## Medicare Monthly Review

**Issue No.** MMR 2014-03  
**March 2014**

### Contents

<table>
<thead>
<tr>
<th>National Government Services – Articles for Part A and Part B Providers</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Coverage Determinations and Article Revisions and Updates Effective March 2014</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Centers for Medicare &amp; Medicaid Services – Articles for Part A and Part B Providers</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modifying the Daily Common Working File to Medicare Beneficiary Database File to Include Diagnosis Codes on the Health Insurance Portability and Accountability Act Eligibility Transaction System 270/271 Transactions (MM8456)</td>
<td>12</td>
</tr>
<tr>
<td>International Classification of Diseases, 10th Revision (ICD-10) Testing with Providers through the Common Edits and Enhancements Module and Common Electronic Data Interchange (MM8465 Revised)</td>
<td>14</td>
</tr>
<tr>
<td>Fluorodeoxyglucose (FDG) Positron Emission Tomography for Solid Tumors (MM8468)</td>
<td>17</td>
</tr>
<tr>
<td>Reporting Principal and Interest Amounts When Refunding Previously Recouped Money on the Remittance Advice (MM8485)</td>
<td>20</td>
</tr>
<tr>
<td>Changes to the Laboratory National Coverage Determination Software for ICD-10 Codes (MM8494 Revised)</td>
<td>22</td>
</tr>
<tr>
<td>Pub 100-03, Chapter 1, Language-only Update (MM8506)</td>
<td>24</td>
</tr>
<tr>
<td>National Coverage Determination for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers (MM8525)</td>
<td>26</td>
</tr>
<tr>
<td>Medicare National Coverage Determination for Beta Amyloid Positron Emission Tomography in Dementia and Neurodegenerative Disease (MM8526)</td>
<td>32</td>
</tr>
<tr>
<td>Claim Status Category and Claim Status Codes Update (MM8582 Revised)</td>
<td>37</td>
</tr>
<tr>
<td>Correction CR - Advance Beneficiary Notice of Noncoverage, Form CMS R-131 (MM8597)</td>
<td>39</td>
</tr>
<tr>
<td>Implementation of Health Insurance Portability &amp; Accountability Act Standards and Operating Rules for Health Care Electronic Funds Transfers (MM8619)</td>
<td>42</td>
</tr>
<tr>
<td>CWF Editing for Vaccines Furnished at Hospice – Correction (MM8620)</td>
<td>46</td>
</tr>
<tr>
<td>Implementation of National Automated Clearinghouse Association Operating Rules for Health Care Electronic Funds Transfers (MM8629)</td>
<td>48</td>
</tr>
<tr>
<td>HIPAA Eligibility Transaction System to Replace Common Working File Medicare Beneficiary Health Insurance Eligibility Queries (SE1249 Revised)</td>
<td>51</td>
</tr>
<tr>
<td>Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency Claims (Change Requests 6417, 6421, 6696, and 6856) (SE1305 Revised)</td>
<td>54</td>
</tr>
<tr>
<td>Updated Mobile Applications (Apps) for Open Payments (SE1402)</td>
<td>66</td>
</tr>
<tr>
<td>Psychiatry and Psychotherapy Services (SE1407 Rescinded)</td>
<td>71</td>
</tr>
<tr>
<td>Medicare Fee-For-Service Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition – A Re-Issue of MM7492 (SE1408)</td>
<td>72</td>
</tr>
<tr>
<td>Medicare Fee-For-Service International Classification of Diseases, 10th Edition Testing Approach (SE1409 Revised)</td>
<td>79</td>
</tr>
<tr>
<td>Centers for Medicare &amp; Medicaid Services – Articles for Part A Providers</td>
<td>Page</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Common Working File and Fiscal Intermediary Standard System Informational Unsolicited Response or Denial of Inpatient Services Related to a Hospice Terminal Diagnosis (MM8273 Rescinded)</td>
<td>84</td>
</tr>
<tr>
<td>Additional Data Reporting Requirements for Hospice Claims (MM8258 Revised)</td>
<td>85</td>
</tr>
<tr>
<td>Aprepitant for Chemotherapy Induced Emesis (MM8418)</td>
<td>90</td>
</tr>
<tr>
<td>Update to Pub 100-04, Claims Processing Manual, Chapter One (MM8442)</td>
<td>94</td>
</tr>
<tr>
<td>Implementing the Part B Inpatient Payment Policies from CMS-1599-F (MM8445)</td>
<td>96</td>
</tr>
<tr>
<td>Addition of New Fields and Expansion of Existing Model 1 Discount Percentage Field in the Inpatient Hospital Provider Specific File and Renaming Payment Fields in the Inpatient Prospective Payment System Pricer Output (MM8546)</td>
<td>102</td>
</tr>
<tr>
<td>Therapy Modifier Consistency Edits (MM8556)</td>
<td>105</td>
</tr>
<tr>
<td>Enforcement of the 5 Day Payment Limit for Respite Care under the Hospice Medicare Benefit (MM8569)</td>
<td>107</td>
</tr>
<tr>
<td>Point of Origin for Admission or Visit Code (Formerly Source of Admission Code) for Inpatient Psychiatric Facilities (SE1401)</td>
<td>110</td>
</tr>
<tr>
<td>Special Instructions for the International Classification of Diseases, Clinical Modification 10th Edition Coding on Home Health Episodes that Span October 1, 2014 (SE1410 Revised)</td>
<td>113</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Centers for Medicare &amp; Medicaid Services – Articles for Part B Providers</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Nonphysician Specialty Code for Indirect Payment Procedure Billers (MM8282)</td>
<td>119</td>
</tr>
</tbody>
</table>

Contact information can be found on our Web site at http://www.NGSMedicare.com. Medicare policies can be accessed from the Medical Policy Center section of our Web site. Providers without access to the Internet can request hard copies from National Government Services.

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This bulletin should be shared with all health care practitioners and managerial members of the providers/suppliers staff. Bulletins issued during the last two years are available at no cost from our Web site at http://www.NGSMedicare.com.
Local Coverage Determinations and Article Revisions and Updates
Effective March 2014

February 2014 Revisions


Article A51849 for Percutaneous Laminotomy/Laminectomy (Intralaminar Approach) (0275T) has been retired effective January 9, 2014. Centers for Medicare & Medicaid Services (CMS) issued a Decision Memo for Percutaneous Image-guided Lumbar Decompression for Lumbar Spinal Stenosis (CAG-00433N) which replaces Article A51849.

Denosumab (Prolia™, Xgeva™) - Related to Local Coverage Determination (LCD) L25820 (A50361)

Article published February 2014: The International Classification of Diseases, Clinical Modification, 9th Revision (ICD-9-CM) Code Groups have been revised for clarification. The Group 4: Paragraph section has been revised to indicate that an ICD-9-CM code from Group 4, Group 5 and Group 6 must be reported to indicate treatment to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer.

The Group 7: Paragraph has been added to indicate that an ICD-9-CM code from Group 7, Group 8 and Group 9 must be reported to indicate treatment to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer.

Health and Behavior Assessment/Intervention - Medical Policy Article (A48209)

Article published February 2014: The following statement “Health and Behavior Assessment/Intervention (CPT codes 96150-96154) may only be performed by a Clinical Psychologist (CP-Specialty Code 68) and Clinical Social Worker (CSW-Specialty Code 80).” has been revised to remove a Clinical Social Worker (CSW-Specialty Code 80) from the article effective January 16, 2014. It has been determined that a CSW is not eligible to render health and behavior assessment/intervention services, based on the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 170B, (1 MB) which states:

“Section 1861(hh)(2) of the Act defines “clinical social work services” as those services that the CSW is legally authorized to perform under state law (or the state regulatory mechanism provided by state law) of the state in which such services are performed for the diagnosis and treatment of mental illnesses.”

March 2014 New and Revised LCDs

Endoscopic Treatment of GERD (L33371) (New for Jurisdiction K [JK])

Benefits are not available for endoluminal treatment for Gastroesophageal Reflux Disease (GERD) using the Stretta® procedure, the Bard EndoCinch™ Suturing System, Plicator™, Enteryx®, EsophyX™ or similar treatments as these procedures are not considered reasonable and necessary for the diagnosis or treatment of an injury or disease.

Currently, these procedures are considered noncovered due to the fact that current peer-reviewed literature does not support the efficacy of the services.

Molecular Pathology (L34506) (New for Jurisdiction 6 [J6] and JK)

The American Medical Association (AMA) CPT Manual states molecular pathology procedures are medical laboratory procedures involving the analyses of nucleic acid to detect variants in genes that may be indicative of germline (e.g., constitutional disorders) or somatic (e.g., neoplasia) conditions, or to test for histocompatibility antigens (e.g., HLA).

Many applications of the molecular pathology procedures are not covered services given lack of benefit category (preventive service) and/or failure to reach the reasonable and necessary threshold for coverage (based on quality of clinical evidence and strength of recommendation). Furthermore, payment of claims

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in the past (based on stacking codes) or in the future (based on the new code series) is not a statement of coverage since the service was not audited for compliance with program requirements and documentation supporting the reasonable and necessary testing for the beneficiary. Certain molecular pathology procedures may be subject to prepayment medical review (records requested) and paid claims must be supportable, if selected, for post payment audit by the Medicare Administrative Contractor (MAC) or other contractors. Molecular pathology tests for diseases or conditions that manifest severe signs or symptoms in newborns and in early childhood or that result in early death (e.g., Canavan disease) could be subject to automatic denials since these tests are not usually relevant to a Medicare beneficiary.

This LCD gives general guidance to the medically reasonable and necessary applications of the Molecular Pathology Procedures described in CPT range 81200–81408 (with the exception of HLA testing 81370–81383).

Nerve Blocks for Peripheral Neuropathy (L33385) (New for JK)
At present, the literature and scientific evidence supporting the use of peripheral nerve blocks or injections in multiple neuropathies or underlying systemic diseases that are producing peripheral neuropathies, especially for the Medicare population, is insufficient to warrant coverage. These procedures are considered investigational, and are not eligible for coverage for the treatment of multiple neuropathies or peripheral neuropathies caused by underlying systemic diseases.

Nerve Conduction Studies and Electromyography (L33386) (Revised for J6 and JK)
The existing J6 LCD was submitted as a proposed LCD revision to the JK and J6 MAC jurisdictions, for public and Carrier Advisory Committee (CAC) comment from 10/18/2013 through 12/01/2013 and has been revised as follows:

- Specific Indications and Limitations, and Covered ICD-9 Codes for Neuromuscular Junction Testing have been added to the LCD.
- Language restricting testing to Neurologists and Physical Medicine and Rehabilitation specialists has been deleted.
- A statement that neuromuscular junction testing code 95937 is not allowed by Physical Therapists has been deleted.
- Statements defining the supervision levels for Needle electromyographic (EMG) codes 95860-95872 and 95885-95887 have been clarified to add this provision: If authorized by state law and if meeting certification criteria, Physical Therapists are allowed the technical and professional components of the test.
- Reference to the LCD for Botulinum Toxins has been added in relation to EMG use for injection of botulinum toxins.

For the JK MAC, this LCD supersedes LCD L26869 effective 03/01/2014.

Radiofrequency Treatment for Urinary Incontinence (L33388) (New for JK)
At present, the literature and scientific evidence supporting the use of radiofrequency micro-remodeling by a transurethral, transvaginal or paraurethral approach, (Renessa™ and similar devices) especially for the Medicare population, is insufficient to warrant coverage. These procedures are considered investigational, and are not eligible for coverage for the treatment of urinary incontinence.

Reduction Mammaplasty (L34186) (New for J6)
The existing JK LCD was submitted as a Proposed LCD Revision to the JK and J6 MAC jurisdictions for public and CAC comment from 10/18/2013 through 12/01/2013 and has been revised as follows:

- Under Indications of Coverage, deleted the following language: “evidenced by nerve conduction studies” from the bullet under Indications of Coverage that states “Signs and symptoms of ulnar paresthesias evidenced by nerve conduction studies”
- Under Indications of Coverage, deleted the following language:
  1. “The amount of breast tissue anticipated to be removed is at least 300 grams per breast.”
  2. When the patient’s normal breast is reduced to achieve symmetry with a breast reconstructed after cancer surgery.
• Under Indications of Coverage, deleted the following language:
  "The following are guidelines (not rules) that address the patient’s weight and the amount of
  breast tissue removed: 95-119 lbs. 300 grams excised per breast 110-130 lbs. 400 grams
  excised per breast 130+ lbs. 500 grams excised per breast"
• Under Indications of Coverage, added the following guidelines:
  Considerable attention has been given to the amount of breast tissue removed in differentiating
  between cosmetic and medically necessary reduction mammoplasty. To be considered a non-
  cosmetic procedure, it is expected that at least a minimal amount of breast tissue will be removed.
  Yet, arbitrary minimum weight breast tissue removed criteria do not consistently reflect the
  consequences of mammary hypertrophy in individuals with a unique body habitus. There are wide
  variations in the range of height, weight, and associated breast size that cause symptoms. The
  amount of tissue that must be removed in order to relieve symptoms will vary and depend upon
  these variations.
• The following are guidelines (not rules) that address the patient's body surface area (BSA) and
  the amount of breast tissue removed:
  BSA 1.35-1.45 199-238g
  BSA 1.46-1.55 239-284g
  BSA 1.56-1.69 285-349g
  Equal to or greater than 350g

Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) (L34187) (Revised for J6 and JK)
The existing JK LCD was submitted as a Proposed LCD Revision to the JK and J6 MAC jurisdictions for
public and CAC comment from 10/18/2013 through 12/01/2013 and has been revised as follows:
• Under ICD9CM Codes That Support Medical Necessity section for CPT Code 92133: Deleted
diagnosis code 379.27 and added diagnosis code 365.9
• Under ICD9CM Codes That Support Medical Necessity section for CPT Code 92132: Deleted
diagnosis codes 364.81 and 366.16
• Under ICD9CM Codes That Support Medical Necessity section for CPT Code 92134: Added
diagnosis codes: 115.02, 115.12, 115.92, 228.03, 361.11, 361.12, 361.13, 361.14, 361.19,
  362.33, 362.34, 362.84, 363.50, 363.51, 363.52, 363.53, 363.54, 363.55, 363.56, 363.57, 368.14
• Added the following language that relates to CPT code 92134:
  "Use V71.89 when testing is necessary prior to chloroquine (CQ) and hydroxychloroquine (HCQ)
  therapy.
  *Use V58.69 and V67.51 to report testing due to the use of chloroquine (CQ) and/or
  hydroxychloroquine (HCQ).
  *Use V71.89 when testing is necessary prior to GILENYA™ (fingolimod) therapy.
  *Use V58.69 and V67.51 to report testing due to the use of GILENYA (fingolimod) therapy.
• Added Revenue Code 0969 Other Professional Services

The following indication of coverage is reordered to the first position from the seventh position:
  "Diagnose and manage medically and surgically retinal and neuro-ophthalmic diseases which involve
  changes in the optic nerve, subretinal and intraretinal changes, vtreo-retinal relationships and
  changes in the nerve fiber layer."

Venous Angioplasty with or without Stent Placement for the Treatment of Chronic Cerebrospinal
Venous Insufficiency (L33389) (New for JK)
Venous angioplasty (with or without stent placement) is currently under investigation as a method to
improve blood flow in chronic cerebrospinal venous insufficiency (CCSVI). The hypothesis is that
symptoms of MS might improve with this treatment. Unfortunately, MS is associated with frequent
spontaneous exacerbations of signs and symptoms. Thus it is very difficult to determine whether any
change in medical condition is due to a treatment, or merely represents a normal fluctuation of the
disease process. The literature currently is inconclusive on whether balloon angioplasty and/or stent
placement are clinically effective in treating patients with MS.
The evidence is inconclusive as to whether CCSVI impacts multiple sclerosis and therefore if treatment with angioplasty would impact the disease. Therefore, venous angioplasty (with or without stent placement) for any of the jugular veins, azygos veins, or other thoracic veins is considered investigational and not medically necessary for the treatment of multiple sclerosis and not covered by Medicare.

**Bevacizumab (e.g., Avastin™) – Related to LCD L25820 (A46095)**

**Article published March 2014:** Uterine neoplasms – endometrial carcinoma has been added to the “Indications” section of the article and ICD-9-CM code 182.0 has been added to “Group 1: Codes” in the “Covered ICD-9 Codes” section of the article effective for dates of service on or after 01/01/2014.

**Category III CPT Code Coverage – Related to LCD L25275 (A46075)**

**Article published March 2014:** Based on a reconsideration request for coverage of high dose rate electronic brachytherapy, per fraction (0182T), received on August 7, 2013, sources were added to the “Sources of Information and Basis for Decision” section. No changes were made in coverage.

**Initial Hospital Care Visits – Medical Policy Article (A48210)**

The article has been retired, effective 03/01/2014, because current guidance regarding initial hospital care is available in the CMS manuals.

**Psychiatry and Psychology Services (L26895)**

Under Section II Interactive Complexity (90785)

The following language was revised from the Documentation section from “The medical record must reflect the elements outlined in the above description and must be rendered by a qualified provider (see "Limitations" subsection below) and must indicate that the person being evaluated does not have the ability to interact through normal verbal communicative channels. Additionally, the medical record must include adaptations utilized in the session and the rationale for employing these interactive techniques. If the patient is capable of ordinary verbal communication, this code should not be used. The medical record must include treatment recommendations.” to read “The medical record must reflect the elements outlined in the above description and must be rendered by a qualified provider (see "Limitations" subsection below). Additionally, the medical record must include adaptations utilized in the session and the rationale for employing these interactive techniques. The medical record must include treatment recommendations.”

**Under Limitations**

Added clarification of mild dementia “(e.g., Mini Mental Status Examination score above 15)”

Patients with dementia represent a very vulnerable population in which comorbid psychiatric conditions are common. However, for such a patient to benefit from psychotherapy services requires that their dementia be mild (e.g., Mini Mental Status Examination score above 15), and that they retain their capacity to recall their therapeutic encounter from one session, individual or group, to another. This capacity to meaningfully benefit from psychotherapy must be documented in the medical record. Psychotherapy services are not covered when documentation indicates that dementia has produced a severe enough cognitive defect to prevent psychotherapy from being effective.

**Under Section VII: Central Nervous System Assessments/Tests**

Under Comments, revised the following sentence, “Neuropsychological testing does not rely on self-report questionnaires such as the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), rating scales such as the Hamilton Depression Rating Scale, or projective techniques such as the Rorschach or Thematic Apperception Test (TAT)” to read “Neuropsychological testing does not rely on self-report questionnaires such as the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), rating scales such as the Hamilton Depression Rating Scale, or projective techniques such as the Rorschach or Thematic Apperception Test (TAT) when questions of how brain damage or degenerative disease processes (e.g. right hemisphere CVA) may be affecting emotional expression or how significant emotional distress or mood impairment might be affecting cognitive function (e.g. question of presence of "pseudodementia") arise.
Under Limitations
Revised the following language, "The psychological testing codes should not be reported by the treating physician for reading the testing report or explaining the results to the patient or family. Payment for these services is included in the payment for other services rendered to the patient, such as evaluation and management services." to read "The psychological testing codes should not be reported by the treating physician for only reading the testing report, generated by another clinician, or explaining the results of a neuropsychological assessment generated by another clinician to the patient or family."

