	$14.22
2	1 to 14	0.9742	$51.35
3	15 to 27	2.6712	$140.80
4	28 to 48	3.9686	$209.18
5	49 to 98	6.1198	$322.57
6	99+	10.5254	$554.79

The NRS conversion factor for 2016 payments for HHAs that do not submit quality data is shown in Table 7a and the payment amounts for the various NRS severity levels are shown in Table 7b.

Table 7a: 2016 NRS Conversion Factor for HHAs that DO NOT submit the required quality data

2015 NRS conversion factor	2016 rebasing adjustment	2016 HH payment update percentage	2016 NRS conversion factor
$53.23	X 0.9718	X 0.999	$51.68

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Table 7b: 2016 Relative weights and payment amounts for the 6-Severity NRS System for HHAs that DO NOT Submit Quality Data

Severity level	Points (scoring)	Relative weight	2016 NRS payment amount
1	0	0.2698	$13.94
2	1 to 14	0.9742	$50.35
3	15 to 27	2.6712	$138.05
4	28 to 48	3.9686	$205.10
5	49 to 98	6.1198	$316.27
6	99+	10.5254	$543.95

Rural add-on

As stipulated in section 421(a) of the MMA, the 3 percent rural add-on is applied to the national standardized 60-day episode rate, national per-visit payment rates, LUPA add-on payments, and the NRS conversion factor when home health services are provided in rural (non-CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2018. Refer to Tables 8 through 10b for the 2016 rural payment rates.

Table 8a: 2016 payment amounts for 60-day episodes for services provided in a rural area before case-mix and wage index adjustment for HHAs that DO submit quality data

2016 national, standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	2016 rural national standardized 60-day episode payment rate
$2,965.12	X 1.03	$3,054.07

Table 8b: 2016 payment amounts for 60-day episodes for services provided in a rural area before case-mix and wage index adjustment for HHAs that DO NOT submit quality data

2016 national, standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	2016 rural national standardized 60-day episode payment rate
$2,906.92	X 1.03	$2,994.13

Table 9a: 2016 Per-visit amounts for services provided in rural area, before wage index adjustment for HHAs that DO submit quality data

Home health discipline type	2016 per-visit rate	Multiply by the 3 percent rural add-on	2016 rural per-visit rate
HH Aide	$60.87	X 1.03	$62.70
MSS	$215.47	X 1.03	$221.93
OT	$147.95	X 1.03	$152.39
PT	$146.95	X 1.03	$151.36
SN	$134.42	X 1.03	$138.45
SLP	$159.71	X 1.03	$164.50

Table 9b: 2016 per-visit amounts for services provided in rural area, before wage index adjustment for HHAs that DO NOT submit quality data

Home health discipline type	2016 per-visit rate	Multiply by the 3 Percent rural add-on	2016 rural per-visit rate
HH Aide	$59.68	X 1.03	$61.47
MSS	$211.24	X 1.03	$217.58
OT	$145.05	X 1.03	$149.40
PT	$144.07	X 1.03	$148.39
SN	$131.79	X 1.03	$135.74
SLP	$156.58	X 1.03	$161.28

Table 10a: 2016 conversion factor for services provided in rural areas

For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
2016 conv. rates	Multiply by the 3 percent rural add-on	2016 rural conv. factor	2016 conv. factor	Multiply by the 3 percent rural add-on	2016 rural conv. factor
$52.71	X 1.03	$54.29	$51.68	X 1.03	$53.23

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Table 10b: 2016 relative weights and payment amounts for the 6-Severity NRS System for services provided in rural areas

		For HHAs that DO submit quality data		For HHAs that DO NOT submit quality data	
Sev. level	Points (Scoring)	Relative weight	Total 2016 NRS payment amount for rural areas	Relative weight	Total 2016 NRS payment amount for rural areas
1	0	0.2698	$14.65	0.2698	$14.36
2	1 to 14	0.9742	$52.89	0.9742	$51.86
3	15 to 27	2.6712	$145.02	2.6712	$142.19
4	28 to 48	3.9686	$215.46	3.9686	$211.25
5	49 to 98	6.1198	$332.24	6.1198	$325.76
6	99+	10.5254	$571.42	10.5254	$560.27

Clarification regarding the use of the "Initial Encounter" seventh character, applicable to certain ICD-10-CM code categories, under the HH PPS

The ICD-10-CM coding guidelines regarding the use of the seventh character assignment for diagnosis codes in Chapter 19, "Injury, Poisoning, and Certain Other Consequences of External Causes (S00–T88)" were revised.

