# Medicare Monthly Review

## Issue No. MMR 2014-07

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Contact information can be found on our Web site at [http://www.NGSMedicare.com](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](http://www.NGSMedicare.com).
Centers for Medicare & Medicaid Services
Articles for Part A&B Providers
NEW products from the Medicare Learning Network® (MLN)

“Annual Wellness Visit,” Podcast, ICN 908726, Downloadable only.

MLN Matters® Number: MM8401 Revised
Related Change Request (CR) #: CR 8401
Related CR Release Date: May 13, 2014
Effective Date: January 1, 2014
Related CR Transmittal #: R2955CP
Implementation Date: January 6, 2014

Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims

Note: This article was revised on June 9, 2014, to emphasize that coding "CT" in front of the clinical trial number applies ONLY to paper claims. The "CT" is not to be coded on electronic claims. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) and A/B MACs) for items and services provided in clinical trials to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8401, which informs you that, effective January 1, 2014, it will be mandatory to report a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the "Medicare National Coverage Determination (NCD) Manual," Section 310.1.

The clinical trial number to be reported is the same number that has been reported voluntarily since the implementation of CR 5790, dated January 18, 2008. That is the number assigned by the National Library of Medicine (NLM) http://clinicaltrials.gov/ website when a new study appears in the NLM Clinical Trials data base.

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Make sure that your billing staffs are aware of this requirement.

**Background**


This number is listed prominently on each specific study’s page and is always preceded by the letters ‘NCT’.

The Centers for Medicare & Medicaid Services (CMS) uses this number to identify all items and services provided to beneficiaries during their participation in a clinical trial, clinical study, or registry. Furthermore, this identifier permits CMS to better track Medicare payments, ensure that the information gained from the research is used to inform coverage decisions, and make certain that the research focuses on issues of importance to the Medicare population.

Suppliers may verify the validity of a trial/study/registry by consulting CMS’s clinical trials/registry website at [http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html](http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html) on the CMS website.

For institutional claims that are submitted on the electronic claim 837I, the 8-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:

- Condition code 30;
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

For professional claims, the 8-digit clinical trial number preceded by the 2 alpha characters of CT (use CT only on paper claims) must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REF01=P4) **(do not use CT on the electronic claim, e.g., 12345678)** when a clinical trial claim includes:

- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

Medicare Part B clinical trial/registry/study claims with dates of service on and after January 1, 2014, not containing an 8-digit clinical trial number will be returned as
unprocessable to the provider for inclusion of the trial number using the messages listed below.

- Claim Adjustment Reason Code (CARC) 16: “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either National Council for Prescription Drug Programs (NCPDP) Reject Reason Code, or Remittance Advice Remark Code (RARC) that is not an ALERT.)”
- RARC MA50: “Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.”
- RARC MA130: “Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.”
- Group Code-Contractual Obligation (CO).

**NOTE:** This is a reminder/clarification that clinical trials that are also investigational device exemption (IDE) trials must continue to report the associated IDE number on the claim form as well.

### Additional Information


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

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NEW products from the Medicare Learning Network® (MLN)

- “Medicare Enrollment Guidelines for Ordering/Referring Providers”, Fact Sheet, ICN 906223, Downloadable, EPUB, QR

MLN Matters® Number: MM 8691

Related Change Request (CR) #: CR 8691

Effective Date: July 1, 2014 (ICD-9 updates, local system edits), October 1, 2014 (designated ICD-9 shared system edits), October 1, 2015 (or whenever ICD-10 is implemented) (ICD-10 updates) determined for ICD-10

Related CR Release Date: May 23, 2014

Implementation Date: July 7, 2014 (designated ICD-9 updates, local system edits, October 6, 2014 (or whenever ICD-10 is implemented (ICD-10 updates) to be determined for ICD-10)

Related CR Transmittal #: R1388OTN

ICD-10 Conversion/ Coding Infrastructure Revisions/ ICD-9 Updates to National Coverage Determinations (NCDs) - Maintenance CR

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 and Hospice MACs (HH&H MACs) and Durable Medical Equipment MACs (DME MACs), for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8691 which is the first maintenance update of ICD-10 conversions and coding updates specific to National Coverage Determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous feedback.

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ICD-10 NCD CRs, specifically CR7818, CR8109, and CR8197. Links to related MLN Matters® Articles MM7818, MM8109, and MM8197 are available in the additional information section of this article. Some are the result of revisions required to other NCD-related CRs released separately that also included ICD-10.