Revised the following sentence, "Payment for psychological testing is limited to physicians, clinical psychologists, and on a limited basis, to qualified non-physician practitioners (e.g., speech language pathologists for aphasia evaluation)." to read "Payment for these services is included in the payment for other services rendered to the patient, including both services provided by neuropsychologists and psychologists and evaluation and management services, billed provided by physicians, e.g., neurologists, rehabilitation medicine physicians, and psychiatrists.

Revised the following language, "Psychological testing to evaluate adjustment reactions or dysphoria associated with placement in a nursing home is not medically necessary." to read "Adjustment reactions or dysphoria associated with moving to a nursing facility do not constitute medical necessity for psychological testing. However, if a more serious mood disorder (e.g., major depression) is suspected upon admission to a nursing facility, psychological or neuropsychological testing may be indicated for differential diagnostic purposes and to develop appropriate treatment planning."

Section VII: Central Nervous System Assessments/Tests
Added the following note: Neuropsychological Testing (96101, 96102, 96103, 96105, 96110*, 96111, 96116, 96118, 96119, and 96120):
  Requires the submission of any ICD-9CM Code that is consistent with the indications of coverage.

Revised the following language "Typically, psychological testing will require from four (4) to six (6) hours to perform, including administration, scoring and interpretation. If the testing is done over several days, the testing time should be combined and reported all on the last date of service. If the testing time exceeds eight (8) hours, a report may be requested to indicate the medical necessity for extended testing" to read "Typically, psychological testing will require from four (4) to six (6) hours to perform, including administration, scoring and interpretation. If the testing is done over several days, the testing time should be combined and reported all on the last date of service. If the testing time exceeds eight (8) hours, medical necessity for extended time should be documented. Medical records may be requested.

Under Sources of Information Section
Added the following references:

Under Other Comments Section
Removed the following “Other Comment” Language:
  For claims submitted to the fiscal intermediary or Part A MAC: this coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated National Government Services to process their claims.

Bill type codes only apply to providers who bill these services to the fiscal intermediary or Part A MAC. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the Part B MAC.
Limitation of liability and refund requirements apply when denials are anticipated, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

No comment and notice periods required and none given.

**Removal of Benign Skin Lesions (L27362)**

**Under Abstract**

The following language was deleted:

"Benign skin lesions are common in the elderly and are frequently removed at the patient's request to improve appearance. Removals of certain benign skin lesions that do not pose a threat to health or function are considered cosmetic, and as such, are not covered by the Medicare Program. These cosmetic reasons include, but are not limited to, emotional distress, “makeup trapping,” and non-problematic lesions in any anatomic location. Lesions in sensitive anatomical locations that are not creating problems do not qualify for removal coverage on the basis of location alone.”

The following language was moved from the Abstract to the Limitations section:

"Removals of certain benign skin lesions that do not pose a threat to health or function are considered cosmetic, and as such, are not covered by the Medicare Program."

The following language was moved from the Abstract to the Documentation section:

"The type of removal is at the discretion of the treating physician and the appropriateness of the technique used will not be a factor in deciding if a lesion merits removal. However, a benign lesion excision (CPT 11400-11446) must have medical record documentation as to why an excisional removal, other than for cosmetic purposes, was the surgical procedure of choice."

The following language was moved from the Abstract to the Limitations section:

"Removals of certain benign skin lesions that do not pose a threat to health or function are considered cosmetic, and as such, are not covered by the Medicare Program."

**Under Documentation**

The following language was deleted:

“A statement of “irritated skin lesion” will be insufficient justification for lesion removal when used solely to refer a patient, describe a complaint or the physician's physical findings. Similarly, use of an ICD-9 code 702.11 (Inflamed seborheic keratosis) will be insufficient to justify lesion removal, without the medical record documentation of the patients’ symptoms and physical findings. It is important to document the patient's signs and symptoms as well as the physician's physical findings.

Drawings or diagrams to describe the precise anatomical location of the lesion are helpful. A procedural note, protocol describing indications, diagnosis, methodology of treatment, or modality is advised.

The decision to submit a specimen for pathologic interpretation will be independent of the decision to remove or not remove the lesion. It is assumed, however, that a tissue diagnosis will be part of the medical record when an ultimately benign lesion is removed based on physician uncertainty as to the final clinical diagnosis.

Not all of the conditions listed in the Indications section of this LCD represent a specific diagnosis, but may be conditions supporting a diagnosis. For example, if a lesion is excised because of suspicion of malignancy (e.g., ICD-9-CM code 238.2), the Medical Record might include “increase in size” to support this diagnosis. “Increase in size” might also support the diagnosis of disturbance of skin sensation (782.0)."

**Under Limitations**

The following language was deleted:
“If the beneficiary wishes one or more of these benign asymptomatic lesions removed for cosmetic purposes, the beneficiary becomes liable for the service rendered. The physician has the responsibility to notify the patient in advance that Medicare will not cover cosmetic dermatological surgery and that the beneficiary will be liable for the cost of the service. It is strongly advised that the beneficiary, by his or her signature, accept responsibility for payment. Charges should be clearly stated as well.

Other Comments
- For claims submitted to the fiscal intermediary or Part A MAC: this coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated National Government Services to process their claims.
- Bill type codes only apply to providers who bill these services to the fiscal intermediary or Part A MAC. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.
- Limitation of liability and refund requirements apply when denials are anticipated, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.”

The following language was moved to the Documentation section:

“The type of removal is at the discretion of the treating physician and the appropriateness of the technique used will not be a factor in deciding if a lesion merits removal. However, a benign lesion excision (CPT 11400-11446) must have medical record documentation as to why an excisional removal, other than for cosmetic purposes, was the surgical procedure of choice”

The following language was moved to the Supplemental Instructions Article (SIA):

“Excision is defined as full-thickness (through the dermis) removal of a lesion, including margins, and includes simple (nonlayered) closure when performed. Each benign lesion excised should be reported separately.

Code selection is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margins required equals the excised diameter). The margins refer to the most narrow margin required to adequately excise the lesion, based on the physician's judgment. The measurement of lesion plus margin is made prior to excision.”

Under ICD-9-CM Codes that Support Medical Necessity
The requirement to report both a primary and secondary diagnosis code has been eliminated. The following ICD-9-CM codes have been added to the primary diagnosis code section: 682.0-682.9, 686.8, 782.0, 782.9, V10.82, V10.83.

The following ICD9CM codes have been deleted:
279.00- 279.13, 279.19, 279.2-279.3, 279.41, 279.49, 338.19, 368.40, 368.44, 368.8, 368.9, 369.8, 372.10, 372.11, 372.12, 372.30, 374.81, 459.0, 682.0-682.9,686.8-686.9,,692.9,695.89, 695.9, 698.9, 708.9, 729.5, 782.0, 782.9, 959.8, V10.82, V10.83, V58.77

Removal of Benign Skin Lesions – SIA (A47397)
Article published March 2014: The following language was added to the CPT coding section of the article:

“Excision is defined as full-thickness (through the dermis) removal of a lesion, including margins, and includes simple (nonlayered) closure when performed. Each benign lesion excised should be reported separately.

Code selection is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margins required
equals the excised diameter). The margins refer to the most narrow margin required to adequately excise the lesion, based on the physician's judgment. The measurement of lesion plus margin is made prior to excision."

The following language was deleted from the ICD-9 coding section:

"Report ICD-9 code 338.19 to reflect acute pain (other than in a lesion) as a complication supporting the need for removal of a lesion, in addition to a primary ICD-9 code representing the type of lesion being removed.

Report ICD-9 code 782.9 to report lesion pain as a secondary diagnosis supporting the need for removal of the lesion, in addition to a primary ICD-9 code representing the type of lesion."
Centers for Medicare & Medicaid Services
Articles for Part A&B Providers
NEW product from the Medicare Learning Network® (MLN)

- “Information on the National Physician Payment Transparency Program: Open Payments,” Podcast, ICN 908961, downloadable only.

MLN Matters® Number: MM8456
Related Change Request (CR) #: CR 8456
Related CR Release Date: February 5, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R1336OTN
Implementation Date: July 7, 2014

Modifying the Daily Common Working File (CWF) to Medicare Beneficiary Database (MBD) File to Include Diagnosis Codes on the Health Insurance Portability and Accountability Act Eligibility Transaction System (HETS) 270/271 Transactions

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs and Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8456, which informs Medicare contractors about changes to the Medicare Beneficiary Database (MBD) File to include Diagnosis Codes on the Health Insurance Portability and Accountability Act Eligibility Transaction System (HETS) 270/271 transactions.

The HETS 271 response transaction will include as much Medicare Secondary Payer (MSP) information as possible to assist providers, physicians, and suppliers to identify which diagnosis codes

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are relevant to given MSP no-fault, liability, and workers’ compensation cases. The diagnosis codes that the provider community will access via the HETS 270/271 process will assist providers, physicians, and other suppliers to better determine when Medicare is the secondary payer in association with their patients’ current liability, no fault, or workers’ compensation incidents that may prompt beneficiaries to seek medical services. Please ensure that your billing staffs are aware of these changes.

Background

The HETS 270/271 process is used by providers, physicians, and other suppliers to receive individual beneficiary eligibility information under the Medicare program, including information found on the CWF MSP auxiliary file. Although most MSP information from the MSP record is currently included on the HETS 271 response transaction, International Classification of Diseases (ICD), Clinical Modification (CM), diagnosis codes are not included. The Centers for Medicare & Medicaid Services (CMS) believes it would be beneficial for CWF to include ICD-CM diagnosis codes, as derived from MSP no-fault, liability, and workers’ compensation MSP auxiliary records, on the interface file that it sends to MBD. Through a separate Medicare Advantage Prescription Drug CR, CMS will ensure that the MBD table information that is exchanged with HETS will be modified to include ICD diagnosis codes. Thereafter, the diagnosis codes will be included in the HETS 271 response transaction that CMS makes available to providers, physicians, and suppliers.

Since the HETS 271 response transaction can only accommodate up to 8 diagnosis codes, CR8456 instructs CWF to send up to 25 iterations of diagnosis codes associated with MSP no-fault, liability, and workers’ compensation records for inclusion on the HETS 271 response transaction.

Additional Information


If you have any questions, please contact your MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

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INTERNATIONAL CLASSIFICATION OF DISEASES, 10TH REVISION (ICD-10) TESTING WITH PROVIDERS THROUGH THE COMMON EDITS AND ENHANCEMENTS MODULE (CEM) AND COMMON ELECTRONIC DATA INTERCHANGE (CEDI)

Note: This article was revised on February 27, 2014, to reflect a revised CR that provides additional information to providers, suppliers, and clearinghouses about how claims will be submitted for testing (page 2 in bold). The transmittal number, CR release date and link to the CR were also changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for Medicare providers and suppliers submitting claims to Medicare contractors (A/B Medicare Administrative Contractors (A/B MACs), Home Health and Hospice MACs (HHH MACs) and the Durable Medical Equipment MACs (DME MACs) for services to Medicare beneficiaries.

What Providers Need to Know

This article is based on Change Request (CR) 8465, which announces plans for front-end ICD-10 testing between MACs and their trading partners.

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For dates of service of October 1, 2014 (and after) providers are required to submit ICD-10 codes on their claims. MACs must provide the opportunity for providers and suppliers to submit test claims through the CEM or the CEDI on the designated testing days.

- Test claims with ICD-10 codes must be submitted with current dates of service (i.e. October 1, 2013 through March 3, 2014), since testing does not support future dated claims.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected in the system.
- Testing will not confirm claim payment or produce remittance advice.
- MACs and CEDI will be staffed to handle increased call volume during this week.

Make sure that your billing staff is aware of these upcoming ICD-10 testing periods.

**Background**

CMS is in the process of implementing ICD-10. All covered entities have to be fully compliant on October 1, 2014.

CR8465 instructs all Medicare MACs and the DME MACs CEDI contractor to implement an ICD-10 testing week with trading partners. The concept of trading partner testing was originally designed to validate the trading partners’ ability to meet technical compliance and performance processing standards during the HIPAA 5010 implementation. The ICD-10 testing week has been created to generate awareness and interest and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

This testing week will give trading partners access to the MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on each MAC and the CEDI website as well as the CMS website.

The testing week will be March 3 through March 7, 2014.

**Testing Week Information:**

- Your MAC will announce and actively promote the testing week via listserv messages and will post the testing week announcement on their website.
- Your MAC will host a registration site for the testing week, or provide an email address for the trading partners to provide registration information. The registration site or email address information will be available and publicized to trading partners at least four weeks prior to the testing week.
- During the testing week, EDI help desk support will be available, at a minimum, from 9:00 a.m. to 4:00 p.m. local contractor time, with enough support to handle any increased call volume.
• Providers and suppliers participating during the testing week will receive electronic acknowledgement confirming that the submitted test claims were accepted or rejected.

• On or before March 18, 2014, your contractor will report the following to CMS:
  • Number of trading partners conducting testing during the testing week.
  • Percent of trading partners that conducted testing during the testing week (versus number of trading partners supported) by contract.
  • Percent of test claims accepted versus rejected.
  • Report of any significant issues found during testing.

Additional Information


• If you have any questions, please contact your MAC at their toll-free number, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.

News Flash - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:


• [HealthMap Vaccine Finder](http://www.cms.gov/Regulations-and-Guidance/Transmittals/Downloads/R1353OTN.pdf) - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community.


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Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) for Solid Tumors

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers and suppliers submitting claims to Medicare A/B Administrative Contractors (MACs) for services to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8468, which advises you that, effective for claims with dates of service on and after June 11, 2013, the Centers for Medicare & Medicaid Services (CMS) will cover three Fluorodeoxyglucose Positron Emission Tomography (FDG PET) scans (without the Coverage with Evidence Development (CED) requirement) when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same cancer diagnosis. Coverage of any additional FDG PET scans (that is, beyond three) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer...
therapy for the same diagnosis will be determined by the local MACs. Make sure that your billing staffs are aware of these changes.

**Background**

CMS was asked to reconsider Section 220.6, of the "National Coverage Determinations (NCD) Manual," to end the prospective data collection requirements across all oncologic indications of FDG PET in the context of this document. The term FDG PET includes PET/Computed Tomography (CT) and PET/Magnetic Resonance (MRI).

CMS is revising the NCD Manual, Section 220.6.17, to reflect that CMS has ended the CED requirement for 18 Fluorodeoxyglucose FDG PET and PET/CT and PET/MRI for all oncologic indications contained in Section 220.6.17 of the NCD Manual. This removes the current requirement for prospective data collection by the National Oncologic PET Registry (NOPR) for oncologic indications for FDG (HCPCS A9552) only.

Effective for services performed on or after June 11, 2013:

- The CED requirement has ended and modifier -Q0/-Q1, along with condition code 30 (institutional claims only), or V70.7 (both institutional and practitioner claims) are no longer required.
- MACs shall pay FDG PET claims for subsequent management, identified by CPT codes 78608, 78811, 78812, 78813, 78814, 78815, or 78816, modifier –PS, HCPCS A9552, and the same cancer dx code, which exceeded 3 FDG PET scans when the -KX modifier is included on the claim line.
- MACs will not search their files to identify claims processed prior to implementation of CR8468; however, they will adjust such claims that you bring to their attention.

MACs will deny subsequent treatment strategy (-PS) claims for FDG PET, which exceeded 3 FDG PET scans when a -KX modifier is not included on the claim line using the following:

- Claim Adjustment Reason Code (CARC) 96: “Non-covered charge(s). Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- Remittance Advice Remarks Code N435: “Exceeds number/frequency approved/allowed within time period without support documentation.”
- 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; or,
- Group Code PR assigning financial liability to the beneficiary if a claim is received with a GA modifier indicating a signed ABN is on file.

**NOTE:** For clarification purposes, as an example, each, different, cancer dx is allowed 1 initial treatment strategy (-PI modifier) PET scan and 3 subsequent treatment strategy (-PS modifier) PET scans without the -KX modifier. The 4th PET scan and beyond for the same cancer dx will always require the -KX modifier. If a different cancer dx is reported, that cancer dx will allow the same
scenario as above, 1 initial, 3 subsequent, no -KX modifier required, 4 or more for same dx requires a -KX modifier.

**Note:** The only exception to the above frequency is with dx 185.0, prostate cancer, which is non-covered for initial treatment strategy. Therefore, all -PI modifiers for 185.0 would be denied, and -PS modifiers would follow the same frequency as all other cancer dx codes.

For claims with dates of service on or after July 7, 2014, contractors shall deny subsequent treatment strategy (-PS) claims for oncologic FDG PET scans when no initial treatment strategy (-PI) claim is present in history when appropriate. CWF will begin counting at this point. The prostate cancer exception above applies.

MACs shall deny subsequent treatment strategy (-PS) claims for oncologic FDG PET scan claims when no initial treatment strategy (-PI) claim is present in history using the following:

- CARC B5: "Coverage/program guidelines were not met or were exceeded."
- RARC N640: "Exceeds number/frequency approved/allowed within time period."
- Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- 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:** Providers should refer to Attachment A of CR8468 for appropriate oncologic diagnosis codes.


**Additional Information**


If you have any questions, please contact your MAC at their toll-free number, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.

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- “Information on the National Physician Payment Transparency Program: Open Payments,” Podcast, ICN 908961, downloadable only.

MLN Matters® Number: MM8485  
Related Change Request (CR) #: CR 8485
Related CR Release Date: February 6, 2014  
Effective Date: July 1, 2014
Related CR Transmittal #: R1342OTN  
Implementation Date: July 7, 2014

Reporting Principal and Interest Amounts When Refunding Previously Recouped Money on the Remittance Advice (RA)

Provider Types Affected

This MLN Matters® Article is intended for physicians and other providers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8485 which informs MACs about changes necessary to create a new process that insures refunded principal and associated interest amounts can be reported separately on remittance advices and that claim identifiers are used to identify the appropriate claim for which those amounts apply. Make sure that your billing staffs are aware of these changes.

Background

CMS was advised that the current practice of reporting principal and interest amounts for all related claims on the Remittance Advice (RA) as one lump sum amount was creating problems for the provider community since it was not conducive to the proper posting of payments. CR8485 instructs...
the MACs on how to report refunded principal and interest amounts separately and how to use claim identifiers to indicate the appropriate claim for those amounts. Providers should see these changes appear on RAs created after CR8485 is implemented on July 7, 2014.

Step-by-step instructions on how refunds with interest on previously recouped money are handled (including step(s) required by providers), as well as an example of reporting for the new Refund PLB Codes, are found in Attachment 1 to this CR.

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number, which is at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.