Based upon the revised guidance, coding certain diagnosis codes as "initial encounters" would be appropriate when the patient is receiving active treatment during a home health episode. Initial encounters are not based on chronology of care or whether the patient is seeing the same or a new provider for the same condition. A revised translation list effective January 1, 2016, will be posted on the CMS website.

Also effective, January 1, 2016, the home health prospective payment system grouper logic will be revised to award points for certain initial encounter codes based upon the revised ICD-10-CM coding guidelines for M0090 dates on or after October 1, 2015.

HHAs should review their OASIS records and claims submitted between October 1, 2015, and December 31, 2015, to determine if they should submit a modification of their assessment and adjust their claim with a revised HIPPS code that was assigned to the OASIS record based upon the revised grouper logic.

These changes are implemented through the home health pricer software found in Medicare contractor standard systems.

Additional information

The official instruction, CR 9406, issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3383CP.pdf*.

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

MLN Matters® Number: MM9406
Related Change Request (CR) #: CR 9406
Related CR Release Date: October 23, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3383CP
Implementation Date: January 4, 2016

Note: MM9406 is continued on Page 42 with Tables 1-4 referenced in the "National standardized 60-day episode payment section of the article. "

See **HPPS**, next page

HPPS

From previous page

Table 1: For HHAs that DO submit quality data – national 60-day episode amounts updated by the MFP-adjusted home health market basket update for 2016 before case-mix adjustment, wage index adjustment based on the site of service for the beneficiary

2015 Nat'l, Std. 60-Day Episode Payment	Wage Index budget neutrality factor	Case-mix weights budget neutrality factor	Nominal case-mix growth adjustment	2016 rebasing adjustment	2016 HH payment update percentage	2016 national, standardized 60-day episode payment
$2,961.38	X 1.0011	X 1.0187	X 0.9903	-$80.95	X 1.019	=$2,965.12

Table 2: For HHAs that DO NOT submit quality data – national 60-day episode amounts updated by the MFP adjusted home health market basket update for 2016 before case-mix adjustment, wage index adjustment based on the site of service for the beneficiary

2015 national, standardized 60-day episode payment	Wage index budget neutrality factor	Case-mix weights budget neutrality factor	Nominal case-mix growth adjustment	2016 rebasing adjustment	2016 HH payment update percentage	2016 nat'l, standardized 60-day episode payment
$2,961.38	X 1.0011	X 1.0187	X 0.9903	-$80.95	X 0.999	=$2,906.92

Table 3: For HHAs that DO submit quality data – 2016 national per-visit amounts for LUPAs and outlier calculations updated by the MFP adjusted HH market basket update, before wage index adjustment

HH discipline type	2015 per-visit payment	Wage index budget neutrality factor	2016 rebasing adjustment	2016 HH payment update percentage	2016 per-visit payment
Home Health Aide	$57.89	X 1.0010	+$1.79	X 1.019	$60.87
Medical Social Services	$204.91	X 1.0010	+$6.34	X 1.019	$215.47
Occupational Therapy	$140.70	X 1.0010	+$4.35	X 1.019	$147.95
Physical Therapy	$139.75	X 1.0010	+$4.32	X 1.019	$146.95
Skilled Nursing	$127.83	X 1.0010	+$3.96	X 1.019	$134.42
Speech-Language Pathology	$151.88	X 1.0010	+$4.70	X 1.019	$159.71

Table 4: For HHAs that DO NOT submit quality data – 2016 national per-visit amounts for LUPAs and outlier calculations updated by the MFP adjusted HH market basket update, before wage index adjustment

HH discipline type	2015 per-visit payment	Wage index budget neutrality factor	2016 rebasing adjustment	2016 HH payment update percentage	2016 per-visit payment
Home health aide	$57.89	X 1.0010	+$1.79	X 0.999	$59.68
Medical social services	$204.91	X 1.0010	+$6.34	X 0.999	$211.24
Occupational therapy	$140.70	X 1.0010	+$4.35	X 0.999	$145.05
Physical therapy	$139.75	X 1.0010	+$4.32	X 0.999	$144.07
Skilled nursing	$127.83	X 1.0010	+$3.96	X 0.999	$131.79
Speech-language pathology	$151.88	X 1.0010	+$4.70	X 0.999	$156.58

Ambulance inflation factor for 2016 and productivity adjustment

Provider types affected

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

Provider action needed

CR 9412 furnishes the 2016 ambulance inflation factor (AIF) for determining the payment limit for ambulance services. Make sure that your billing staffs are aware of the change.

Background

CR 9412 furnishes the 2016 ambulance inflation factor (AIF) for determining the payment limit for ambulance services required by Section 1834(l)(3)(B) of the Social Security Act (the Act).

It also clarifies the *Medicare Claims Processing Manual*, Chapter 15 (Ambulance), Section 20.3 (Air Ambulance) and updates Section 20.4 (Ambulance Inflation Factor (AIF)). You will find these updated manual chapters as an attachment to this CR.

Section 1834(l)(3)(B) of the Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year.

Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

Section 3401 of the Affordable Care Act requires that specific prospective payment system (PPS) and fee schedule (FS) update factors be adjusted by changes in economy-wide productivity.

The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as projected by the Secretary of Health and Human Services for the 10-year period ending with the applicable fiscal year, cost reporting period, or other annual period).

The MFP for 2016 is 0.5 percent and the CPI-U for 2016 is 0.1 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for 2016 is -0.4 percent.

Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule. The 2016 ambulance fee schedule file is available in November 2015. It may be retrieved at any time and will reside indefinitely for your access. It may be updated with each quarterly common working file (CWF) update.

Additional information

The official instruction, CR 9412, issued to your MAC regarding this change, is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3380CP.pdf*.

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

MLN Matters® Number: MM9412
Related Change Request (CR) #: CR 9412
Related CR Release Date: October 23, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3380CP
Implementation Date: January 4, 2016

Reporting principal and interest amounts when refunding previously recouped money on the remittance advice

Provider types affected

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

Provider action needed

Change request (CR) 9168 explains to providers who received a favorable appeals decision that it will be easier and consequently more transparent to identify the claim and/or the refund of principal and interest paid by Medicare. Your MAC will make sure that the remittance advices are reporting the refunded principal and interest amounts separately, and provide individual claim information. CR 9168 applies to electronic remittance advice (ERA) only.

Background

Currently reporting of refunded principal and interest amounts for all related claims on the Remittance Advice (RA) is shown as one lump sum amount. This practice creates problems for the provider community as this is not conducive to posting payment properly. Providers have the money but are not able to identify the claim and/or the refund of principal and interest paid by Medicare.

CR 9168 instructs MACs to report the principal and interest separately and also to provide individual claim information. Specifically, the reporting will be in the provider level balance (PLB) segment of the 835 as follows:

PLB details – reporting principal refunds

PLB03-1: WW to report overpayment recovery (negative sign for the amount in PLB04) being refunded

PLB03-2: Positions 1 – 25: Account Payable (AP) Invoice Number

PLB03-2: Positions 26 – 50: Claim Adjustment Account Receivable (AR) number

PLB 04: Refund Amount (Principal Refund Amount)

PLB Details – reporting interest refunds

PLB03-1: RU to report interest paid (negative sign for the amount in PLB04)

PLB03-2: Positions 1 – 25: AP Invoice Number

PLB03-2: Positions 26 – 50: Claim Adjustment AR number

PLB04: Interest Amount on Refund

Additional information

The official instruction, CR 9168 issued to your MAC regarding this change is available at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1570OTN.pdf*.

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

MLN Matters® Number: MM9168
Related Change Request (CR) #: CR 9168
Related CR Release Date: November 6, 2015
Effective Date: July 1, 2016
Related CR Transmittal #: R1570OTN
Implementation Date: July 5, 2016

Expand your knowledge of Medicare

Visit the *Medicare Learning Network*® (MLN) Educational Web Guides Overview page, for educational and informational resources to improve your knowledge of Medicare billing and policies.