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**News Flash** - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- **MLN Matters® Article #MM8433**, “Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season”
- **MLN Matters® Article #SE1336**, “2013-2014 Influenza (Flu) Resources for Health Care Professionals”
- **HealthMap Vaccine Finder** - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community.
- **Free Resources** can be downloaded from the CDC website including prescription-style tear-pads that will allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu. On the CDC order form, under “Programs”, select “Immunizations and Vaccines (Influenza/Flu)” for a list of flu related resources.

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In September 2012, the Centers for Medicare & Medicaid Services (CMS) announced the availability of a new electronic mailing list for those who refer Medicare beneficiaries for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Referral agents play a critical role in providing information and services to Medicare beneficiaries. To ensure you give Medicare patients the most current DMEPOS Competitive Bidding Program information, CMS strongly encourages you to review the information sent from this new electronic mailing list. In addition, please share the information you receive from the mailing list and the link to the “mailing list for referral agents” subscriber webpage with others who refer Medicare beneficiaries for DMEPOS. Thank you for signing up!

MLN Matters® Number: MM8494 Revised Related Change Request (CR) #: CR 8494
Related CR Release Date: January 31, 2014 Effective Date: October 1, 2014
Related CR Transmittal #: R2865CP Implementation Date: January 6, 2014

Changes to the Laboratory National Coverage Determination (NCD) Software for ICD-10 Codes

Note: This article was revised on February 4, 2014, to reflect the revised CR8494, issued on January 31, 2014. In the article, the transmittal number, CR release date, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for clinical diagnostic laboratories submitting claims to A/B Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

CR8494, from which this article is taken, provides that the Laboratory National Coverage Determination (NCD) Edit Software will be updated to accommodate the processing of the International Classification of Diseases, Tenth Revision (ICD-10) diagnosis codes. This is a follow-up to CR8202 Changes to the Laboratory National Coverage Determination (NCD) Software for ICD-10

**Background**

In accordance with the “Medicare Claims Processing Manual”, Chapter 16 (Laboratory Services), Section 120.2 (Implementation and Updates of Negotiated National Coverage Determinations (NCDs) for Clinical Diagnostic Laboratory Services), the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintaining codes in the negotiated NCDs and for biannual updates of the ICD-9-CM codes.

CR 8494, from which this article is taken, instructs the Medicare Shared Systems Maintainers to update the Laboratory NCD Edit Software to accommodate the processing of the ICD-10 diagnosis codes. There are no updates to the laboratory NCD code lists for this quarter.

**Additional Information**


If you have any questions, please contact your A/B MAC at their toll-free number, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS Website.

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- “Vaccine Payments Under Medicare Part D” Fact Sheet, ICN 908764, downloadable and hard copy

MLN Matters® Number: MM8506
Related Change Request (CR) #: CR 8506
Related CR Release Date: February 5, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R159NCD
Implementation: October 1, 2014

Pub 100-03, Chapter 1, Language-only Update

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to A/B Medicare Administrative Contractors (A/B MACs), Hospice and Home Health (HH&H MACs), and Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8506 as an informational alert to providers that language-only changes—updates to the “Medicare National Coverage Determinations (NCD) Manual”, Pub 100-03—were made.

The changes were made to comply with:

1. Conversion from ICD-9 to ICD-10;
2. Conversion from ASC X12 Version 4010 to Version 5010;
3. Conversion of former contractor types to MACs; and,

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4. Other miscellaneous editorial and formatting updates provided for better clarity, correctness, and consistency.

**NOTE:** The edits made to the NCD Manual are technical/editorial only and in no way alter existing NCD policies.

**Background**

These edits to Pub. 100-03 are part of a CMS-wide initiative to update its manuals and bring them in line with recently released instructions regarding the above-noted subject matter.

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.
National Coverage Determination (NCD) for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare Claims Administration Contractors (A/B Medicare Administrative Contractors (A/B MACs)) for cardiac pacemaker services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8525 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” (Chapter 1, Part 1, Section 20.8, Cardiac Pacemakers) and the “Medicare Claims Processing Manual” (Chapter 32, Section 320, Billing Requirements for Cardiac Pacemakers: Single and Dual Chamber) which were revised by and included as attachments to CR 8525. CR 8525 is effective for claims with dates of service on or after August 13, 2013.

Make sure that your billing personnel know about 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.

The implantation procedure is typically performed under local anesthesia and requires only a brief hospitalization. A catheter is inserted into the chest, and the pacemaker’s leads are threaded through the catheter to the appropriate chamber(s) of the heart. The surgeon then makes a small “pocket” in the pad of the flesh under the skin on the upper portion of the chest wall to hold the power source. The pocket is then closed with stitches.

On August 13, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD). In this NCD, 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.
3. Asymptomatic sinus bradycardia.
4. Asymptomatic sino-atrial block or asymptomatic sinus arrest.
5. Ineffective atrial contractions (e.g., chronic atrial fibrillation or flutter, or giant left atrium) without symptomatic bradycardia.
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.
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.
10. Asymptomatic bradycardia in post-myocardial infarction patients about to initiate long-term beta-blocker drug therapy.
11. Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of tachycardia.
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 the Social Security Act (Section 1862(a)(1)(A); see http://www.ssa.gov/OP_Home/ssact/title18/1862.htm) 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.

Note: MACs will 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)).

Other key notes for billing:

- MACs will pay professional claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, provided the claim contains at least one of the CPT codes of 33206, 33207, or 33208 AND one of the following ICD-9_CM/ICD-10-CM diagnostic codes, and only when the claim is submitted with the KX modifier:
  - 426.0/I44.2
  - 426.12/I44.1
  - 426.13/I44.1
  - 427.81/I49.5, or
  - 746.86/Q24.6

- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the CPT codes and at least one of the diagnosis codes listed above along with the KX modifier:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
  - 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

- Contractors will return claim lines if the KX modifier is not present using the following message:
  - Claim Adjustment Reason Code (CARC) 4: The procedure code is inconsistent with the modifier used or a required modifier is missing.

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• Remittance Advice Remarks Code (RARC) N517: Resubmit a new claim with the requested information.

• Effective for claims with dates of service on or after August 13, 2013, MACs will pay **outpatient institutional** claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, (codes C1785, C1786, C2619, or C2620) provided the claim contains the KX modifier, and contains at least one of the CPT codes 33206, 33207, or 33208, AND one of the following ICD-9_CM/ICD-10-CM diagnostic codes:
  - 426.0/I44.2
  - 426.12/I44.1
  - 426.13/I44.1
  - 427.81/I49.5, or
  - 746.86/Q24.6

• MACs will return outpatient institutional claims for implanted permanent cardiac pacemakers that do not meet the preceding requirements.

• The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the CPT codes and diagnosis codes listed above:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
  - 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

• Effective for claims with dates of service on or after August 13, 2013, MACs will pay **inpatient** claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, provided the claim contains one of the following ICD-9/ICD-10 diagnosis AND procedure codes:
  - 37.81/0JH604Z, 0JH634Z, 0JH804Z, 0JH834Z, 37.82/0JH605Z, 0JH635Z, 0JH805Z, 0JH835Z, or 37.83/0JH606Z, 0JH636Z, 0JH806Z, 0JH836Z, AND
  - 426.0/I44.2, 426.12/I44.1, 426.13/I44.1, 427.81/I49.5, or 746.86/Q24.6

• The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the CPT codes and diagnosis codes listed above:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
o 426.4 Right bundle branch block / I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block

o 427.0 Paroxysmal supraventricular tachycardia / I47.1 Supraventricular tachycardia

In addition, be aware of the following:

- MACs will deny claims for implanted dual chamber for one of the following CPT codes: 33206, 33207, or 33208 and contains at least one of the following ICD-9-CM/ICD-10-CM diagnosis codes (even if submitted with at least one of the acceptable diagnosis codes listed above):
  
  o 426.11/I44.0
  o 427.31/I48.1/I48.2/I48.91
  o 427.32/I48.2/I48.3/I48.4/ or l48.91
  o 427.89/I49.8/ R00.1
  
  o 780.2/R55

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 at least one diagnosis code from the list of ICD-9/ICD-10 diagnosis codes above:

- CARC 96: Non-covered charge(s).
- RARC N569: Not covered when performed for the reported diagnosis.
- Group Code - CO (contractual obligation), if claim received with GZ modifier indicating no signed Advance Beneficiary Notice (ABN) is on file or Group Code PR (Patient Responsibility) if occurrence code 32 indicating a signed ABN is on file or occurrence code 32 with modifier GA is present.

NCDs are binding on all MACs and contractors with the Federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and administrative law judges (ALJs). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See the Social Security Act, Section 1869(f)(1)(A)(i), at [http://www.ssa.gov/OP_Home/ssact/title18/1869.htm](http://www.ssa.gov/OP_Home/ssact/title18/1869.htm) on the Internet.)

Additional Information

The official instruction, CR 8525, was issued to your MACs regarding this change via two transmittals. The first is the transmittal that updates the NCD Manual and it is available at may be viewed at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R161NCD.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R161NCD.pdf) on the CMS website. The second transmittal updates the “Medicare Claims Processing Manual” and it is at

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Are you ready to transition to ICD-10 on October 1, 2014? In this MLN Connects™ video on ICD-10 Coding Basics, Sue Bowman from the American Health Information Management Association (AHIMA) provides a basic introduction to ICD-10 coding, including:

- Similarities and differences;
- ICD-10 code structure; and
- Coding process and examples.

To receive notification of upcoming MLN Connects videos and calls and the latest Medicare program information on ICD-10, subscribe to the weekly MLN Connects™ Provider eNews.

MLN Matters® Number: MM8526
Related Change Request (CR) #: CR 8526
Related CR Release Date: February 6, 2014
Effective Date: September 27, 2013
Related CR Transmittal #: 2871CP/160NCD
Implementation July 7, 2014

Medicare National Coverage Determination (NCD) for Beta Amyloid Positron Emission Tomography (PET) in Dementia and Neurodegenerative Disease

Provider Types Affected

This MLN Matters® Article is intended for physicians and other providers who submit claims to Medicare A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries with dementia or neurodegenerative disease.

What You Need to Know

Effective for claims with dates of service on or after, September 27, 2013, the Centers for Medicare & Medicaid Services (CMS) will only allow coverage for PET Aβ imaging (one PET Aβ scan per patient) through coverage with evidence development (CED) to: (1) develop better treatments or prevention strategies for Alzheimer’s Disease (AD), or, as a strategy to identify subpopulations at risk for developing AD, or (2) resolve clinically difficult differential diagnoses (e.g., frontotemporal dementia

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(FTD) versus AD) where the use of PET Aβ imaging appears to improve health outcomes, when the patient is enrolled in an approved clinical study under CED.

**Background**

After careful consideration, effective for claims with dates of service on or after September 27, 2013, CMS believes that the evidence is insufficient to conclude that PET Aβ imaging improves health outcomes for Medicare beneficiaries with dementia or neurodegenerative disease. However, there is sufficient evidence that the use of PET Aβ imaging could be promising in certain scenarios. Therefore, Medicare will only allow coverage for PET Aβ imaging (one PET Aβ scan per patient) through CED to:

1. Develop better treatments or prevention strategies for AD, or, as a strategy to identify subpopulations at risk for developing AD, or

2. Resolve clinically difficult differential diagnoses (e.g., FTD versus AD) where the use of PET Aβ imaging appears to improve health outcomes, when the patient is enrolled in an approved clinical study under CED.

Health outcomes may include:

1. Avoidance of unnecessary or potentially harmful treatment or tests;
2. Improving, or slowing the decline of, quality of life (to include maintenance of independence) and cognitive and functional status; and,

Outcomes may be short-term (e.g., related to meaningful changes in clinical management) or long-term (e.g., related to dementia outcomes).

A list of ICD-9 and corresponding ICD-10 Codes for Beta Amyloid for Dementia and Neurodegenerative Diseases is in the following table.

<table>
<thead>
<tr>
<th>ICD-9 Codes</th>
<th>Corresponding ICD-10 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>290.0 Senile dementia, uncomplicated</td>
<td>F03.90 Unspecified dementia without behavioral disturbance</td>
</tr>
<tr>
<td>290.10 Presenile dementia, uncomplicated</td>
<td>F03.90 Unspecified dementia without behavioral disturbance</td>
</tr>
<tr>
<td>290.11 Presenile dementia with delirium</td>
<td>F03.90 Unspecified dementia without behavioral disturbance</td>
</tr>
<tr>
<td>290.12 Presenile dementia with delusional features</td>
<td>F03.90 Unspecified dementia without behavioral disturbance</td>
</tr>
<tr>
<td>290.13 Presenile dementia with depressive features</td>
<td>F03.90 Unspecified dementia without behavioral disturbance</td>
</tr>
<tr>
<td>290.20 Senile dementia with delusional features</td>
<td>F03.90 Unspecified dementia without behavioral disturbance</td>
</tr>
<tr>
<td>290.21 Senile dementia with depressive features</td>
<td>F03.90 Unspecified dementia without behavioral disturbance</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>290.3</td>
<td>F03.90 Unspecified dementia without behavioral disturbance</td>
</tr>
<tr>
<td>290.40</td>
<td>F01.50 Vascular dementia without behavioral disturbance</td>
</tr>
<tr>
<td>290.41</td>
<td>F01.51 Vascular dementia with behavioral disturbance</td>
</tr>
<tr>
<td>290.42</td>
<td>F01.51 Vascular dementia with behavioral disturbance</td>
</tr>
<tr>
<td>290.43</td>
<td>F01.51 Vascular dementia with behavioral disturbance</td>
</tr>
<tr>
<td>294.10</td>
<td>F02.80 Dementia in other diseases classified elsewhere without behavioral disturbance</td>
</tr>
<tr>
<td>294.11</td>
<td>F02.81 Dementia in other diseases classified elsewhere with behavioral disturbance</td>
</tr>
<tr>
<td>294.20</td>
<td>F03.90 Unspecified dementia without behavioral disturbance</td>
</tr>
<tr>
<td>294.21</td>
<td>F03.91 Unspecified dementia with behavioral disturbance</td>
</tr>
<tr>
<td>331.11</td>
<td>G31.01 Pick's disease</td>
</tr>
<tr>
<td>331.19</td>
<td>G31.09 Other frontotemporal dementia</td>
</tr>
<tr>
<td>331.6</td>
<td>G31.85 Corticobasal degeneration</td>
</tr>
<tr>
<td>331.82</td>
<td>G31.83 Dementia with Lewy bodies</td>
</tr>
<tr>
<td>331.83</td>
<td>G31.84 Mild cognitive impairment, so stated</td>
</tr>
<tr>
<td>780.93</td>
<td>R41.1 Anterograde amnesia</td>
</tr>
<tr>
<td></td>
<td>R41.2 Retrograde amnesia</td>
</tr>
<tr>
<td></td>
<td>R41.3 Other amnesia (Amnesia NOS, Memory loss NOS)</td>
</tr>
<tr>
<td>V70.7</td>
<td>Z00.6 Encounter for examination for normal comparison and control in clinical research program</td>
</tr>
</tbody>
</table>

Effective for claims with dates of service on or after September 27, 2013, MACs will return to provider/return as unprocessable claims for PET Aβ imaging, through CED during a clinical trial, not containing the following:

- Condition code 30, (for institutional claims only);
- Modifier Q0 and/or modifier Q1 as appropriate;
- ICD-9 dx code V70.7/ICD-10 dx code Z00.6 (on either the primary/secondary position);

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• A PET HCPCS code 78811 or 78814;
• Dx codes (see list in table above); and
• Aβ HCPCS code A9586 or A9599.

MACs will return as unprocessable claims for PET Aβ imaging using the following messages:

• Claim Adjustment Reason Code (CARC) 4 – the procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
• Remittance Advice Remark Code (RARC) N517 – Resubmit a new claim with the requested information.
• RARC N519 – Invalid combination of HCPCS modifiers.

For claims with dates of service on or after September 27, 2013, Medicare will deny/reject claims for more than one PET Aβ scan; HCPCS code A9586 or A9599, in a patient's lifetime.

MACs will line-item deny claims for PET Aβ, HCPCS code A9586 or A9599, where a previous PET Aβ, HCPCS code A9586 or A9599 is paid in history using the following messages:

• CARC 149: “Lifetime benefit maximum has been reached for his service benefit category.”
• RARC N587: “Policy benefits have been exhausted.”
• 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.
• 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 that MACs will not automatically adjust claims processed prior to implementation of CR8526, but they will adjust such claims that you bring to their attention.

NOTE: Each new beta amyloid radiopharmaceutical will require a separate code. Therefore, for the interim period, HCPCS code (A9599) - Radiopharmaceutical for beta-amyloid positron emission tomography (PET) imaging, diagnostic, per study dose shall be used with an effective date of January 1, 2014. After a new beta amyloid radiopharmaceutical is approved for a separate, individual HCPCS code, a subsequent CR will be issued to update this NCD policy.

NOTE: Contractors should refer to the business requirements in CR8526 well as general clinical trial billing requirements at Pub. 100-03, chapter 1, section 310, and Pub. 100-04, chapter 32, section 69. See Pub. 100-03, NCD Manual, chapter 1, section 220.6.20, for the coverage of Beta Amyloid PET in Neurodegenerative Disease and Dementia, and Pub. 100-04, Claims Processing Manual, chapter 13, section 60.12, for claims processing instructions.
**Additional Information**


If you have any questions, please contact your A/B MAC contractor at their toll-free number, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.

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NEW product from the Medicare Learning Network® (MLN)

- “Information on the National Physician Payment Transparency Program: Open Payments,” Podcast, ICN 908961, downloadable only.

MLN Matters® Number: MM8582 Revised
Related Change Request (CR) #: CR 8582
Related CR Release Date: February 24, 2014
Effective Date: April 1, 2014
Related CR Transmittal #: R2884CP
Implementation Date: April 7, 2014

Claim Status Category and Claim Status Codes Update

Note: This article was revised on February 27, 2014, to reflect an updated Change Request (CR). The CR corrects the date when the Claim Status Category Codes and Claim Status Codes will be posted, which is March 1, 2014. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) and Home Health & Hospice MACs, for services to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8582 which informs Medicare contractors about the changes to Claim Status Category Codes and Claim Status Codes. Make sure that your billing personnel are aware of these changes.

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Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (e.g. previous HIPAA named versions included 004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at [http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/](http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/) and [http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/](http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/) on the Internet.

All code changes approved during the January 2014 committee meeting shall be posted on these sites on or about March 1, 2014. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

These code changes are to be used in the editing of all X12 276 transactions processed on or after the date of implementation and are to be reflected in X12 277 transactions issued on and after the date of implementation of CR 8582.

Additional Information


If you have any questions, please contact your MAC at their toll-free number, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.

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MLN Matters® Number: MM8597
Related Change Request (CR) #: CR 8597
Related CR Release Date: February 14, 2014
Effective Date: May 15, 2014
Related CR Transmittal #: R2878CP
Implementation Date: May 15, 2014

Correction CR - Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, (including Home Health Agencies) and suppliers that submit claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice Medicare Administrative Contractors (H&HH MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs), for services to Medicare beneficiaries.