The *MLN Educational Web Guides* provides information on evaluation and management (E/M) services; guided pathways to resources and topics of interest; lists of health care management products; as well as easy-to-understand billing and coding products.

Click here to explore educational Web guides.

Clarification of patient discharge status codes and hospital transfer policies

This article was reissued November 17, 2015, to clarify language in the Background section. This article was previously published in the March 2014 edition of Medicare A Connection, Page 41.

Provider types affected

This *MLN Matters*® special edition (SE) article is intended for hospitals that submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries.

What you need to know

The Office of Inspector General (OIG) conducted several reviews identifying Medicare overpayments to hospitals that did not comply with the post-acute care transfer policy.

Hospitals transferred inpatients to certain post-acute care settings but coded the patient discharge status as a discharge to home. To assure proper payment under the Medicare severity-diagnosis related group (MS-DRG) payment system, hospitals must be sure to code the discharge/transfer status of patients accurately to reflect the level of post-discharge care to be received by the patient.

Background

Hospitals are responsible for coding the discharge bill based on the discharge plan for the patient, and if the hospital subsequently learns that post-acute care was provided, the hospital should submit an adjustment bill to correct the discharge status code following Medicare's claim adjustment criteria located in the *Medicare Claims Processing Manual*, (*http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending*) Chapter 1, Section 130.1.1 and Chapter 34.

Patient discharge status codes are part of the *Official UB-04 Data Specifications Manual* and are used nationwide by institutional, private, and public providers, and payers of health care claims. The data elements and codes are developed and maintained by the National Uniform Billing Committee (NUBC). To assist in the proper coding of patient discharge status code, providers may access data elements, codes, and frequently asked questions by referring to the *UB-04 Data Specifications Manual*. Information on obtaining a manual is located at *http://www.nubc.org*.

For the purpose of discussing transfers the following terms describe when a patient leaves the hospital. Discharges and transfers under the inpatient hospital prospective payment system (IPPS) are defined in *42 CFR 412.4(a) and (b).*

A "discharge" occurs when a Medicare beneficiary:

1. Leaves a Medicare IPPS acute care hospital after receiving complete acute care treatment; or
2. Dies in the hospital.

Medicare makes full MS-DRG payments to inpatient prospective payment system (IPPS) hospitals when the patient is discharged to their home (Patient Discharge Status Code 01) or certain types of health care institutions (such as Patient Discharge Status Code 04 to an Intermediate Care Facility).

An "acute care transfer" occurs when a Medicare beneficiary in an IPPS hospital (with any MS-DRG) is:

1. Transferred to another acute care IPPS hospital or unit for related care – Patient Discharge Status Code 02 (or 82 when an Acute Care Hospital Inpatient Readmission is planned); or
2. Leaves against medical advice – Patient Discharge Status Code 07 but is admitted to another PPS hospital on the same day; or
3. Transferred to a hospital that would ordinarily be paid under prospective payment, but is excluded because of participation in a state or area wide cost control program – Patient Discharge Status Code 02 (or 82 when an Acute Care Hospital Inpatient Readmission is planned); or
4. Transferred to a hospital or hospital unit that has not been officially determined as being excluded from PPS such as:
   a. An acute care hospital that would otherwise be eligible to be paid under the IPPS, but does not have an agreement to participate in the Medicare program (Patient Discharge Status Code 02 or 82 when an Acute Care Hospital Inpatient Readmission is planned);
   b. A critical access hospital (Patient Discharge Status Code 66 or 94 when an Acute Care Hospital Inpatient Readmission is planned).
5. Discharged but then readmitted the same day to another IPPS hospital (unless the readmission is unrelated to the initial discharge). This may occur when a hospital discharges the patient to home (01), the patient goes to a doctor's appointment the same day and is then admitted to another hospital. If the first hospital was unaware of the planned admission at the second hospital, it is likely the first hospital will have to adjust the previously submitted claim to correct the patient discharge status code to indicate a transfer (02), which reflects where the patient was later admitted on the same date.