What You Need to Know

This article, based on Change Request (CR) 8597, provides the removal of language that was erroneously included in CR8404 and in the "Medicare Claims Processing Manual," Chapter 30, Sections 50.3 and 50.6.2. It also provides clarified manual instructions regarding home health agency issuance of the Advance Beneficiary Notice of Noncoverage (ABN) to dual eligible beneficiaries.

Background

The ABN is an Office of Management and Budget (OMB)-approved written notice issued by providers and suppliers for items and services provided under Medicare Part B, including hospital outpatient

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services, and care provided under Part A by home health agencies (HHAs), hospices, and religious non-medical healthcare institutes only.

**Key Points of CR8597**

- With the exception of Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) suppliers, providers and suppliers who are not enrolled in Medicare cannot issue the ABN to beneficiaries. DMEPOS suppliers not enrolled as Medicare suppliers are required by statute to provide ABN notification prior to furnishing any items or services to Medicare beneficiaries.

- An example of an approved customization of the ABN which can be used by providers of laboratory services (Sample Lab ABN) is now available for download at [http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html).

- When issuing ABNs to dual eligibles or beneficiaries having a secondary insurer, HHAs are permitted to direct the beneficiary to select a particular option box on the notice to facilitate coverage by another payer. This is an exception to the usual ABN issuance guidelines prohibiting the notifier from selecting one of the options for the beneficiary. When a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer, HHAs should instruct beneficiaries to select Option 1 on the ABN. HHAs may add a statement in the “Additional Information” section to help a dual eligible better understand the payment situation such as, “We will submit a claim for this care with your other insurance,” or “Your Medical Assistance plan will pay for this care.” HHAs may also use the “Additional Information” on the ABN to include agency specific information on secondary insurance claims or a blank line for the beneficiary to insert secondary insurance information. Agencies can pre-print language in the “Additional Information” section of the notice.

- Some States have specific rules established regarding HHA completion of liability notices in situations where dual eligibles need to accept liability for Medicare noncovered care that will be covered by Medicaid. Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is recognized as the “payer of last resort”, meaning other Federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid picks up any remaining charges. In the past, some States directed HHAs to select the third checkbox on the HHABN to indicate the choice to bill Medicare. On the ABN, the first check box under the “Options” section indicates the choice to bill Medicare and is similar to the third checkbox on the outgoing HHABN. **Note: If there has been a State directive to submit a Medicare claim for a denial, HHAs must mark the first check box when issuing the ABN.**

- HHAs serving dual eligibles should comply with existing HHABN State policy within their jurisdiction as applicable to the ABN unless the State instructs otherwise. The appropriate option selection for dual eligibles will vary depending on the State’s Medicaid directive. If the HHA’s State Medicaid office does NOT want a claim filed with Medicare prior to filing a claim with Medicaid, the HHA should direct the beneficiary to choose Option 2. When Option 2 is chosen based on State guidance, but the HHA is aware that the State sometimes asks for a Medicare claim submission at a later time, the HHA must add a statement in the “Additional
Information” box such as “Medicaid will pay for these services. Sometimes, Medicaid asks us to file a claim with Medicare. We will file a claim with Medicare if requested by your Medicaid plan.

Additional Information


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MLN Matters® Number: MM8619
Related Change Request (CR) #: CR 8619
Related CR Release Date: February 21, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R1351OTN
Implementation Date: July 7, 2014

Implementation of Health Insurance Portability & Accountability Act (HIPAA) Standards and Operating Rules for Health Care Electronic Funds Transfers

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and Home Health and Hospice (HH&H) MACs, for services to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8619, which informs Medicare contractors that Section 1104 of the Affordable Care Act mandates the adoption of a standard for the Health Care Electronic Funds Transfers (EFT) HIPAA transaction and operating rules for the Health Care EFT and Remittance Advice Transaction.

The main intent of these standards and operating rules is to assure health plans transmit a trace number that allows providers to re-associate the EFT health care payment with its associate electronic remittance advice. Make sure that your billing staffs are aware of these changes.

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Note that CR 8619 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the ACH (EFT) Network with electronic health care payments.

Physicians, other providers, and suppliers should be aware that, consequently, the payment information that a provider receives or that is transmitted from a provider’s financial institution regarding the health care EFT payment may change as per these requirements. Specifically, the Company Entry Description and the TRN Segment that is reported or transmitted to a provider from its financial institution may change in terms of content or length.

Providers are urged to contact their financial institutions directly in order to understand the form in which payment information will be transmitted or reported on a per payment basis as a result of CR8619. We suggest that providers should subsequently take steps to assure that the payment information that is changed as a result of related CR 8629 (see the related article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8629.pdf can be accommodated by your accounting processes and systems.

Background


A new National Automated Clearinghouse Association (NACHA) standard for electronic healthcare claim payments went into effect on September 20, 2013, impacting all originators and receivers of electronic funds transfers (EFT) used to pay healthcare claims. This Healthcare EFT standard stems from the Affordable Care Act, which requires that healthcare payers must pay healthcare claim payments electronically using HIPAA standards if requested by the healthcare provider.

The standard designated for these claim payments is the Healthcare EFT Standard, which is a NACHA CCD+ transaction that includes the ASC X12 835 TRN data segment in the addenda record. The Healthcare EFT Standard requires the following:

- Company Entry Description of “HCCLAIMPMT” to identify the payment as healthcare;
- Company Name should be the health plan or third party administrator paying the claim;
- An addenda record must be included with a Record Type Code of “7” and an Addenda Type Code equal to “05”; and
- Payment Related Information in the addenda record must contain the ASC X12 835 TRN (Re-association Trace Number) data segment that is included on the electronic remittance advice.

Healthcare providers will use the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result,

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specific addenda formatting requirements must be followed for healthcare EFT payments. The TRN data segment must contain the following data elements, separated by an asterisk "*".

Example: TRN*1*12345*1512345678*9999999~

TRN, TRN01, TRN02, TRN03, TRN04, Segment Terminator

* data element separator

<table>
<thead>
<tr>
<th>Element</th>
<th>Element Name</th>
<th>Mandatory or Optional</th>
<th>Data Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRN</td>
<td>Re-association Trace Number</td>
<td>M</td>
<td>ASC X12 835 segment identifier. This is always “TRN”.</td>
</tr>
<tr>
<td>TRN01</td>
<td>Trace Type Code</td>
<td>M</td>
<td>Trace Type Code is always a “1”.</td>
</tr>
<tr>
<td>TRN02</td>
<td>Re-association Information</td>
<td>M</td>
<td>This data element must contain the EFT trace number.</td>
</tr>
<tr>
<td>TRN03</td>
<td>Origination Company ID</td>
<td>M</td>
<td>A unique identifier designating the company initiating the funds transfer.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>This must be a “1” followed by the payer’s Tax Identification Number (TIN).</td>
</tr>
<tr>
<td>TRN04</td>
<td>Reference Identification</td>
<td>O</td>
<td>This data element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.</td>
</tr>
<tr>
<td>Segment Terminator</td>
<td>Segment Terminator</td>
<td>M</td>
<td>The TRN data segment in the addenda record must end with either a tilde “~” or a backslash “\”.</td>
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**Additional Information**


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

**News Flash** - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- **MLN Matters® Article #MM8433**, “Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season”
- **MLN Matters® Article #SE1336**, “2013-2014 Influenza (Flu) Resources for Health Care Professionals”
- **HealthMap Vaccine Finder** - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community.

**Free Resources** can be downloaded from the CDC website including prescription-style tear-pads that will allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu. On the CDC order form, under “Programs”, select “Immunizations and Vaccines (Influenza/Flu)” for a list of flu related resources.

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CWF Editing for Vaccines Furnished at Hospice - Correction

Provider Types Affected

This MLN Matters® Article is intended as an update for non-hospice providers furnishing vaccines to hospice beneficiaries and submitting claims to Medicare Administrative Contractors (MACs).

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8620 to alert providers that any provider may furnish vaccines to hospice beneficiaries. Be sure your billing staffs are aware of this change.

Background

When CR 8098, Transmittal 1298, was published, effective October 1, 2013, it denied claims for vaccines furnished to hospice patients that were provided by anyone other than the patient's hospice provider. This was to enforce the statement in the “Medicare Claims Processing Manual”, chapter 18, section 10.2.4 that vaccines “may be covered when furnished by the hospice.” CMS has determined that this enforcement is too restrictive, since the manual does not say “only when furnished by the hospice.”

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hospice.” CR 8620 removes the changes made to Medicare systems in CR 8098, in order to allow any provider to furnish vaccines to hospice beneficiaries.

**Key Points**

- Your MAC will allow professional claims for vaccines (Influenza, PPV, and Hepatitis B) and vaccine administration containing modifier GW when the date of service falls within a hospice election.

- Your MAC will adjust vaccine claims with dates of service on or after October 1, 2013, which were previously rejected due to a hospice election, if you bring such claims to your MAC’s attention.

**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](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.

**News Flash** - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- **MLN Matters® Article #MM8433**, “Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season”
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- **Free Resources** can be downloaded from the CDC website including prescription-style tear-pads that will allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu. On the CDC order form, under “Programs”, select “Immunizations and Vaccines (Influenza/Flu)” for a list of flu related resources.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

REVISED product from the Medicare Learning Network® (MLN)

- “Quick Reference Information: Medicare Immunization Billing” Educational Tool, ICN 006799, downloadable

MLN Matters® Number: MM8629 Related Change Request (CR) #: CR 8629
Related CR Release Date: February 21, 2014 Effective Date: July 1, 2014
Related CR Transmittal #: R1349OTN Implementation Date: July 7, 2014

Implementation of National Automated Clearinghouse Association (NACHA) Operating Rules for Health Care Electronic Funds Transfers (EFT)

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) for services to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8629 which informs MACs that they must comply with NACHA Operating Rules that are applicable to initiators of health care payments. CR 8629 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the ACH (EFT) Network with electronic health care payments. The overarching goal of the requirements of CR 8629 are to assure that providers receiving health care payments via EFT will receive a “trace number” that facilitates automatic reassociation of the EFT health care payment with its associated remittance advice.

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Physicians, other providers, and suppliers should be aware that, consequently, the payment information that a provider receives or that is transmitted from a provider’s financial institution regarding the health care EFT payment may change as per these requirements. Specifically, the Company Entry Description and the TRN Segment that is reported or transmitted to a provider from its financial institution may change in terms of content or length.

Providers are urged to contact their financial institutions directly in order to understand the form in which payment information will be transmitted or reported on a per payment basis as a result of CR8629. We suggest that providers should subsequently take steps to assure that the payment information that is changed as a result of CR 8629 can be accommodated by your accounting processes and systems.

Background

In support of Health Insurance Portability & Accountability Act of 1996 (HIPAA) Operating Rules for health care EFT and remittance advice transactions adopted by HHS, NACHA – The Electronic Payments Association has adopted its own operating rules that apply to ACH transactions that are health care payments from health plans to providers. NACHA manages the development, administration and governance of the ACH Network used by all types of financial networks and represents more than 10,000 financial institutions.

A new NACHA standard for electronic healthcare claim payments went into effect on September 20, 2013, impacting all originators and receivers of EFT used to pay healthcare claims. This Healthcare EFT standard stems from the Affordable Care Act, which requires that healthcare payers must pay healthcare claim payments electronically using HIPAA standards if requested by the healthcare provider.

The standard designated for these claim payments is the Healthcare EFT Standard, which is a NACHA CCD+ transaction that includes the ASC X12 835 TRN data segment in the addenda record. The Healthcare EFT Standard requires the following:

- Company Entry Description of “HCCLAIMPMT” to identify the payment as healthcare;
- Company Name should be the health plan or third party administrator paying the claim;
- An addenda record must be included with a Record Type Code of “7” and an Addenda Type Code equal to “05”; and
- Payment Related Information in the addenda record must contain the ASC X12 835 TRN (Re-association Trace Number) data segment that is included on the electronic remittance advice.

Healthcare providers will utilize the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result, specific addenda formatting requirements must be followed for healthcare EFT payments. See “Healthcare EFT Standard Format” in the Medicare IOM for more information.

Example:

TRN*1*12345*1512345678*9999999~
TRN, TRN01, TRN02, TRN03, TRN04, Segment Terminator

* data element separator

The following table explains this example:

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<td>Reference Identification</td>
<td>O</td>
<td>This data element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.</td>
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<td>The TRN data segment in the addenda record must end with either a tilde “~” or a backslash “\”.</td>
</tr>
</tbody>
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Additional Information

For information on the NACHA Operating Rules that apply to health care payments, particularly with regard to requirements for originators, see https://healthcare.nacha.org/healthcarerules . The official instruction, CR 8629 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1349OTN.pdf on the CMS website. If you have any questions, please contact your MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

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In September 2012, the Centers for Medicare & Medicaid Services (CMS) announced the availability of a new electronic mailing list for those who refer Medicare beneficiaries for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Referral agents play a critical role in providing information and services to Medicare beneficiaries. To ensure you give Medicare patients the most current DMEPOS Competitive Bidding Program information, CMS strongly encourages you to review the information sent from this new electronic mailing list. In addition, please share the information you receive from the mailing list and the link to the “mailing list for referral agents” subscriber webpage with others who refer Medicare beneficiaries for DMEPOS. Thank you for signing up!

MLN Matters® Number: SE1249 Revised
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

HIPAA Eligibility Transaction System (HETS) to Replace Common Working File (CWF) Medicare Beneficiary Health Insurance Eligibility Queries

Note: This article was revised on February 10, 2014, to update certain language to reflect the current status of this change (see bolded language on page 2). Also, clarifications have been made to the last question in the Frequently Asked Questions section on page 3. All other information is unchanged.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for health care providers, suppliers and their billing agents, software vendors and clearinghouses that use Medicare’s Common Working File (CWF) queries to obtain their patient’s Medicare health insurance eligibility information from Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)).

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Provider Action Needed

If you currently use CWF queries to obtain Medicare health insurance eligibility information for Medicare fee-for-service patients, you should immediately begin transitioning to the Medicare Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS).

What You Need to Know

This article describes upcoming changes to Medicare beneficiary health insurance eligibility inquiry services that the Centers for Medicare & Medicaid Services (CMS) will implement in the coming months. In April 2013, access to CWF eligibility query functions implemented in the Multi-Carrier System (MCS) and ViPS Medicare System (VMS), also referred to as PPTN and VPIQ, was terminated. CMS intends to terminate access to the other CWF eligibility queries implemented in the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE), often referred to as the HIQA, HIQH, ELGA and ELGH screens and HUQA. Change Request 8248 creates the ability for CMS to terminate these queries. While termination was originally scheduled for April 2014, CMS is delaying the date. CMS will provide at least 90 days advanced notice of the new termination date. This will not affect the use of DDE to submit claims or to correct claims and will not impact access to beneficiary eligibility information from Medicare Contractor’s Interactive Voice Response (IVR) units and/or Internet portals.

Background

In 2005, CMS began offering HETS in a real-time environment to Medicare health care providers, suppliers and their billing agents, software vendors and clearinghouses. HETS is Medicare’s Health Care Eligibility Benefit Inquiry and Response electronic transaction, ASCX12 270/271 Version 5010, adopted under HIPAA. HETS replaces the CWF queries, and is to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

Key Points

General Information

CMS plans to discontinue access to the CWF queries through the shared systems. Medicare providers and their agents that currently access the CWF queries through the shared system screens will need to modify their business processes to use HETS to access Medicare beneficiary eligibility information.

HETS

HETS allows Medicare providers and their agents to submit and receive X12N 270/271 eligibility request and response files over a secure connection. Many Medicare providers and their agents are already receiving eligibility information from HETS. For more information about HETS and how to obtain access to the system, refer to the CMS HETS Help web page at...
Frequently Asked Questions

Are Medicare providers that currently use CWF to obtain beneficiary eligibility information required to switch to HETS?

No, but it is recommended. Providers may also choose to use a Medicare Contractor's IVR or Internet portal.

What are the minimum data elements required in order to complete an eligibility search in HETS?

HETS applies search logic that uses a combination of four data elements: Health Insurance Claim Number (HICN), Medicare Beneficiary's Date of Birth, Medicare Beneficiary's Full Last Name (including Suffix, if applicable), and Medicare Beneficiary's Full First Name. The Date of Birth and First Name are optional, but at least one must be present.

Does HETS return the same eligibility information that is currently provided by the CWF eligibility queries?

Changes are currently underway in HETS to return psychiatric information to authorized providers and to return Hospice period information in the same format as CWF. When these changes are made, HETS will return all of the information provided by the CWF eligibility queries that is needed to process Medicare claims. These changes will be in place before the termination date for the FISS DDE CWF query access.

HETS returns additional information that CWF does not return. For example, HETS returns:

- Part D plan number, address and enrollment dates; and.
- Medicare Advantage Organization name, address, website and phone number.


Additional Information

If you use a software vendor or clearinghouse to access Medicare beneficiary health insurance eligibility information, you should direct questions to your vendor or clearinghouse. If you have any questions about HETS, please contact the MCARE Help Desk at 1-866-324-7315.

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In September 2012, the Centers for Medicare & Medicaid Services (CMS) announced the availability of a new electronic mailing list for those who refer Medicare beneficiaries for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Referral agents play a critical role in providing information and services to Medicare beneficiaries. To ensure you give Medicare patients the most current DMEPOS Competitive Bidding Program information, CMS strongly encourages you to review the information sent from this new electronic mailing list. In addition, please share the information you receive from the mailing list and the link to the “mailing list for referral agents” subscriber webpage with others who refer Medicare beneficiaries for DMEPOS. Thank you for signing up!

**MLN Matters® Number:** SE1305 Revised
**Related Change Request (CR) #:** 6421, 6417, 6696, 6856
**Related CR Release Date:** N/A
**Effective Date:** N/A
**Related CR Transmittal #:** R642OTN, R643OTN, R328PI, and R781OTN
**Implementation Date:** N/A

**Note:** This article was revised on February 6, 2014, to modify the answer to question J on page 10 (underlined). The article was previously changed on November 6, 2013, to provide updated information regarding the effective date of the edits (January 6, 2014). Additional clarifying information regarding the Advance Beneficiary Notice, CARC codes and DME rental equipment has also been updated. Please review the article carefully for these changes. All other information remains the same.

**Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)**
Note: This article was previously revised on April 19, 2013, to add references to the CMS-1450 form and to add question H. on page 9. Previously, it was revised on April 3, 2013, to advise providers to not include middle names and suffixes of ordering/referring providers on paper claims. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid National Provider Identifier (NPI) and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html on the CMS website.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA), the Department of Defense (DoD), or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries,

- Part B providers and suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare Administrative Contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and

- Part A Home Health Agency (HHA) services who submit claims to Regional Home Health Intermediaries (RHHIs), Fiscal Intermediaries (FIs, who still maintain an HHA workload), and Part A/B MACs.

- Optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.

Provider Action Needed

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) or by completing the paper enrollment application (CMS-855O). Review the background and additional information below and make sure that your billing staff is aware of these updates.

What Providers Need to Know

Phase 1: Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication.
Phase 2: Effective January 6, 2014, CMS will turn on the edits to deny Part B clinical laboratory and imaging, DME, and Part A HHA claims that fail the ordering/referring provider edits.

Claims submitted identifying an ordering/referring provider and the required matching NPI is missing will continue to be rejected. Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit will not expose a Medicare beneficiary to liability. Therefore, an Advance Beneficiary Notice is not appropriate in this situation. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services, including home health, DMEPOS, imaging and clinical laboratory.

Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring field found on http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html on the CMS website. Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the ordering/referring fields.

All enrollment applications, including those submitted over the Internet, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application. Waiting too long to begin this process could mean that your enrollment application may not be processed prior to the implementation date of the ordering/referring Phase 2 provider edits.

Background

The Affordable Care Act, Section 6405, "Physicians Who Order Items or Services are required to be Medicare Enrolled Physicians or Eligible Professionals," requires physicians or other eligible professionals to be enrolled in the Medicare Program to order or refer items or services for Medicare beneficiaries. Some physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program. Also, effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the NPI. The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B clinical laboratory and imaging, DME, and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:
• Claims from clinical laboratories for ordered tests;
• Claims from imaging centers for ordered imaging procedures;
• Claims from suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for ordered DMEPOS; and
• Claims from Part A Home Health Agencies (HHA).

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

• Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.)
• Physician Assistants,
• Clinical Nurse Specialists,
• Nurse Practitioners,
• Clinical Psychologists,
• Interns, Residents, and Fellows,
• Certified Nurse Midwives, and
• Clinical Social Workers.

CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

• Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
• Home Health Agency (HHA) services may only be ordered or referred by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Doctor of Podiatric Medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
• Optometrists may only order and refer DMEPOS products/services, and laboratory and X-Ray services payable under Medicare Part B.
Questions and Answers Relating to the Edits

1. What are the ordering and referring edits?

The edits will determine if the Ordering/Referring Provider (when required to be identified in Part B clinical laboratory and imaging, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and contains a valid NPI (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. Why did Medicare implement these edits?

These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. How and when will these edits be implemented?

These edits were implemented in two phases:

**Phase 1 - Informational messaging:** Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication. The informational messages used are identified below:

For Part B providers and suppliers who submit claims to carriers:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N264</td>
<td>Missing/incomplete/invalid ordering provider name</td>
</tr>
<tr>
<td>N265</td>
<td>Missing/incomplete/invalid ordering provider primary identifier</td>
</tr>
</tbody>
</table>

For adjusted claims, the Claims Adjustment Reason Code (CARC) code 16 (Claim/service lacks information which is needed for adjudication.) is used.

DME suppliers who submit claims to carriers (applicable to 5010 edits):

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N544</td>
<td>Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future</td>
</tr>
</tbody>
</table>

For Part A HHA providers who order and refer, the claims system initially processed the claim and added the following remark message:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N272</td>
<td>Missing/incomplete/invalid other payer attending provider identifier</td>
</tr>
</tbody>
</table>
For adjusted claims the CARC code 16 and/or the RARC code N272 was used.

CMS has taken actions to reduce the number of informational messages.

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.¹

On January 28, 2010, CMS made available to the public, via the Downloads section of the “Ordering Referring Report” page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the Report twice a week. At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report and to download it, go to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html; click on “Ordering & Referring Information” (on the left). Information about the Report will be displayed.

Phase 2: Effective January 6, 2014, CMS will turn on the Phase 2 edits. In Phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral.

Below are the denial edits for Part B providers and suppliers who submit claims to Part A/B MACs, including DME MACs:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>254D or 001L</td>
<td>Referring/Ordering Provider Not Allowed To Refer/Order</td>
</tr>
<tr>
<td>255D or 002L</td>
<td>Referring/Ordering Provider Mismatch</td>
</tr>
</tbody>
</table>

CARC code 16 or 183 and/or the RARC code N264, N574, N575 and MA13 shall be used for denied or adjusted claims.

Claims submitted identifying an ordering/referring provider and the required matching NPI is missing (edit 289D) will continue to be rejected. CARC code 16 and/or the RARC code N265, N276 and MA13 shall be used for rejected claims due to the missing required matching NPI.

¹ NPIs were added only when the matching criteria verified the NPI.

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CPT only copyright 2012 American Medical Association.
Below are the denial edits for Part A HHA providers who submit claims:

<table>
<thead>
<tr>
<th>Reason Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| 37236       | - The statement “From” date on the claim is on or after the date the phase 2 edits are turned on  
- The type of bill is ‘32’ or ‘33’  
- Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code |
| 37237       | - The statement “From” date on the claim is on or after the date the phase 2 edits are turned on  
- The type of bill is ‘32’ or ‘33’  
- The type of bill frequency code is ‘7’ or ‘F-P’  
- Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code |

**Effect of Edits on Providers**

I order and refer. How will I know if I need to take any sort of action with respect to these two edits?

In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, you, the ordering/referring provider, need to ensure that:

a. You have a current Medicare enrollment record.
   - If you are not sure you are enrolled in Medicare, you may:
     i. Check the Ordering Referring Report and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI;  
     ii. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or  
     iii. Use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare).
iv. If you choose iii, please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.

b. If you do not have an enrollment record in Medicare.
   - You need to submit either an electronic application through the use of internet-based PECOS or a paper enrollment application to Medicare.
     i. **For paper applications** - fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor.
     ii. **For electronic applications** – complete the online submittal process and either e-sign or mail a printed, signed, and dated Certification Statement and digitally submit any required supporting paper documentation to your designated Medicare enrollment contractor.
     iii. In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement.
     iv. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment web page to learn more about the web-based system before you attempt to use it. Go to [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html), click on “Internet-based PECOS” on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.
     v. If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via internet-based PECOS or .pdf for downloading from the CMS forms page ([http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html)).

c. You are an opt-out physician and would like to order and refer services. What should you do?
   If you are a physician who has opted out of Medicare, you may order items or services for Medicare beneficiaries by submitting an opt-out affidavit to a Medicare contractor within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit).

d. You are of a type/specialty that can order or refer items or services for Medicare beneficiaries. When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty (Chiropractors are excluded) and only the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.

e. I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the Ordering/Referring Provider edits?
   - You need to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records and are of a type/specialty that is...
eligible to order or refer in the Medicare program. If you are not sure that the physician or non-
physician practitioner who is ordering or referring items or services meets those criteria, it is
recommended that you check the Ordering Referring Report described earlier in this article.

- Ensure you are correctly spelling the Ordering/Referring Provider's name.
- If you furnished items or services from an order or referral from someone on the Ordering
  Referring Report, your claim should pass the Ordering/Referring Provider edits.
- The Ordering Referring Report will be replaced twice a week to ensure it is current. It is possible
  that you may receive an order or a referral from a physician or non-physician practitioner who is
  not listed in the Ordering Referring Report but who may be listed on the next Report.

f. Make sure your claims are properly completed.

- On paper claims (CMS-1500), in item 17, only include the first and last name as it appears on the
  Ordering and Referring file found on CMS.gov.
- On paper claims (CMS-1450), you would capture the attending physician's last name, first name
  and NPI on that form in the applicable sections. On the most recent form it would be fields in FL
  76.
- On paper claims (CMS-1500 and CMS-1450), do not enter “nicknames”, credentials (e.g., “Dr.”,
  “MD”, “RPNA”, etc.) or middle names (initials) in the Ordering/Referring name field, as their use
  could cause the claim to fail the edits.
- Ensure that the name and the NPI you enter for the Ordering/Referring Provider belong to a
  physician or non-physician practitioner and not to an organization, such as a group practice that
  employs the physician or non-physician practitioner who generated the order or referral.
- Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1
  (person). Organizations (qualifier 2) cannot order and refer.

If there are additional questions about the informational messages, Billing Providers should contact
their local A/B MAC, or DME MAC.

Claims from billing providers and suppliers that are denied because they failed the ordering/referring
edit shall not expose a Medicare beneficiary to liability. Therefore, an Advance Beneficiary Notice is
not appropriate in this situation. This is consistent with the preamble to the final rule which
implements the Affordable Care Act requirement that physicians and eligible professionals enroll in
Medicare to order and certify certain Medicare covered items and services including home health,
DMEPOS, imaging and clinical laboratory.

g. What if my claim is denied inappropriately?

If your claim did not initially pass the Ordering/Referring provider edits, you may file an appeal through
the standard claims appeals process or work through your A/B MAC or DME MAC.
h. **How will the technical vs. professional components of imaging services be affected by the edits?**

Consistent with the Affordable Care Act and 42 CFR 424.507, suppliers submitting claims for imaging services must identify the ordering or referring physician or practitioner. Imaging suppliers covered by this requirement include the following: IDTFs, mammography centers, portable x-ray facilities and radiation therapy centers. The rule applies to the technical component of imaging services, and the professional component will be excluded from the edits. However, if billing globally, both components will be impacted by the edits and the entire claim will deny if it doesn’t meet the ordering and referring requirements. It is recommended that providers and suppliers bill the global claims separately to prevent a denial for the professional component.

i. **Are the Phase 2 edits based on date of service or date of claim receipt?**

The Phase 2 edits are effective for claims with dates of service on or after January 6, 2014.

j. **A Medicare beneficiary was ordered a 13-month DME capped rental item. Medicare has paid claims for rental months 1 and 2. The equipment is in the 3rd rental month at the time the Phase 2 denial edits are implemented. The provider who ordered the item has been deactivated. How will the remaining claims be handled?**

Claims for capped rental items will continue to be paid for up to 13 months from the physician’s date of deactivation to allow coverage for the duration of the capped rental period.

**Additional Guidance**

1. **Terminology:** Part B claims use the term “ordering/referring provider” to denote the person who ordered, referred, or certified an item or service reported in that claim. The final rule uses technically correct terms: 1) a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services to a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.

2. **Orders or referrals by interns or residents:** The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that State-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if States provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with State law.
3. Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense (DoD)/Tricare: These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

4. Orders or referrals by dentists: Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional Information

For more information about the Medicare enrollment process, visit [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html) or contact the designated Medicare contractor for your State. Medicare provider enrollment contact information for each State can be found at [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf) on the CMS website.


Additional Article Updates


MLN Matters® Article MM6417, “Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors


MLN Matters Article SE1311, " Opting out of Medicare and/or Electing to Order and Refer Services" is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf) informs ordering and referring providers about the information they must provide in a written affidavit to their Medicare contractor when they opt-out of Medicare.

If you have questions, please contact your Medicare Carrier, Part A/B MAC, or DME MAC, at their toll-free numbers, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.

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NEW products from the Medicare Learning Network® (MLN)

- “Hospice Related Services – Part B” Podcast, ICN 908995, downloadable only.

MLN Matters® Number: SE1402  Related Change Request (CR) #: NA
Related CR Release Date: NA  Effective Date: NA
Related CR Transmittal #: NA  Implementation NA

Updated Mobile Applications (Apps) for Open Payments

Provider Types Affected

This MLN Matters® Special Edition (SE) is intended for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs), for services to Medicare beneficiaries.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is issuing this article to alert the provider community of updates to the mobile applications (apps), Open Payments Mobile for Industry and Open Payments Mobile for Physicians, implemented as a result of user feedback to CMS. See the Background and Key Points sections of this article for details.

Also, a part of SE1402 is new technical documentation: “The Open Payments QR Code Reader How-To Guide.” Included are the technical instructions for creating or importing contact information using a QR code reader and generating a QR code to transfer profile or payment information to other user devices.

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Background

In July 2013, CMS released two mobile apps: Open Payments Mobile for Industry and Open Payments Mobile for Physicians. Below are enhancements to the original Open Payments mobile apps. The changes to the apps include the following:

- Streamlining the menu on the Welcome screen;
- Adding the ability to export all profile data associated with a payment into CSV format; and
- Developing a new function to view reports of payments in bar and pie charts.

The apps are intended to support reporting under the Open Payments program. For more details refer to: http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/index.html on the CMS website. For help with the apps contact the CMS helpdesk at OpenPayments@cms.hhs.gov.

Key Points of SE1402

If you already downloaded the apps, you will need to run an update to take advantage of the new app functionality. To do so, visit either the Google Play™ app store or iOS Apple™ app store, look for your available updates, and select the Open Payments apps to download the updates. If you have not yet downloaded the apps, search for Open Payments in the applicable app store and you'll be prompted to download the newly updated versions.

In response to user feedback, the table below describes the enhancements made to the apps since their initial launch in July 2013. All changes are intuitive and will add elements of ease expected by app users.

<table>
<thead>
<tr>
<th>Enhancement Topic</th>
<th>Details – What It Does</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes that Apply to Both Apps</td>
<td>(Open Payments Mobile for Industry and Open Payments Mobile for Physicians)</td>
</tr>
<tr>
<td>Streamlined “Welcome” screen options</td>
<td>• A number of infrequently used menu options (e.g., “Program Information” and “Change Password”) moved from the “Welcome” screen and now appear in a hidden menu.</td>
</tr>
<tr>
<td></td>
<td>• To access the menu, swipe to the right at the “Welcome” screen.</td>
</tr>
<tr>
<td>Reports/Statistics</td>
<td>• A new “Reports/Statistics” button, accessible on the “Welcome” screen, allows the user to create a chart (bar and pie), showing their transfer of value data sorted by physician (within Open Payments Mobile for Industry) or vendor (within Open Payments Mobile for Physicians).</td>
</tr>
<tr>
<td></td>
<td>• This new chart creation capability will streamline data review.</td>
</tr>
</tbody>
</table>
## Enhancement Topic

| CSV exporting                                                                 | When payment data is exported via CSV format, **all** profile data for the associated vendor/physician is included in the CSV file (including address, phone number, etc.).  
|                                                                              | The prior app version included only vendor/physician name in the CSV file. This enhancement will simplify the data review process. |
| Streamlined “Add Payment” process                                          | The steps to "Add Payment" are streamlined to allow the user to enter contact information for the vendor or physician, while staying within the “Add Payment” menu.  
|                                                                              | The prior app version required the user to first enter contact information for the vendor or physician separately, and then go to the “Add Payment” menu. |
| Easy payment duplication                                                    | A new button available on the “View Payment” screen allows payment data to be easily duplicated, in case a physician or vendor has multiple occurrences of the same payment.  
|                                                                              | The only data field that needs to be re-entered is the date. |
| Vendors/Physicians sorted alphabetically                                    | In “Manage Vendors/Physicians,” vendors or physicians are now listed alphabetically.  
<p>|                                                                              | The prior app version listed vendors and physicians in the order in which they were entered. |
| Email/print QR code added                                                   | A “Share” button is available to email or print a QR code that is generated within the app, for sharing at a later time. |
| Payment QR code warning added                                               | After a payment QR code is scanned, a red warning message appears to remind the user to manually add the vendor or physician name to the payment data conveyed in the QR code. |
| Additional data elements added in “Add Payment” &gt; “Travel &amp; Lodging”       | When nature of payment in “Add Payment” is “Travel &amp; Lodging,” the following additional data elements can be entered: city, state, and country of travel (note that these new data elements are required for reporting purposes; but remember, the apps are not used for reporting data, only for tracking it). |
| Tablet support                                                             | Both apps are optimized for viewing on tablet devices. |</p>
<table>
<thead>
<tr>
<th>Enhancement Topic</th>
<th>Details – What It Does</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes that Apply to Just One App</td>
<td></td>
</tr>
<tr>
<td><em>Open Payments Mobile for Physicians</em></td>
<td></td>
</tr>
</tbody>
</table>
| “Manage Companies” added | • Within “Manage Vendors”, a new data field allows users to assign vendors to companies when entering new vendor information.  
• Company information is needed for the “Reports/Statistics” functionality to illustrate all payments by company name. |

The updated [Frequently Asked Questions](#) about the mobile apps contain all the details about these enhancements (link to the document above, or visit the “Apps for Tracking Assistance” page on the Open Payments website).

**QR Code Technical Guide Available for Apps:** Also now available to support use of the Open Payments apps is a how-to-guide that explains the technical details associated with how to create Quick Response (QR) codes usable in the apps. “The Open Payments QR Code Reader How-To Guide” includes detailed, highly technical instructions for creating or importing contact information using a QR code reader, and generating a QR code to transfer profile or payment information to other user’s devices.

**Additional Information**

If you have any questions, please contact your A/B MAC contractor at their toll-free number, which may be found at: [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.


To review the series of SE articles leading up to SE1402 see the following:


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**News Flash** - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- [MLN Matters® Article #MM8433](#), “Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season”
- [MLN Matters® Article #SE1336](#), “2013-2014 Influenza (Flu) Resources for Health Care Professionals”
- [HealthMap Vaccine Finder](#) - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community.
- The [CDC website](#) for Free Resources, including prescription-style tear-pads that allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Are you ready to transition to ICD-10 on October 1, 2014? In this MLN Connects™ video on ICD-10 Coding Basics, Sue Bowman from the American Health Information Management Association (AHIMA) provides a basic introduction to ICD-10 coding, including:

- Similarities and differences;
- ICD-10 code structure; and
- Coding process and examples.

To receive notification of upcoming MLN Connects videos and calls and the latest Medicare program information on ICD-10, subscribe to the weekly MLN Connects™ Provider eNews.

MLN Matters® Number: SE1407 Rescinded 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

Psychiatry and Psychotherapy Services

This article has been rescinded in order to be revised. It will be posted again when the revisions are completed.