See **HOSPITAL**, next page

HOSPITAL

From previous page

The transferring hospital is paid a per diem payment (when the patient transfers to an IPPS hospital) up to and including the full DRG payment. The transferring hospital may be paid a cost outlier payment. For more detailed information regarding payment, please refer to the *Medicare Claims Processing Manual, Chapter 3, Section 20*. The receiving hospital is paid based on the full prospective payment rate which may include a cost outlier payment if applicable or based on the rate of its respective payment system (if not IPPS).

For unrelated admissions, where a transfer case results in treatment in the second hospital under a MS-DRG different than the MS-DRG in the transferring hospital, payment to each hospital is based upon the MS-DRG under which the patient was treated.

For transfers from an IPPS hospital to a hospital or unit excluded from IPPS with a DRG that is not subject to the post acute care transfer policy, the transferring hospital is paid the full IPPS rate including an outlier payment if applicable. The outlier threshold and payment are calculated the same as any other discharge without a transfer. The payment to the final discharging hospital or unit is made at the rate of its respective payment system.

A "post-acute care transfer" occurs when a Medicare beneficiary in an IPPS hospital stay is grouped to one of the MS-DRGs listed in Table 5 of the applicable Fiscal Year IPPS Final Rule Home Page (*http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html*) and the transfer occurs to:

1. A hospital or distinct part hospital unit excluded from IPPS:
   - Inpatient rehabilitation facilities and units – Patient Discharge Status Code 62 (or 90 when an Acute Care Hospital Inpatient Readmission is planned.),
   - Long term care hospitals – Patient Discharge Status Code 63 (or 91 when an Acute Care Hospital Inpatient Readmission is planned),
   - Psychiatric hospitals and units – Patient Discharge Status Code 65 (or 93 when an Acute Care Hospital Inpatient Readmission is planned),
   - Cancer hospitals – Patient Discharge Status Code 05 (or 85 when an Acute Care Hospital Inpatient Readmission is planned), and
   - Children's hospitals – Patient Discharge Status Code 05 (or 85 when an Acute Care Hospital Inpatient Readmission is planned); or
2. A skilled nursing facility – Patient Discharge Status Code 03 (or 83 when an Acute Care Hospital Inpatient Readmission is planned); or
3. Home under a written plan of care for the provision of home health services from a home health agency and those services occur within 3 days after the date of discharge – Patient Discharge Status Code 06 (or 86 when an Acute Care Hospital Inpatient Readmission is planned).

Note: Condition code 42 may be used to indicate that the care provided by the home care agency is not related to the hospital care and therefore, will result in payment based on the MS-DRG and not a per diem payment. Condition code 43 may be used to indicate that home care was started more than three days after discharge from the hospital and therefore payment will be based on the MS-DRG and not a per diem payment.

The transferring hospital is paid based upon a per diem rate up to and including the full DRG payment which may include a cost outlier payment if applicable. The final discharging hospital is paid based on the full prospective payment rate which may include a cost outlier payment if applicable.

A '**special payment post-acute care transfer**' occurs when a Medicare beneficiary in an IPPS hospital stay is grouped to one of the MS-DRGs in the column titled, "Special Pay DRG" in Table 5 of the applicable Fiscal Year IPPS Final Rule Home Page on the CMS website (*http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatient PPS/index.html*). For these cases, the transferring hospital is paid 50 percent of the appropriate inpatient prospective payment rate and 50 percent of the appropriate transfer payment.

Additional information

If you have any questions, please contact your MAC at their toll-free number, which is available at *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html*.

MLN Matters® Number: SE1411 *Reissued*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Document history

Date	Description
November 17, 2015	The article was changed to clarify language in *Background* section of this article.

Educational Events

Provider outreach and educational events – December 2015

Medicare Part A changes and regulations

When: Tuesday, December 15
Time: 10:00 a.m. -11:30 a.m. ET – Delivery language: English
Type of Event: Webcast
http://medicare.fcso.com/Events/0302306.asp

Medicare Part A/B changes and regulations

When: Thursday, December 17
Time: 1:00 p.m. - 2:30 p.m. ET – Delivery language: English
Type of Event: webinar
http://medicare.fcso.com/Events/0304834.asp

Two easy ways to register

1. **Online** – Visit *www.fcsouniversity.com*, logon 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 a New Account" online. Providers with no national provider identifier may enter "99999" in the NPI field. You will receive logon information within 72 hours of your request.
2. **Fax** – Providers without Internet access may request a fax registration form through our Registration Hotline at 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 the *Education* section of 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 904-791-8103 to learn more about the about our newest training opportunities for providers.