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**MLN Matters® Number:** SE1408  
**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

**Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) - A Re-Issue of MM7492**

**Provider Types Affected**

This 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, 2014, 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, 2014. As a result of CR7492 (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, 2014, 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](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, 2014. Institutional claims containing ICD-9 codes for services on or after October 1, 2014, 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, 2014, 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 diagnosis codes on the same claim. For dates of service prior to October 1, 2014, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2014, 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, 2014, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2014, 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, 2014. Institutional claims containing ICD-10 codes for services prior to October 1, 2014, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2014, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

**Claims that Span the ICD-10 Implementation Date**

The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2014, and earlier and where ICD-10 codes are effective for the portion of the services that were...
rendered October 1, 2014, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2014. 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

<table>
<thead>
<tr>
<th>Bill Type(s)</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>11X</td>
<td>Inpatient Hospitals <em>(incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)</em></td>
<td>If the hospital claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>12X</td>
<td>Inpatient Part B Hospital Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>13X</td>
<td>Outpatient Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>14X</td>
<td>Non-patient Laboratory Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>18X</td>
<td>Swing Beds</td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>21X</td>
<td>Skilled Nursing <em>(Inpatient Part A)</em></td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/14, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>Bill Type(s)</td>
<td>Facility Type/Services</td>
<td>Claims Processing Requirement</td>
<td>Use FROM or THROUGH Date</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------------</td>
<td>-------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>22X</td>
<td>Skilled Nursing Facilities (Inpatient Part B)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>23X</td>
<td>Skilled Nursing Facilities (Outpatient)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>32X</td>
<td>Home Health (Inpatient Part B)</td>
<td>Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2014, but require those claims to be submitted using ICD-10 codes.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>3X2</td>
<td>Home Health – Request for Anticipated Payment (RAPs)*</td>
<td>*NOTE - RAPs can report either an ICD-9 code or an ICD-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 10/1/2014.</td>
<td>*See Note</td>
</tr>
<tr>
<td>34X</td>
<td>Home Health – (Outpatient )</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>71X</td>
<td>Rural Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>72X</td>
<td>End Stage Renal Disease (ESRD)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Bill Type(s)</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>73X</td>
<td>Federally Qualified Health Clinics <em>(prior to 4/1/10)</em></td>
<td>N/A – Always ICD-9 code set.</td>
<td>N/A</td>
</tr>
<tr>
<td>74X</td>
<td>Outpatient Therapy</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>75X</td>
<td>Comprehensive Outpatient Rehab facilities</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>76X</td>
<td>Community Mental Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>77X</td>
<td>Federally Qualified Health Clinics <em>(effective 4/4/10)</em></td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>81X</td>
<td>Hospice - Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>82X</td>
<td>Hospice – Non hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>83X</td>
<td>Hospice – Hospital Based</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Bill Type(s)</td>
<td>Facility Type/Services</td>
<td>Claims Processing Requirement</td>
<td>Use FROM or THROUGH Date</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------------</td>
<td>-------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>85X</td>
<td>Critical Access Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2014 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2014 and later.</td>
<td>FROM</td>
</tr>
</tbody>
</table>

### Table B - Special Outpatient Claims Processing Circumstances

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-day /1-day Payment Window</td>
<td>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 10/1/2014, the claim must be billed with ICD-10 for those bundled outpatient services.</td>
<td>THROUGH</td>
</tr>
</tbody>
</table>

### Table C – Professional Claims

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>All anesthesia claims</td>
<td>Anesthesia procedures that begin on 9/30/14 but end on 10/1/14 are to be billed with ICD-9 diagnosis codes and use 9/30/14 as both the FROM and THROUGH date.</td>
<td>FROM</td>
</tr>
</tbody>
</table>

### Table D – Supplier Claims

<table>
<thead>
<tr>
<th>Supplier Type</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH/TO Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMEPOS</td>
<td>Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/14 (i.e., the FROM date of service occurs prior to 10/1/14 and the TO date of service occurs after 10/1/14).</td>
<td>FROM</td>
</tr>
</tbody>
</table>
Additional Information


If you have any questions, please contact your MAC at their toll-free number, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.

**News Flash** - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- **MLN Matters® Article #MM8433**, “Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season”
- **MLN Matters® Article #SE1336**, “2013-2014 Influenza (Flu) Resources for Health Care Professionals”
- **HealthMap Vaccine Finder** - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community.

**Free Resources** can be downloaded from the CDC website including prescription-style tear-pads that will allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu. On the CDC order form, under “Programs”, select “Immunizations and Vaccines (Influenza/Flu)” for a list of flu related resources.

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Implementation Date: N/A

Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach

Note: This article was revised on February 27, 2014, to add information about the second week of acknowledgement testing and to provide more details about end-to-end testing.

Provider Types Affected

This 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.

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Provider Action Needed

For dates of service on and after October 1, 2014, 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, 2014. Be sure you are ready. This MLN Matters® Special Edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

Background

The implementation of International Classification of Diseases, 10th Edition (ICD-10) represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2014, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing to ensure that CMS as well as the Medicare Fee-For-Service (FFS) provider community is ready.

When “you” is used in this publication, we are referring to the FFS provider community.

The four-pronged approach includes:

- CMS internal testing of its claims processing systems;
- Provider-initiated Beta testing tools;
- Acknowledgement testing; and
- End-to-end testing.

Each approach is discussed in more detail below

CMS Internal Testing of Its Claims Processing Systems

CMS has a very mature and rigorous testing program for its Medicare FFS claims processing systems that supports the implementation of four quarterly releases per year. Each release is supported by a three-tiered and time-sensitive testing methodology:

- Alpha testing is performed by each FFS claims processing system maintainer for 4 weeks;
- Beta testing is performed by a separate Integration Contractor for 8 weeks; and
- Acceptance testing is performed by each MAC for 4 weeks to ensure that local coverage requirements are met and the systems are functioning as expected.

CMS began installing and testing system changes to support ICD-10 in 2011. As of October 1, 2013, all Medicare FFS claims processing systems were ready for ICD-10 implementation. CMS continues to test its ICD-10 software changes with each quarterly release.

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Provider-Initiated Beta Testing Tools

To help you prepare for ICD-10, CMS recommends that you leverage the variety of Beta versions of its software that include ICD-10 codes as well as National Coverage Determination (NCD) code crosswalks to test the readiness of your own systems. The following testing tools are available for download:

- The ICD-10 Medicare Severity-Diagnosis Related Groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the General Equivalence Mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at [http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html](http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html) on the CMS website. On this web page, you can also find current versions of the ICD-10-CM MS-DRG Grouper, Medicare Code Editor (available from National Technical Information Service), and MS-DRG Definitions Manual that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and

Crosswalks for Local Coverage Determinations (LCDs) will be available in April 2014.

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2014, you should investigate downloading the free billing software that CMS offers from their MACs. The software has been updated to support ICD-10 codes and requires an internet connection. This billing software only works for submitting fee-for-service claims to Medicare. Alternatively, many MACs offer provider internet portals, and some MACs offer a subset of these portals that you can register for to ensure that you have the flexibility to submit professional claims this way as a contingency.

Acknowledgement Testing

CMS will offer ICD-10 acknowledgement testing from March 3–7, 2014. This testing will allow all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A) that confirms whether the submitted test claims
were accepted or rejected. For more information about acknowledgement testing, refer to the information on your MAC’s website.

CMS plans to offer a second week of acknowledgement testing in early May 2014.

**End-to-End Testing**

In late July 2014, CMS will offer end-to-end testing to a small sample group of providers.

End-to-end testing includes the submission of test claims to CMS with ICD-10 codes and the provider’s receipt of a Remittance Advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

- Providers or submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems;
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims (based on the pricing data used for testing purposes); and
- Accurate RAs are produced.

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. Information about the volunteer registration will be available in March 2014. Over 500 volunteer submitters will be selected nationwide to participate in the end-to-end testing. The small sample group of participants will be selected to represent a broad cross-section of provider types, claims types, and submitter types.

Additional details about the end-to-end testing process will be disseminated at a later date in a separate MLN Matters® article.

If you have any questions, please contact your MAC at their toll-free number, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index.html) on the CMS website.

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RELEASED product from the Medicare Learning Network® (MLN):

- "Transitional Care Management Services," Fact Sheet, ICN 908628, Hard Copy only.

MLN Matters® Number: MM8273 Rescinded  Related Change Request (CR) #: CR 8273
Related CR Release Date: November 7, 2013  Effective Date: April 1, 2014
Related CR Transmittal #: R1312OTN  Implementation Date: April 7, 2014

**Common Working File (CWF) and Fiscal Intermediary Standard System (FI SS) Informational Unsolicited Response (IUR) or Denial of Inpatient Services Related to a Hospice Terminal Diagnosis**

**Note:** This article was rescinded on February 20, 2014, as the related CR8273 was rescinded.

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Video Slideshow Presentation from April 18 “Begin Transitioning to ICD-10 in 2013”
National Provider Call Now Available

Are you ready to transition to ICD-10? Now is the time to prepare. The Centers for Medicare & Medicaid Services has released a YouTube video slideshow presentation from the April 18 call on “Begin Transitioning to ICD-10 in 2013.” The call presentation is now available on the CMS YouTube Channel as a video slideshow that includes the call audio. Visit the April 18 call web page for access to all of the related call materials, including the slide presentation, complete audio recording, and written transcript.

MLN Matters® Number: MM8358 Revised
Related Change Request (CR) #: CR 8358

Related CR Release Date: January 31, 2014
Voluntary Reporting Effective January 1, 2014
Mandatory Reporting Effective April 1, 2014

Related CR Transmittal #: R2864CP
Implementation Date: January 6, 2014

Additional Data Reporting Requirements for Hospice Claims

Note: This article was revised on February 3, 2014, to reflect the revised CR8358 issued on January 31. The article was revised to add clarifying language and examples in the “Background” section. In addition, references to legacy contractors were removed. The CR release date, transmittal number, and the Web address for accessing the CR were also revised.

Provider Types Affected

This MLN Matters® article is intended for hospices submitting claims to Medicare Home Health and Hospice Medicare Administrative Contractors (HH & H MACs)) for services provided to Medicare beneficiaries.

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Provider Action Needed

This article is based on Change Request (CR) 8358 which requires additional claim data reporting for hospices to support hospice payment reform as authorized by Section 3132(a) of the Affordable Care Act. Additional data reporting includes visit reporting for general inpatient care, reporting the service facility National Provider Identifier (NPI) where the service was performed when the service is not performed at the same location as the billing hospice’s location, and reporting of infusion pumps and prescription drugs.

Specifically, hospices shall report line-item visit data for hospice staff providing General Inpatient Care (GIP) to hospice patients in skilled nursing facilities or in hospitals for claims with dates of service on or after April 1, 2014. Hospices may voluntarily begin this reporting as of January 1, 2014. This includes visits by hospice nurses, aides, social workers, physical therapists, occupational therapists, and speech-language pathologists, on a line-item basis, with visit and visit length reported as is done for the home levels of care. Make sure that your billing staff is aware of these changes.

Background

Over the past several years the Medicare Payment Advisory Commission (MedPAC), the Government Accountability Office (GAO), and the Office of the Inspector General (OIG) have all recommended that the Centers for Medicare & Medicaid Services (CMS) collect more comprehensive data in order to better evaluate trends in utilization of the Medicare hospice benefit.

CMS began collecting additional data on hospice claims beginning in January, 2007, when CMS began required reporting of a Healthcare Common Procedure Code System (HCPCS) code on the claim to describe the location where services were provided. (See MLN Matters® article MM5245 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5245.pdf on the CMS website.)

CMS continued the data collection effort with CR5567 which requires Medicare hospices to, beginning in July 2008, provide detail on their claims about the number of physician, nurse, aide, and social worker visits provided to beneficiaries. (See the MLN Matters® article MM5567 corresponding to CR5567 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5567.pdf on the CMS website),

In January 2010, with the issuance of CR6440, CMS required the reporting of visits performed by therapists and certain phone calls made by social workers, who are paid by the hospice, on hospice claims. CR6440 also required that hospices report the length of visits made by nurses, aides, therapists, and social workers (to include certain phone calls made by social workers) who are paid by the hospice, with the associated time per visit (or per social worker call) in the number of 15 minute increments. (See MM6440 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6440.pdf on the CMS website.)

Effective in October 2010, CR6905 added an additional HCPCS site of service code (Q5010, for hospice home care provided in a hospice facility), to supplement those Q-codes implemented in 2007 with CR5245. (See the MLN Matters® article MM6905 corresponding to CR6905 at
On several occasions, industry representatives have communicated to CMS that the required claims information was not comprehensive enough to accurately reflect hospice care. Industry stakeholders also commented that to understand hospice costs, CMS should consider non-labor costs, as these 1) can be significant, and 2) are largely comprised of data on drugs, Durable Medical Equipment (DME), and medical supplies.

Finally, the Affordable Care Act, Section 3132(a) gives CMS the authority to collect additional data as needed to revise payments for hospice care. This claims data collection will support hospice payment reform. See [http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf](http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf) to view the Affordable Care Act.

CR8358 instructs that Medicare hospices will report line-item visit data for hospice staff providing General Inpatient Care (GIP) to hospice patients in skilled nursing facilities (site of service HCPCS code Q5004) or in hospitals (site of service HCPCS codes Q5005, Q5007, Q5008). This includes visits by hospice nurses, aides, social workers, physical therapists, occupational therapists, and speech-language pathologists, on a line-item basis, with visit and visit length reported as is done for routine home care and continuous home care. It also includes certain calls by hospice social workers (as described in CR6440, Transmittal 1738, dated May 15, 2009), on a line-item basis, with call and call length reported as is done for the home levels of care. CMS is not changing the existing GIP visit reporting requirements when the site of service is a hospice inpatient unit (site of service HCPCS code Q5006). For all visit/call reporting, only report visits/calls by the paid hospice staff; do not report visits by non-hospice staff. See the MLN Matters® article MM6440 corresponding to CR6440 at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6440.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6440.pdf) on the CMS website.

Hospices shall report the National Provider Identifier (NPI) of any nursing facility, hospital, or hospice inpatient facility where the patient is receiving hospice services, regardless of the level of care provided, when the site of service is not the billing hospice. In compliance with the 837i requirements, the billing hospice shall report the name, address, and NPI of the service facility where the service is being performed when the service is not performed at the same location as the billing hospice's location. When the patient has received care in more than one facility during the billing month, the hospice shall report the NPI of the facility where the patient was last treated.

Hospices shall report visits and length of visits (rounded to the nearest 15 minute increment), for nurses, aides, social workers, and therapists who are employed by the hospice, that occur on the date of death, after the patient has passed away. Due to system limitations with reporting services after the date of death, post mortem visits occurring on a date subsequent to the date of death shall not be reported. Visits occurring after death, and on the date of death, shall be reported using a PM modifier to differentiate them from visits occurring before death. The reporting of post-mortem visits, on the date of death, shall occur regardless of the patient’s level of care or site of service. Date of death is defined as the date of death reported on the death certificate. Hospices shall report hospice visits that occur before death on a separate line from those which occur after death.

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For example, assume that a nurse arrives at the home at 9 pm to provide routine home care (RHC) to a dying patient, and that the patient passes away at 11 pm. The nurse stays with the family until 1:30 am. The hospice should report a nursing visit with eight 15-minute time units for the visit from 9 pm to 11 pm. On a separate line, the hospice should report a nursing visit with a PM modifier with four 15-minute time units for the portion of the visit from 11 pm to midnight to account for the 1 hour post mortem visit. If the patient passes away suddenly, and the hospice nurse does not arrive until after his death at 11:00 pm, and remains with the family until 1:30 am, then the hospice should report a line item nursing visit with a PM modifier and four 15-minute increments of time as the units to account for the 1 hour post mortem visit from 11:00 pm to midnight.

Hospice agencies shall report injectable and non-injectable prescription drugs for the palliation and management of the terminal illness and related conditions on their claims. Both injectable and non-injective prescription drugs shall be reported on claims on a line-item basis per fill, based on the amount dispensed by the pharmacy. Over-the-counter drugs shall not be reported.

When a facility (hospital, SNF, NF, or hospice inpatient facility) uses a system (such as Pyxis) where each administration of a hospice medication is considered a fill for hospice patients receiving care, the hospice shall report a monthly total for each drug (i.e., report a total for the period covered by the claim), along with the total dispensed.

Hospices shall report multi-ingredient compound prescription drugs (non-injectable) using revenue code 0250. The hospice shall specify the same prescription number for each ingredient of a compound drug according to the 837i guidelines in loop 2410. In addition, the hospice shall provide the National Drug Code (NDC) for each ingredient in the compound; the NDC qualifier represents the quantity of the drug filled (meaning the amount dispensed) and shall be reported as the unit measure.

When reporting prescription drugs in a comfort kit/pack, the hospice shall report the NDC of each prescription drug within the package, in accordance with the procedures for non-injective prescriptions given in this instruction.

Hospice agencies shall report infusion pumps (a type of DME) on a line-item basis for each pump and for each medication fill and refill. The hospice claim shall reflect the total charge for the infusion pump for the period covered by the claim, whether the hospice is billed for it daily, weekly, biweekly, with each medication refill, or in some other fashion. The hospice shall include on the claim the infusion pump charges on whatever basis is easiest for its billing systems so long as, in total, the claim reflects the charges for the pump for the time period of that claim. DME other than infusion pumps, and medical supplies, are not to be reported at this time.

**Note:** CMS is not making any changes to the existing claims requirements for physician services reported on the hospice claim.

**Coding for New Required Hospice Claims Reporting:**

**Hospice staff provided GIP visit reporting:** Code appropriate visit revenue code + HCPCS for the discipline + Units of 15 minute increments, when site of service = Q5004, Q5005, Q5007, or Q5008.
Other provider NPI reporting: Other Provider Location Loop 2310 E (Only required on the 5010 Electronic Claim). Required for hospice claims reporting site of service HCPCS Q5003, Q5004, Q5005, Q5006 when not the same as the billing hospice, Q5007 and Q5008.

Post-mortem visit reporting: Code appropriate visit revenue code + HCPCS for the discipline + PM Modifier + Units of 15 minute increments

Injectable drugs: Report on a line-item basis per fill, using revenue code 0636 and the appropriate HCPCS code, with units representing the amount filled (i.e. if says Q1234 Drug 100mg and the fill was for 200 mg, units reported = 2).

Non-injectable prescriptions: Report on a line-item basis per fill (based on the amount dispensed by the pharmacy), using revenue code 0250 and the National Drug Code (NDC). The NDC qualifier represents the quantity of the drug filled, and shall be reported as the unit measure.

Infusion pumps: Report on the claim, on a line-item basis per pump order and per medication refill, using revenue code 029X for the equipment and 0294 for the drugs along with the appropriate HCPCS.

Additional Information


If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.
NEW product from the Medicare Learning Network® (MLN)

- “Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 2]” Educational Tool, ICN 908994, downloadable

MLN Matters® Number: MM8418
Related Change Request (CR) #: CR 8418
Related CR Release Date: February 21, 2014
Effective Date: May 29, 2013
Related CR Transmittal #: R180BP, R2883CP, and R163NCD
Implementation Date: July 7, 2014

Aprepitant for Chemotherapy Induced Emesis

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Part A Medicare Administrative Contractors (A/MACs) and/or Durable Medical Equipment MACs (DME MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8418, which informs MACs that, effective for claims with dates of service on or after May 29, 2013, the Centers for Medicare & Medicaid Services (CMS) extends coverage of the oral antiemetic three-drug regimen of oral aprepitant, an oral 5HT3 antagonist, and oral dexamethasone to beneficiaries who are receiving certain anticancer chemotherapeutic agents. Make sure that your billing personnel are aware of these changes.

Background

Chemotherapy induced emesis is the occurrence of nausea and vomiting during or after anticancer treatment with chemotherapy agents. The Social Security Act (the Act) permits oral drugs to be paid...
under Part B in very limited circumstances, one of which is antiemetic therapy administered immediately before and within 48 hours after anticancer chemotherapy as described in section1861(s)(2) of the Act. These drugs must fully replace the non-self-administered drug that would otherwise be covered.

On April 4, 2005, CMS announced a National Coverage Determination (NCD) for the use of the oral three-drug regimen of aprepitant, a 5HT3 antagonist, and dexamethasone for patients who are receiving certain highly emetogenic chemotherapeutic agents.

On May 29, 2013, CMS announced an update to that NCD, to cover the use of the oral antiemetic three-drug combination of oral aprepitant (J8501), an oral 5HT3 antagonist (Q0166, Q0179, Q0180), and oral dexamethasone (J8540) for patients receiving highly and moderately emetogenic chemotherapy. As a result, effective for services on or after May 29, 2013, the following anticancer chemotherapeutic agents have been added to the list of anticancer chemotherapeutic agents for which the use of the oral antiemetic 3-drug combination of oral aprepitant, an oral 5HT3 antagonist, and oral dexamethasone is deemed reasonable and necessary:

- Alemtuzumab (J9010);
- Azacitidine (J9025);
- Bendamustine (J9033);
- Carboplatin (J9045);
- Clofarabine (J9027);
- Cytarabine (J9098, J9100, J9110);
- Daunorubicin (J9150, J9151);
- Idarubicin (J9211);
- Ifosfamide (J9208);
- Irinotecan (J9206); and
- Oxaliplatin (J9263).

Please note the entire list includes the 11 new codes listed above and the 9 existing anticancer chemotherapeutic agents listed below:

- Carmustine (J9050);
- Cisplatin (J9060, J9062);
- Cyclophosphamide (J8530, J9070, J9080, J9090, J9091, J9092, J9093, J9094, J9095, J9096, J9097);
- Dacarbazine (J9130, J9140);
- Mechlorethamine (J9230);
- Streptozocin (J9320);
- Doxorubicin (J9000, J9001, J9002, Q2048, Q2049);
- Epirubicin (J9178); and
- Lomustine (S0178).

CMS also permits the MACs to determine coverage for other all-oral three-drug antiemesis regimens of aprepitant or any other Food and Drug Administration (FDA) approved oral NK-1 antagonist in

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combination with an oral 5HT3 antagonist and oral dexamethasone with the chemotherapeutic agents listed, or any other anticancer chemotherapeutic agents that are FDA-approved and may in the future be defined as highly or moderately emetogenic.

CMS is defining highly emetogenic chemotherapy and moderately emetogenic chemotherapy as those anticancer agents so designated in at least two of three guidelines published by the National Comprehensive Cancer Network (NCCN), American Society of Clinical Oncology (ASCO), and European Society of Medical Oncology (ESMO)/Multinational Association of Supportive Care in Cancer (MASCC). The inclusive examples are: NCCN plus ASCO, NCCN plus ESMO/MASCC, or ASCO plus ESMO/MASCC.

Until a specific code is assigned to the new drug, any new FDA-approved oral antiemesis drug (oral NK-1 antagonist or oral 5HT3 antagonist) as part of the three-drug regimen must be billed with the following not-otherwise-classified (NOC) code effective April 1, 2014, in the IOCE update:

- Q0181 - Unspecified oral dosage form, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for a IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen.

This NOC code must also be accompanied with a diagnosis code of an encounter for antineoplastic chemotherapy (ICD9/10 codes V58.11/Z51.11).

This coverage policy applies only to the oral forms of the three-drug regimen as a full replacement for their intravenous equivalents. All other indications or combinations for the use of oral aprepitant are non-covered under Medicare Part B, but may be considered under Medicare Part D.

For claims with dates of service on or after May 29, 2013, MACs will adjust claims processed before CR8418 was implemented if you bring those claims to the attention of your MAC.

Effective for claims with dates of service on or after May 29, 2013, MACS will deny lines for oral aprepitant (J8501), or NOC code Q0181 if an encounter for antineoplastic chemotherapy identified by ICD 9/10 codes V58.11/Z51.11 is not present. The denied lines will reflect the following messages on the remittance advice:

- Claim Adjustment Reason Code 96: Non-covered Charge(s)
- Remittance Advice Remarks Code (RARC) M100: We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy; and
- 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.

**Additional Information**

The official instruction, CR8418, was issued to your MAC via three transmittals. The first updates the "Medicare Benefit Policy Manual" and that is available at [http://www.cms.gov/Regulations-and-

If you have any questions, please contact your MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

**News Flash** - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- [MLN Matters® Article #MM8433](#), “Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season”
- [MLN Matters® Article #SE1336](#), “2013-2014 Influenza (Flu) Resources for Health Care Professionals”
- [HealthMap Vaccine Finder](#) - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community.

**Free Resources** can be downloaded from the CDC website including prescription-style tear-pads that will allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu. On the CDC order form, under “Programs”, select “Immunizations and Vaccines (Influenza/Flu)” for a list of flu related resources.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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- Similarities and differences;
- ICD-10 code structure; and
- Coding process and examples.

To receive notification of upcoming MLN Connects videos and calls and the latest Medicare program information on ICD-10, subscribe to the weekly MLN Connects™ Provider eNews.

MLN Matters® Number: MM8442
Related Change Request (CR) #: CR 8442
Related CR Release Date: February 7, 2014
Effective Date: March 7, 2014
Related CR Transmittal #: R2876CP
Implementation Date: March 7, 2014

Update to Pub 100-04, Claims Processing Manual, Chapter One

Provider Types Affected

This MLN Matters® Article is intended for individual providers or chains submitting claims to Part A Medicare Administrative Contractors (MAC) for services to Medicare beneficiaries.

What You Need To Know

CR 8442 removes amends the "Medicare Claims Processing Manual" to show that provider chains and individual providers are no longer permitted to select the fiscal intermediary of their choice.

Background

CR 8442, from which this article is taken removes certain sections from the "Medicare Claims Processing Manual" because they contain policy based on the legacy environment during which chains and individual providers were permitted to select the fiscal intermediary of their choice.

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Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173 (which you can find at [http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/pdf/PLAW-108publ173.pdf](http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/pdf/PLAW-108publ173.pdf) on the internet), amended Title XVIII of the Social Security Act (the Act) to repeal its provider nomination provision, and replaced it with the geographic assignment rule. This means that a chain, or an individual provider, can no longer select the fiscal intermediary (FI) or MAC of its choice, and you should be aware that your MAC will no longer accept your requests for "change of intermediary."

Rather, an individual provider will be assigned to the MAC that covers the state in which the provider is located; and a chain that meets the criteria set forth at 42 CFR 421.404 may contact CMS and ask to have all eligible, downstream providers assigned to the MAC that covers the state in which the chain’s home office is located. (A chain home office wishing to contact CMS to request “qualified chain” status may send an email to [Provider_MAC_Assignment_Inquiry@cms.hhs.gov](mailto:Provider_MAC_Assignment_Inquiry@cms.hhs.gov).)

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.

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MLN Matters® Number: MM8445
Related Change Request (CR) #: CR 8445
Related CR Release Date: February 7, 2014
Effective Date: For Admissions occurring on or after October 1, 2013
Related CR Transmittal #: R2877CP
Implementation Date: April 7, 2014

Implementing the Part B Inpatient Payment Policies from CMS-1599-F

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare Claims Administration Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8445 which provides details regarding the implementation of payment policies related to hospital Part B inpatient billing from the final regulation CMS-1599-F. Make sure that your billing staffs are aware of these changes.
Background

The Centers for Medicare & Medicaid Services (CMS) issued the Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS) /Long-Term Care Hospital (LTCH) Final Rule (CMS-1599-F; CMS-1455-F) on August 19, 2013, in which CMS finalized a policy to provide additional payment under Medicare Part B for hospital inpatient services when a hospital inpatient admission is determined not reasonable and necessary for payment under Medicare Part A, and the beneficiary should have been treated as a hospital outpatient. You can find the CMS “FY 2014 IPPS/LTCH Final Rule Home Page” at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcutepatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html on the CMS website.

Change Request (CR) 8445 provides claims processing guidance related to the implementation of this policy for all hospitals and critical access hospitals (CAHs). CR 8445 contains related revisions to the Medicare Claims Processing Manual (Pub. 100-04), and CMS will issue companion revisions to the Medicare Benefit Policy Manual (Pub. 100-02) in a separate release.

Payment of Part B Inpatient Services

When Medicare Part A payment cannot be made because an inpatient admission is found to be not reasonable and necessary and the beneficiary should have been treated as a hospital outpatient rather than a hospital inpatient, Medicare will allow payment under Part B of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require an outpatient status, provided the beneficiary is enrolled in Medicare Part B and provided the allowed timeframe for submitting claims is not expired. The policy applies to all hospitals and critical access hospitals (CAHs) participating in Medicare, including those paid under a prospective payment system or alternative payment methodology such as State cost control systems, and to emergency hospitals services furnished by nonparticipating hospitals. In this document and in CR8445, the term “hospital” includes all hospitals and CAHs, regardless of payment methodology, unless otherwise specified.

This policy applies when a hospital determines under Medicare’s utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, and the beneficiary has already been discharged from the hospital (commonly referred to as hospital self-audit). If the hospital already submitted a claim to Medicare for payment under Part A, the hospital must cancel its Part A claim prior to submitting a claim for payment of Part B services. Whether or not the hospital has submitted a claim to Part A for payment, Medicare requires the hospital to submit a “no pay” Part A claim indicating that the provider is liable under section 1879 of the Social Security Act for the cost of the Part A services. The hospital may then submit an inpatient claim for payment under Part B for all services that would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient rather than admitted as a hospital inpatient, except where those services specifically require an outpatient status.

Those services that specifically require an outpatient status includes those that are, by definition, provided to hospital outpatients and not inpatients, including:

- Hospital outpatient visits (emergency department and clinic visits);

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• Observation services;
• Diabetes Self-Management Training Services.

Hospitals may not bill for inpatient routine services in a hospital. Inpatient routine services generally are those services included by the provider in a daily service charge – sometimes referred to as the “room and board” charge.

Payable and non-payable services are further described in the update of the "Medicare Claims Processing Manual" (Chapter 4 (Part B Hospital – Including Inpatient Hospital Part B and OPPS); Section 240 which is attached to CR8445.

Part B inpatient services are billed using the 12X TOB.

For Part B inpatient services furnished by the hospital that are not paid under the OPPS, but rather under some other Part B payment mechanism, Part B inpatient payment will be made pursuant to the Part B fee schedules or prospectively determined rates for which payment is made for these services when provided to hospital outpatients. All hospitals billing Part A services are eligible to bill the Part B inpatient services, including

• Short-term acute-care hospitals paid under the IPPS;
• Hospitals paid under the OPPS;
• Long-Term Care Hospitals (LTCHs);
• Inpatient Psychiatric Facilities (IPFs) and IPF hospital units;
• Inpatient Rehabilitation Facilities (IRFs) and IRF hospital units;
• Critical Access Hospitals (CAHs);
• Children’s hospitals;
• Cancer hospitals; and
• Maryland waiver hospitals.

Hospitals paid under the OPPS continue billing the OPPS for Part B inpatient services. Hospitals that are excluded from payment under the OPPS in Title 42 of the Code of Federal Regulations (CFR) Section 419.20(b) are eligible to bill Part B inpatient services under their non-OPPS Part B payment methodologies. For more information regarding 42 CFR 419.20(b), refer to http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=f0a3c4c0d051e60e0bf1fe559cc9dfdf&tpl=/ecfrbrowse/Title42/42cfr419_main_02.tpl on the Internet.

**Other Circumstances When Part A Payment Cannot Be Made**

CMS notes that there are no changes to the policies for billing Part B under other circumstances when Part A payment cannot be made. For example, when beneficiaries treated as hospital inpatients are either not entitled to Part A at all, or are entitled to Part A but have exhausted their Part A benefits, hospitals may only bill for a limited set of ancillary Part B inpatient services. Some of these services are typically packaged for payment under the OPPS, and the primary service into which they are packaged is not payable. In these circumstances, CMS will provide separate payment for the ancillary
Part B inpatient service. For example, hospitals should continue to use HCPCS code C9899 created by CMS to obtain separate payment under this provision for certain implantable prosthetic devices which replace all or part of an internal body organ and do not have pass-through payment status. However CMS revised the Medicare Claims Processing Manual Ch. 4 Sec. 240 to specify that this code should not be used when billing Part B following a reasonable and necessary Part A denial, because the primary service (the implantation surgery) is a payable Part B inpatient service and payment of the device is packaged with the surgery.

**Payment of Part B Services in the Payment Window for Outpatient Services Treated as Inpatient Services When Payment Cannot Be Made Under Part A**

Medicare continues the current policy allowing hospitals to bill Part B for services furnished by the hospital that were bundled into the original Part A claim under the 3-day (1-day for non-IPPS hospitals) payment window prior to the inpatient admission. CMS revised the manual to clarify that if these services were furnished by the hospital (including referred hospital lab tests), they may be billed to Part B. CMS is clarifying that both 13X (85x for CAH) and 14X TOB may be submitted for payment of these services, subject to the revised manual instructions.

**Timely Filing and Supporting Documentation**

Timely filing restrictions will apply for the Part B services billed. Therefore, Part B claims that are filed beyond 12 months from the date of service will be rejected as untimely and will not be paid. Hospitals are required to maintain documentation to support the services billed on the Part B claim(s).

**Provider and Beneficiary Liability**

A “no-pay” provider liable Part A claim (110 TOB) must be present in the claims history before accepting the Part B claim(s) for payment. The no-pay Part A claim indicates that the provider and not the beneficiary is liable under the Social Security Act (Section 1879; see [http://www.socialsecurity.gov/OP_Home/ssact/title18/1879.htm](http://www.socialsecurity.gov/OP_Home/ssact/title18/1879.htm)) for the cost of the Part A services. Submission of this claim cancels any claim that may have already been submitted by the hospital for payment under Part A. When a Medicare review contractor denies a Part A claim for medical necessity, the claims system converts the originally submitted 11X claim to a 110 TOB on behalf of the hospital. When the hospital and not the beneficiary is liable for the cost of the Part A services (pursuant to the limitation on liability provision in Section 1879 of the Social Security Act), the beneficiary is not responsible for paying the deductible and coinsurance charges related to the denied Part A claim and the beneficiary's Medicare utilization record is not charged for the services and items furnished. The hospital must refund any payments (including coinsurance and deductible) made by the beneficiary or third party for a denied Part A claim when the provider is held financially liable for that denial (see section 1879(b) of the Act; 42 CFR § 411.402; and chapter 30 §§ 30.1.2, “Beneficiary Determined to Be Without Liability” and 30.2.2, “Provider/Practitioner/Supplier is Determined to Be Liable” of the Medicare Claims Processing Manual).

If the beneficiary's liability under Part A for the initial claim submitted for inpatient services is greater than the beneficiary's liability under Part B for the inpatient services they received, the hospital must...
refund the beneficiary the difference between the applicable Part A and Part B amounts. Conversely, if
the beneficiary's liability under Part A is less than the beneficiary's liability under Part B for the
services they received, the beneficiary may face greater cost sharing.

**Summary of Business Requirements for CR 8445:**

- MACs will ensure that provider submitted medical necessity denial claims contain the Occurrence
  Span Code “M1” and dates on the inpatient claim.
- Hospital part B Inpatient service claims that are billed after a Medical Necessity denial should
  contain the following data elements:
  - A treatment authorization code of A/B Rebilling submitted by a provider.
  - **NOTE:** Providers submitting an 837I will be instructed to place the appropriate
    Prior Authorization code above into Loop 2300 REF02 (REF01 = G1) as follows:
    REF*G1*A/B Rebilling~
    - For DDE or paper Claims, “A/B Rebilling” will be added in FL 63.
  - A condition code “W2” attesting that this is a rebilling and no appeal is in process, and
  - The original denied inpatient claim (CCN/DCN/ICN) number, and
  - **NOTE:** Providers submitting an 837I will be instructed to place the DCN in the
    Billing Notes loop 2300/NTE in the format:
    NTE*ADD*ABREBILL12345678901234~
    - For DDE or paper Claims, Providers will be instructed to use the word
      “ABREBILL” plus the denied inpatient DCN/CCN/ICN will be added to the
      Remarks field (form locator #80) on the claim using the following format:
      “ABREBILL12345678901234”.
      - NOTE: The numeric string above (12345678901234) is meant to represent
        original claim DCN/ICN numbers from the inpatient denial.

- MACs will Return to Provider a TOB 121 A/B Rebilling claim that does not have a medical denied
  11x claim in history that matches the DCN in remarks.

- MACs will dismiss redetermination requests of Part A 11x claims if the provider has previously
  billed a 121 A/B rebilling claim. However, contractors will accept appeal requests of A/B rebilled
  121 claims.

- Medicare will not allow observation services (Revenue Code 762), and outpatient visits (Revenue
  Codes 45x and 51x) to be billed on the A/B rebilling 121 TOB claim. (This includes G0738,
  G0739, 99201-99215, 99281-99285, G0380-G0384, and G0463.)

- Additionally, Medicare's claims processing systems will set edits to prevent payment on Type of
  Bill 12x for claims containing the revenue codes listed as follows:

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Additional Information


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* In the case of Revenue Code 0964, this is used by hospitals that have a CRNA exception.

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“Medical Privacy of Protected Health Information” Fact Sheet, ICN 006942, downloadable

MLN Matters® Number: MM8546
Related Change Request (CR) #: CR 8546
Related CR Release Date: February 5, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R2870CP
Implementation Date: July 7, 2014

Addition of New Fields and Expansion of Existing Model 1 Discount Percentage Field in the Inpatient Hospital Provider Specific File (PSF) and Renaming Payment Fields in the Inpatient Prospective Payment System (IPPS) Pricer Output

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting institutional claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8546 which informs MACs about changes to the PSF. The PSF is maintained by MACs to facilitate proper payments to providers.

Note: CR8546 is not implementing the Hospital Acquired Condition (HAC) Reduction Program initiative or the Electronic Health Records (EHR) Incentive Program, but is only preparing the Centers for Medicare & Medicaid Services (CMS) systems for the future. Specific instructions implementing these programs, including manual updates to Addendum A of the “Medicare Claims Processing Manual,” will be issued in the future in the event these policies are finalized.
Make sure that your billing staff are aware of these changes.

**Background**

Section 3008 of the Affordable Care Act establishes a program, beginning in FY 2015, for IPPS hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain HACs. HACs are conditions that patients did not have when they were admitted to the hospital, but which developed during the hospital stay. Under the HAC Reduction Program, hospitals that rank in the lowest-performing quartile of selected HAC measures will be subject to a reduction of what they would otherwise be paid under the IPPS.

Section 3133 of the Affordable Care Act provides for an additional payment for a hospital’s uncompensated care. Each Medicare Disproportionate-Share (DSH) hospital will receive an Uncompensated Care Payment (UCP) based on its share of uncompensated care as calculated by CMS for Medicare DSH hospitals. Currently, for FY 2014, the estimated per claim UCP amount is stored in PRICER. In order to make changes to the amounts more efficient, CMS is adding the estimated per claim UCP amount to the PSF.

The Medicare EHR Incentive Program provides incentive payments for eligible acute-care inpatient hospitals that are meaningful users of certified EHR technology. Eligible-acute care inpatient hospitals are defined as “subsection (d) hospitals”—which are generally hospitals that are paid under the IPPS and are located in one of the 50 states or the District of Columbia. Hospitals that are not meaningful users of certified EHR technology will be subject to payment adjustments beginning in FY 2015.