Never miss a training opportunity

If you 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 *medicare.fcso.com*, 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 our 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. Our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Explore our catalog of online courses and learn more at *www.fcsouniversity.com*.

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CMS MLN Connects® Provider eNews

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Official Information Health Care Professionals Can Trust

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 29, 2015

MLN Connects® Provider eNews for October 29, 2015

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In this edition:

Editor's Note: If you order or refer items or services for Medicare beneficiaries and do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. See the revised MLN Matters® special edition article #SE1305. Also, see the revised MLN Matters® special edition article #SE1434 on provider enrollment requirements for writing prescriptions for Medicare Part D drugs. Learn how to enroll to order/refer or prescribe Part D drugs using the 855O and more.

ICD-10

- Qualifiers for ICD-10 Diagnosis Codes on Electronic Claims
- Get ICD-10 Answers in One Place

MLN Connects® National Provider Calls and Events

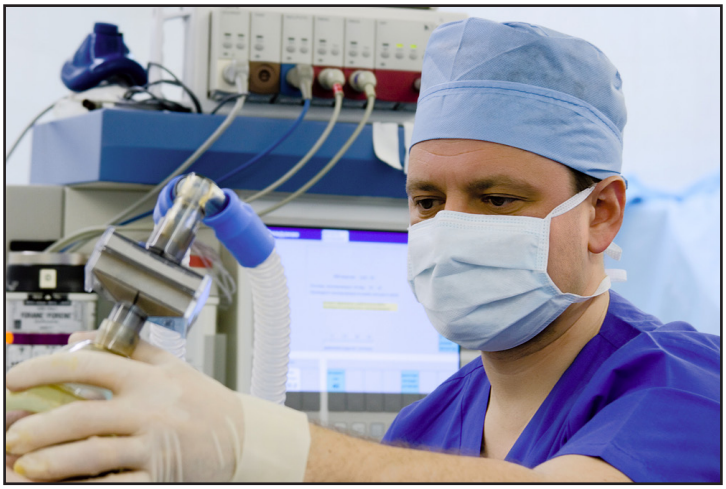
- Clinical Diagnostic Laboratory Test Payment System Proposed Rule Call — Register Now
- National Partnership to Improve Dementia Care and QAPI Call — Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

Other CMS Events

- Webinar for Comparative Billing Report on Optometry Services
- Long-Term Care Hospital Quality Reporting Program Provider Training

Announcements

- October is National Breast Cancer Awareness Month
- Protect Your Patients against Influenza and Pneumonia



- Hospital Value-Based Purchasing Program: FY 2016 Results
- DMEPOS Fee Schedule DME and PEN Text File Formats — Revised
- Antipsychotic Drug use in Nursing Homes: Trend Update
- EHR Incentive Programs: New Public Health Reporting FAQ

Claims, Pricers, and Codes

- Claims Processing Issue for non-Pneumococcal and Influenza Vaccines
- Correction of Mammography Claims
- October 2015 OPPS Pricer File Update

Medicare Learning Network® Educational Products

- Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs" MLN Matters Article — Revised
- "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A HHA Claims" MLN Matters Article — Revised
- New Medicare Learning Network Educational Web Guides Fast Fact

MLN Connects® Provider eNews for November 5, 2015

MLN Connects® Provider eNews for November 5, 2015

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In this edition:

MLN Connects® National Provider Calls and Events

- Clinical Diagnostic Laboratory Test Payment System Proposed Rule Call — Last Chance to Register
- National Partnership to Improve Dementia Care and QAPI Call — Register Now
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call — Registration Now Open
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call — Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

Announcements

- Physician Fee Schedule: Policy and Payment Changes for CY 2016
- Hospital Outpatient and ASC: Policy and Payment Changes for CY 2016
- ESRD Facilities: Policies and Payment Rates for CY 2016
- HHAs: Payment Changes for CY 2016
- Discharge Planning Proposed Rule Focuses on Patient Preferences
- Final Waivers in Connection with the Shared Savings Program
- DMEPOS Competitive Bidding Round 1 2017: Covered Document Review Date November 16
- Physician Compare Preview Period Extended to November 16
- 2016 Value Modifier: Informal Review Deadline Extended to November 23
- 2016 PQRS Payment Adjustment: Informal Review Deadline Extended to November 23