Model 1 of the Bundled Payments for Care Improvement (BPCI) initiative provides a discounted payment to Model 1 participating hospitals for the acute-care hospital stay. The discount will be phased in over the performance period of 3 years. To accommodate the 0.5% discount for months 7 to 12, the Model 1 discount percentage field in the PSF must be expanded.

**SUMMARY OF CR8546 CHANGES**

The inpatient PSF will be expanded to include 3 new fields and an expansion of the existing Model 1 discount percentage field as follows:

1. Add an indicator for hospitals subject to the Hospital Acquired Conditions (HAC) reduction program for future implementation.

2. Add an estimated interim per claim Uncompensated Care Payment amount.

3. Add an indicator for hospitals subject to an Electronic Health Records Incentive Program reduction for future implementation.

4. Expand the existing 2-byte Model 1 discount percentage field to 3-bytes.

In order to avoid confusion with the 4 new payment amount fields created in CR8217, we are renaming them here. In addition, we are redefining existing filler in the output record PRICER returns.
to Fiscal Intermediary Standard System (FISS) to accommodate future policy and/or legislative changes that might require system changes.

The new fields are:

- PPS- EHR-PAYMENT-ADJUST-AMT PIC S9(07)V9(02).
- PPS-FLX5- PAYMENT PIC S9(07)V9(02).
- PPS-FLX6- PAYMENT PIC S9(07)V9(02)
- PPS-FLX7- PAYMENT PIC S9(07)V9(02).

The renamed fields are:

- From PPS-FLX1-PAYMENT to PPS-UNCOMP-CARE-AMOUNT
- From PPS-FLX2-PAYMENT to PPS-BUNDLE-ADJUST-AMT
- From PPS-FLX3-PAYMENT to PPS-VAL-BASED-PURCH-ADJUST-AMT
- From PPS-FLX4-PAYMENT to PPS-READMIS-ADJUST-AMT

Additional Information


If you have any questions, please contact your MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

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Therapy Modifier Consistency Edits

What You Should Know

This MLN Matters® Article is intended for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8556, which creates edits in Original Medicare claims processing systems to ensure that certain ‘always therapy’ evaluation and reevaluation codes are reported with the correct modifier. It also makes several clarifications of details in the "Medicare Claims Processing Manual," Chapter 5 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services.

CR8556 contains no new policy. It updates Medicare systems and manuals to better reflect current published policies. Make sure that your billing staffs are aware of these updates.
Background

Longstanding Original Medicare billing instructions require reporting of discipline specific outpatient rehabilitation modifiers. All claims for therapy service Healthcare Common Procedure Coding System (HCPCS) codes must report a modifier that indicates the discipline of the plan of care under which the services are provided.

Through analysis of Original Medicare claims data, the Centers for Medicare & Medicaid Services (CMS) has identified cases where claims for discipline specific evaluation codes have reported the modifier corresponding to another discipline. For example, occupational therapy evaluations have been billed and paid while reporting a GP modifier (Services delivered under an outpatient physical therapy plan of care.). When information on a claim is clearly self-contradictory, as in this example, the claim should be returned to the provider for correction. The business requirements in CR8556 create edits to do this, effective for dates of service July 1, 2014, and after.

In addition, CR8556 updates “Medicare Claims Processing Manual,” Chapter 5 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services to reflect recent payment regulations. The Fiscal Year (FY) 2014 inpatient hospital final rule contained a policy regarding rebilling of Part B services when an inpatient stay is denied as not reasonable and necessary. This policy is now included in Section 40.8 of Chapter 5 of the "Medicare Claims Processing Manual." Specifically, it states that if a beneficiary receives therapy services during an inpatient hospital stay which was denied because the stay was not medically necessary, the therapy services may be rebilled under Medicare Part B coverage. If the therapy would have been reasonable and necessary as hospital outpatient services, and provided the beneficiary has Part B entitlement, the services can be billed using Type of Bill 012x. All payment and billing requirements for outpatient therapy (including therapy caps, functional reporting and other instructions in this chapter) apply to these claims.

Additional Information


If you have any questions, please contact your MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

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MLN Matters® Number: MM8569  
Related Change Request (CR) #: CR 8569  
Related CR Release Date: February 5, 2014  
Effective Date: July 1, 2014  
Related CR Transmittal #: R2867CP  
Implementation Date: July 7, 2014

**Enforcement of the 5 Day Payment Limit for Respite Care under the Hospice Medicare Benefit**

**Provider Types Affected**

This MLN Matters® Article is intended for providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

**Provider Action Needed**

This article, based on Change Request (CR) 8569, instructs MACs to implement system edits to prevent payment of respite care for more than 5 days at a time for any hospice claim submitted on or after July 1, 2014. This instruction will enforce the current policy that limits payment of respite care to no more than 5 consecutive days. Make sure your billing staffs are aware of this update.

**Background**

The Code of Federal Regulations (CFR) 42, Part 418.302, states that payment for inpatient respite care is subject to the requirement that it may not be provided consecutively for more than 5 days at a time. Payment for the sixth and any subsequent day of respite care is made at the appropriate home care rate. In an effort to prevent potential overpayments in the Medicare Hospice benefit, CR8569
implies new edits to prevent payment of respite care for more than 5 days at a time for any hospice claim submitted on or after July 1, 2014.

Since respite care is payable only for periods of respite up to 5 consecutive days, claims reporting respite periods greater than 5 consecutive days will be Returned to the Provider (RTP). Days of respite care beyond 5 days must be billed at the appropriate home care rate for payment consideration. When a MAC RTPs a claim, it will include an external narrative on the RTP reason code stating that respite care exceeding 5 consecutive days must be billed as routine home care and are not to be included in the M2 occurrence span code.

For example: If the patient enters a respite period on July 1 and is returned to routine home care on July 6, the units of respite reported on the line item would be 5 representing July 1 through July 5, July 6 is reported as a day of routine home care regardless of the time of day entering respite or returning to routine home care.

When there is more than one respite period in the billing period, the provider must include the M2 occurrence span code for all periods of respite. The individual respite periods reported shall not exceed 5 days, including consecutive respite periods.

For example: If the patient enters a respite period on July 1 and is returned to routine home care on July 6 and later returns to respite care from July 15 to July 18, and completes the month on routine home care, the provider must report two separate line items for the respite periods and two occurrence span code M2, as follows:

Revenue Line items:

- Revenue code 0655 with line item date of service 07/01/XX (for respite period July 1 through July 5) and line item units reported as 5
- Revenue code 0651 with line item date of service 07/06/XX (for routine home care July 6 through July 14) and line item units reported as 9
- Revenue code 0655 with line item date of service 07/15/XX (for respite period July 15 through 17th) and line item units reported as 3
- Revenue code 0651 with line item date of service 07/18/XX (for routine home care on date of discharge from respite through July 31 and line item units reported as 14.

Occurrence Span Codes:

- M2 0701XX – 0705XX
- M2 0715XX – 0717XX

Additional Information

The official instruction, CR8569, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2867CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website. If you have any questions, please contact your MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-

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News Flash - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- **MLN Matters® Article #MM8433**, “Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season”
- **MLN Matters® Article #SE1336**, “2013-2014 Influenza (Flu) Resources for Health Care Professionals"
- **HealthMap Vaccine Finder** - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community.
- **Free Resources** can be downloaded from the CDC website including prescription-style tear-pads that will allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu. On the CDC order form, under “Programs”, select “Immunizations and Vaccines (Influenza/Flu)” for a list of flu related resources.

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Revised products from the Medicare Learning Network® (MLN)

- “Medical Privacy of Protected Health Information,” Fact Sheet, ICN 006942, Downloadable only.

MLN Matters® Number: SE1401  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

Point of Origin for Admission or Visit Code (Formerly Source of Admission Code) for Inpatient Psychiatric Facilities (IPFs)

Provider Types Affected

This MLN Matters® Special Edition article is intended for Inpatient Psychiatric Facilities (IPFs) submitting claims to Part A/B Medicare Administrative Contractors (A/B MACs) that involve inpatient transfers within the same facility.

What You Need to Know

Recovery Auditors have conducted reviews of Medicare Prospective Payment System (PPS) claims for Inpatient Psychiatric Facilities (IPF) services. These reviews have identified a substantial number of overpayments for inpatient psychiatric services directly following an acute care stay within the same facility. These errors and overpayments occurred because the Source of Admission Code ‘D’ was not applied to those claims. The Point of Origin for Admission or Visit Code "D" (formerly the Source of Admission Code) must be used when a patient is discharged from an acute-care stay in a hospital and transferred to the same hospital’s inpatient psychiatric Distinct Part Unit (DPU).

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Under the Medicare PPS, the Centers for Medicare & Medicaid Services (CMS) makes an additional payment to an IPF or a DPU for the first day of a beneficiary's stay to account for emergency department costs if the IPF has a qualifying emergency department. However, CMS does not make this payment if the beneficiary was discharged from an acute-care stay and transferred to its own hospital based IPF since payment for the emergency department services are included in the Medicare payment for the acute-care stay. The Point of Origin for Admission or Visit Code "D" prevents this overpayment.

The correct Point of Origin for Admission or Visit code (formerly Source of Admission) must be applied to prevent incorrect payments.

**Case Studies**

**Example 1:** On January 10, 2010, an 85 year old female is admitted through the Emergency Room for a one day stay in an acute-care inpatient hospital setting. On January 11, 2010, the patient is admitted to the inpatient psychiatric unit of the same facility. The claim for this admission was submitted with Point of Origin for Admission or Visit Code "1" (Physician Referral).

**Resolution:** Because the January 11th admission was a transfer from the same facility, the Point of Origin for Admission or Visit Code should be coded "D". The incorrect Source of Admission Code resulted in an overpayment of $105.06.

**Example 2:** On January 19, 2012, a 63 year old male is admitted through the Emergency Room for a two day stay in an acute-care inpatient hospital setting. On January 21, 2012, the patient is admitted to the inpatient psychiatric unit of the same facility. The claim for this admission was submitted with Point of Origin for Admission or Visit Code "2" (Clinic Referral).

**Resolution:** Because the January 21st admission was a transfer from the same facility, the Point of Origin for Admission or Visit Code should be coded "D". The incorrect Source of Admission Code resulted in an overpayment of $98.15.

**Additional Information**

If you have any questions, please contact your MAC at their toll-free number, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.


To review the Inpatient Psychiatric Facility Prospective Payment System Fact Sheet that provides detailed information about the background, coverage requirements, payment rates, Fiscal Year (FY)

**News Flash** - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

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Special Instructions for the International Classification of Diseases, Clinical Modification 10th Edition (ICD-10-CM) Coding on Home Health Episodes that Span October 1, 2014

Note: This article was revised on February 27, 2014, to correct an entry in the table on page 4. The last row and third column of the table should have indicated “OASIS-C”. All other information is unchanged.

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, suppliers, and other covered entities who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in home health (HH) care settings.

Provider Action Needed

This MLN Matters® Special Edition (SE) 1410 alerts providers that on October 1, 2014 all Medicare claims submissions of diagnosis codes will change from the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) to the 10th Edition (ICD-10-CM). All entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must make this transition requiring systems changes throughout the entire health care industry.
Background

In 2011 the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7492, which provided information on reporting guidelines and claims submissions requirements for ICD-10-CM. Particularly, CR 7492 provided instructions regarding claims with service dates that span the ICD-10 effective date. Recently, CMS issued an updated article (SE1408) at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf), which provides special billing instructions for home health agencies (HHAs) to apply to HH claims where the episode begins in August or September 2014 and ends in October 2014. MLN Matters® Article SE1408 also provides details for coding other types of claims for services that span the ICD-10 implementation date of October 1, 2014. This article provides further details regarding HH claims for episodes that span the October 1 date.

Key Points of This Article

Three factors affect how ICD-10-CM must be used on these episodes for services that span the October 1 date:

1. The claim “From” date (episode start date);
2. The Outcome and Assessment Information Set (OASIS) assessment completion date (OASIS item M0090 date); and
3. The claim “Through” date.

Episodes Starting Before October 1, 2014 with OASIS Completion Dates Before October 1, 2014

In the case of initial HH episodes, the OASIS assessment must be completed within 5 days of the start of care. The assessment completion date (M0090 date) determines whether the HH Grouper software that determines the payment group for the episode will apply ICD-9-CM or ICD-10-CM codes to the episode. In the case where the episode start of care date is before October 1, 2014 and the M0090 date is also before October 1, 2014, ICD-9-CM codes will be used on the OASIS and to determine the payment group code (the Health Insurance Prospective Payment System (HIPPS) code).

For HH claims (type of bill 032x), ICD-10-CM reporting is required based on the claim “Through” date. On Requests for Anticipated Payment (RAPs), Medicare billing instructions require that the “From” and “Through” dates are the same. So if the episode begins in September 2014, the “From” and “Through” dates on the RAP would report the same date in September. These RAPs would report ICD-9-CM diagnosis codes using codes matching the OASIS assessment.

If the HH episode spans into October 2014, the corresponding final claim for the episode will be required to report ICD-10-CM codes. HH claims cannot be split into periods before and after October 1, 2014, so these claims will have claim “Through” dates of October 1, 2014 or later. The
HIPPS code on the final claim must match the HIPPS code that was reported on the RAP. The HIPPS code on the RAP was based on the ICD-9-CM codes matching the OASIS assessment.

CR 7492 stated that CMS will:

“Allow HHAs to use the payment group code derived from ICD-9-CM codes on claims which span 10/1, but require those claims to be submitted using ICD-10-CM codes.”

This does not mean that all episodes must be re-coded under ICD-10-CM. CMS intends to avoid any extra burden that could result from requiring HHAs to code these episodes under both the ICD-9-CM and ICD-10-CM systems. To avoid that, we advise HHAs to use the General Equivalence Mappings (GEMs) or other convenient translation tables to derive ICD-10-CM codes for use on claims for episodes that span October 1, 2014. The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes that were used on the RAP and which are stored in the OASIS system.

This may result in some inconsistency between the HIPPS code on the claim and the ICD-10-CM codes. CMS will alert medical reviewers at our MACs to ensure that the ICD-10-CM codes on these claims are not used in making determinations. CMS will also alert researchers using CMS data files of this inconsistency.

These same procedures will apply to resumption of care assessments (M0100 = 03) and to recertification (M0100 = 04) and follow-up (M0100 = 05) assessments when the episode start date and the M0090 date on those assessments are both before October 1, 2014 but the episode ends in October 2014 (see table below).

Episodes Starting Before October 1, 2014 with OASIS Completion Dates in October 2014

There may be cases where the episode start of care date is before October 1, 2014 and, due to the 5 day completion window, the M0090 date is in October 2014. For example, an initial episode with a start of care date of September 28, 2014 could have an M0090 date of October 2, 2014. In these cases, ICD-10-CM codes will be used on the OASIS and to determine the HIPPS code.

The RAP for this example would have “From” and “Through” dates of September 28, 2014. As a result, these RAPs would need to report ICD-9-CM diagnosis codes even though ICD-10-CM codes were used on the OASIS assessment.

As with the previous category of episodes that span October 1, CMS does not require these cases to be coded in both systems. We again advise that HHAs use the GEMs or other convenient translation tables to derive ICD-9-CM codes for use on the RAPs for episodes. Since RAPs are not subject to medical review and are replaced in Medicare claims history by the final claim, there is no need to account for adverse impacts in these situations. The ICD-9-CM codes are simply required in order for the RAP to be processed. The corresponding final claim for the episode will report ICD-10-CM codes matching the OASIS assessment.

Recertification Episodes Beginning in the First Days of October 2014

In the case of recertification episodes, the M0090 date can be up to 5 days earlier than the episode start date. So, a recertification episode starting on October 2, 2014 could have an M0090 date of
September 28, 2014. ICD-9-CM codes are used on the OASIS assessment and will be used to determine the HIPPS code.

But in this case, both the RAP and claim will require ICD-10-CM codes since the “Through” date on both will be after October 1, 2014. HHAs will use the GEMs or other convenient translation tables to derive ICD-10-CM codes for use on these RAPs and claims.

The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes which are stored in the OASIS system. In these cases also, CMS will alert medical reviewers at our MACs and researchers using CMS data files to prevent adverse impacts.

The following table summarizes the above scenarios:

<table>
<thead>
<tr>
<th>Type of OASIS Assessment</th>
<th>RAP “From/ Through” Dates</th>
<th>OASIS M0090 Date/OASIS Version</th>
<th>Claim “Through” Date</th>
<th>Diagnosis Coding Used on OASIS</th>
<th>Diagnosis Coding Used on RAP</th>
<th>Diagnosis Coding Used on Claim</th>
</tr>
</thead>
</table>


**Additional Information**


The ICD-10-related implementation date is now October 1, 2014, as announced in final rule CMS-0040-F issued on August 24, 2012. This final rule is available at [http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html](http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html) on CMS website.

**Disclaimer**

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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 on the CMS website.
Centers for Medicare & Medicaid Services
Articles for Part B Providers
NEW product from the Medicare Learning Network® (MLN)

- “Vaccine Payments Under Medicare Part D” Fact Sheet, ICN 908764, downloadable and hard copy

MLN Matters® Number: MM8282
Related Change Request (CR) #: CR 8282
Related CR Release Date: June 12, 2013
Effective Date: October 1, 2013
Related CR Transmittal #: R2721CP and R221FM
Implementation Date: October 7, 2013

New Non-Physician Specialty Code for Indirect Payment Procedure (IPP) Billers

Provider Types Affected

This MLN Matters® Article is intended for non-physician practitioners submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Effective October 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will use physician specialty code C2 as the primary and/or secondary specialty code for the Indirect Payment Procedure (IPP) billers. IPP billers should self-designate their Medicare specialty on the appropriate Form CMS-855 application when they register in the Medicare program. Specialty codes are used by CMS for programmatic and claims processing purposes.

Background

Certain health benefit plans furnish Medicare complementary coverage for their members. If such an entity qualifies as an IPP biller under 42 CFR section 424.66[i], which may be viewed at http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol3/pdf/CFR-2010-title42-vol3-sec424-66.pdf, it
may seek payment in the Medicare Fee-For-Service program for Part B items and services furnished to a Medicare beneficiary by a physician or other supplier. CR 8282 announces that CMS established a new non-physician specialty code of C2 (Indirect Payment Procedure), effective October 1, 2013. The Provider Enrollment, Chain and Ownership System (PECOS) and MACs will recognize and use this new specialty code.

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number, which may be found at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.

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**News Flash** - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- **MLN Matters® Article #MM8433**, “Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season”
- **MLN Matters® Article #SE1336**, “2013-2014 Influenza (Flu) Resources for Health Care Professionals”
- **HealthMap Vaccine Finder** - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community.

**Free Resources** can be downloaded from the CDC website including prescription-style tear-pads that will allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu. On the CDC order form, under "Programs", select “Immunizations and Vaccines (Influenza/Flu)” for a list of flu related resources.

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