- Part D Prescribers Must Enroll in Medicare: Submit Your Application by January 1
- Considering Opting Out of Medicare to Meet the Prescriber Enrollment Requirements?
- CMS to Release a Comparative Billing Report on Physical Therapy in November
- November is Home Care and Hospice Month
- Each Office Visit is an Opportunity to Recommend Influenza Vaccination
- Find Information on Medicare-Covered Preventive Services

Claims, Pricers, and Codes

- Colorectal Cancer Screening Claims Processing Issue
- FY 2015 Inpatient PPS PC Pricer Update Available
- FY 2015 HH PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- Medicare Learning Network Catalog: November 2015 Version Available
- "ICD-10-CM Diagnosis Codes for Bone Mass Measurement" MLN Matters Article — Released
- "Medicare FFS Claims Processing Guidance for Implementing ICD-10" MLN Matters Article — Revised
- Medicare Learning Network Products Available in Electronic Publication Format

MLN Connects® Provider eNews for November 12, 2015

MLN Connects® Provider eNews for November 12, 2015

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In this edition:

MLN Connects® National Provider Calls and Events

- National Partnership to Improve Dementia Care and QAPI Call — Register Now
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call — Register Now
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call — Register Now

Other CMS Events

- LTCH Quality Reporting Program: In-Person Provider Training in Baltimore, MD

Announcements

- Three DMEPOS Competitive Bidding Reminders for Round 1 2017
- EHR Incentive Programs Stage 3 Final Rule: Submit Comments by December 15
- New FAQs on Participation in EHR Incentive Programs
- CMS Seeking Comment on MACRA Episode Groups by February 15
- Raising Awareness of Diabetes in November

Claims, Pricers, and Codes

- Pap Smear and PET Scan Claims Editing Incorrectly
- Additional Logic Applied to MDC 14

Medicare Learning Network® Educational Products

- Selecting Home Health Claims for Probe and Educate Review MLN Matters® Article — Released
- Clinical Laboratory Improvement Amendments Fact Sheet — Revised
- Inpatient Psychiatric Facility Prospective Payment System Fact Sheet — Revised
- Products Available in an Electronic Publication Format

MLN Connects® Provider eNews for November 19, 2015

MLN Connects® Provider eNews for November 19, 2015

View this edition as a PDF

In this edition:

MLN Connects® National Provider Calls and Events

- National Partnership to Improve Dementia Care and QAPI Call — Register Now
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call — Register Now
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call — Register Now

Other CMS Events

- LTCH Quality Reporting Program: In-Person Provider Training in Baltimore, MD

Announcements

- Registration for DMEPOS Competitive Bidding Round 1 2017 Closes November 20
- CMS Awards Partnership-Driven Special Innovation Projects to QIN-QIOs
- Reducing Improper Payment: A Collaborative Effort
- Comprehensive Care for Joint Replacement Model
- Revised 2014 Annual QRURs Available
- 2016 Value Modifier Informal Review Deadline Ends November 23
- 2016 PQRS Payment Adjustment: Informal Review Deadline Ends November 23
- Comments on Discharge to Community Quality Measure due November 23
- Considering Opting Out of Medicare to Meet the Prescriber Enrollment Requirements? — Updated
- EHR Incentive Programs: New Public Health Reporting FAQs
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Claims, Pricers, and Codes

- ICD-10 Transition: Clarifications about NCDs and LCDs
- CY 2013 Referring Provider DMEPOS Data — Updated

Medicare Learning Network® Educational Products

- Complying with Documentation Requirements for Laboratory Services Fact Sheet — New
- Skilled Nursing Facility Prospective Payment System Booklet — Revised
- Product Available in an Electronic Publication Format

First Coast Service Options Phone Numbers

*(**Note:** Specific geographic contact information is noted when phone numbers and addresses are different for providers in Florida, U.S. Virgin Islands or Puerto Rico.)*

Customer service
Monday to Friday
8:00 a.m. to 4:00 p.m
888-664-4112 (FL/USVI)
877-908-8433 (Puerto Rico)
877-660-1759 (TDD-FL/USVI)
888-216-8261 (TDD-Puerto Rico)

Electronic data interchange
888-670-0940 (FL/USVI)
888-875-9779 (Puerto Rico)

Interactive Voice Response
877-602-8816

Provider education/outreach
Event registration hotline
904-791-8103

Overpayments
904-791-6281

SPOT Help Desk
FCSOSPOTHelp@fcso.com
855-416-4199

Websites
medicare.fcso.com
medicareespanol.fcso.com

First Coast Service Options Addresses

Claims/correspondence
Florida/ U.S. Virgin Islands

Medicare Part A Customer Service
P. O. Box 2711
Jacksonville, FL 32231-0021

Puerto Rico

First Coast Service Options Inc.
P.O. Box 45003
Jacksonville, FL 32232-5003

Medicare EDI
Electronic claim filing
Direct Data Entry
P. O. Box 44071
Jacksonville, FL 32231-4071

Fraud and abuse
Complaint Processing Unit
P. O. Box 45087
Jacksonville, FL 32232-5087

FOIA requests
Provider audit/reimbursement
(relative to cost reports and audits)
Attn: FOIA PARD – 16T
P. O. Box 45268
Jacksonville, FL 32232-5268

General Inquiries

Online Form (Click here)

Email: *AskFloridaA@fcso.com*

Local coverage determinations
Medical Policy and Procedures – 19T
P.O. Box 2078
Jacksonville, FL 32231-0048

Medicare secondary payer (MSP)
Medicare Secondary Payer
P. O. Box 2711
Jacksonville, FL 32231-0021

Hospital audits
MSP – Hospital Review
P. O. Box 45267
Jacksonville, FL 32232-5267

MSPRC DPP debt recovery, auto accident settlements/lawsuits, liabilities
Auto/Liability – 17T
P. O. Box 44179
Jacksonville, FL 32231-4179

Overpayment collections and debt recovery
Repayment, cost reports, receipts and acceptances, tentative settlement determinations, provider statistical and reimbursement reports, cost report settlement, TEFRA target limit and SNF routine cost limit exceptions

Provider Audit and Reimbursement
P. O. Box 45268
Jacksonville, FL 32232-5268

Credit balance reports
First Coast Service Options Inc.
P.O. Box 45011
Jacksonville, FL 32232-5011

Post-pay medical review
First Coast Service Options Inc.
P. O. Box 44159
Jacksonville, FL 32231-4159

Provider enrollment
CMS-855 Applications
P. O. Box 44021
Jacksonville, FL 32231-4021

Redetermination
Florida:
Medicare Part A Redetermination/Appeals
P. O. Box 45053
Jacksonville, FL 32232-5053

Redetermination (cont'd)

U.S. Virgin Islands:
First Coast Service Options Inc
P. O. Box 45097
Jacksonville, FL 32232-5097

Puerto Rico

First Coast Service Options Inc.
P.O. Box 45028
Jacksonville, FL 32232-5028

Special delivery/courier services

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

Other Medicare carriers and intermediaries

DME regional carrier (DMERC)
DME, orthotic, prosthetic device, take-home supply, oral anti-cancer drug claims

CGS Administrators, LLC
P. O. Box 20010
Nashville, Tennessee 37202

Railroad Medicare
Palmetto GBA
P. O. Box 10066
Augusta, GA 30999-0001

Regional home health/hospice intermediary
Palmetto GBA
Medicare Part A
34650 US HWY 19N
Palm Harbor, FL 34684

Contact CMS

Centers for Medicare & Medicaid Services (CMS) *(www.cms.gov)*

Centers for Medicare & Medicaid Services, Division of Financial Management and Fee for Service Operations

ROATLFM@CMS.HHS.GOV

Office of Inspector General (OIG)
Medicare fraud hotline
800-HHS-TIPS (800-447-8477)

Medicare beneficiary customer service
1-800-MEDICARE
1-800-633-4227

Hearing and speech impaired (TDD)
1-800-754-7820