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly recurring updates. No policy-related changes are included with these recurring updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Make sure that your billing staffs are aware of these changes to the following 29 NCDs:

20.5 ECU Using Protein A Columns, 20.7 PTA, 20.20 ECP Therapy, 20.29 HBO Therapy, 50.3 Cochlear Implants, 70.2.1 Diabetic Peripheral Neuropathy, 80.2 Photodynamic Therapy, 80.2.1 OPT, 80.3 Photosensitive Drugs, 80.3.1 Verteporfin, 100.1 Bariatric Surgery, 110.8.1 Stem Cell Transplants, 110.4 Extracorporeal Photopheresis, 110.10 IV Iron Therapy, 150.3 Bone Mineral Density, 160.18 VNS, 160.24 Deep Brain Stimulation, 160.27 TENS for CLBP, 180.1 MNT, 190.1 Histocompatibility Testing, 190.8 Lymphocyte Mitogen Response Assay, 190.11 Home PT/INR, 210.1 PSA Screening Tests, 210.2 Screening Pap/Pelvic Exams, 210.3 Colorectal Cancer Screens, 210.10 Screening for STIs, 250.4 Treatment for AKs, 250.3 IVIG for Autoimmune Blistering Disease, 250.5 Dermal Injections for Facial LDS

### Background

The purpose of CR8691 is to both create and update NCD editing, both hard-coded shared system edits as well as local MAC edits, that contain either ICD-9 diagnosis/procedure codes or ICD-10 diagnosis/procedure codes, or both, plus all associated coding infrastructure such as HCPCS/CPT codes, reason/remark codes, frequency edits, Place of Service (POS)/Type of Bill (TOB)/provider specialties, etc. The requirements described in CR8691 reflect the operational changes that are necessary to implement the conversion of the Medicare systems from ICD-9 to ICD-10 specific to the 29 NCD spreadsheets attached to CR8691.

### Additional Information


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

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Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) for Solid Tumors (This Change Request (CR) rescinds and fully replaces MM 8468, dated February 6, 2014.)

Note: This article was revised on May 30, 2014, to reflect the revised CR8739 issued on May 28. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

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Provider Action Needed

This article is based on Change Request (CR) 8739, which advises MACs, effective for dates of service on or after June 11, 2013, to cover three FDG PET scans 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 your MAC. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) has reconsidered 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 CR8739. The term FDG PET includes PET/computed tomography (CT) and PET/magnetic resonance (MRI).

CMS is revising the “NCD Manual”, Section 220.6, to reflect that CMS has ended the coverage with evidence development (CED) requirement for (2-[F18] fluoro-2-deoxy-D-glucose) FDG PET, 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 (Healthcare Common Procedure Coding System (HCPCS) Code A9552) only.

NOTE: For clarification purposes, as an example, each different cancer diagnosis is allowed one (1) initial treatment strategy (-PI modifier) FDG PET Scan and three (3) subsequent treatment strategy (-PS modifier) FDG PET Scans without the -KX modifier. The fourth FDG PET Scan and beyond for subsequent treatment strategy for the same cancer diagnosis will always require the -KX modifier. If a different cancer diagnosis is reported, whether reported with a -PI modifier or a -PS modifier, that cancer diagnosis will begin a new count for subsequent treatment strategy for that beneficiary. A beneficiary's file may or may not contain a claim for initial treatment strategy with a -PI modifier. The existence or non-existence of an initial treatment strategy claim has no bearing on the frequency count of the subsequent treatment strategy (-PS) claims.

Providers may refer to Attachment 1 of CR8739 for a list of appropriate diagnosis codes.

Effective for claims with dates of service on or after June 11, 2013, Medicare will accept and pay for FDG PET oncologic claims billed to inform initial treatment strategy or subsequent treatment strategy for suspected or biopsy proven solid tumors for all oncologic conditions without requiring the following:

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• Q0 modifier: Investigational clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);

• Q1 modifier: routine clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);

• V70.7: Examination of participant in clinical research; or

• Condition code 30 (institutional claims only).

Effective for dates of service on or after June 11, 2013, MACs will use the following messages when denying claims in excess of **three** for PET FDG scans for subsequent treatment strategy when the –KX modifier is not included, identified by CPT codes 78608, 78811, 78812, 78813, 78814, 78815, or 78816, modifier –PS, HCPCS A9552, and the same cancer diagnosis code:

• Claim Adjustment Reason Code (CARC) 96: “Non-Covered Charge(s). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

• Remittance Advice Remarks Code (RARC) N435: “Exceeds number/frequency approved/allowed within time period without support documentation.”

• 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.

MACs will not search their files to adjust claims processed prior to implementation of CR8739. However, if you have such claims and bring them to the attention of your MAC, the MAC will adjust such claims if appropriate.

**Synopsis of Coverage of FDG PET for Oncologic Conditions**

Effective for claims with dates of service on and after June 11, 2013, the chart below summarizes national FDG PET coverage for oncologic conditions:

<table>
<thead>
<tr>
<th>FDG PET for Cancers Tumor Type</th>
<th>Initial Treatment Strategy (formerly “diagnosis” &amp; “staging”)</th>
<th>Subsequent Treatment Strategy (formerly “restaging” &amp; “monitoring response to treatment”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>FDG PET for Cancers Tumor Type</td>
<td>Initial Treatment Strategy (formerly “diagnosis” &amp; “staging”)</td>
<td>Subsequent Treatment Strategy (formerly “restaging” &amp; “monitoring response to treatment”)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Esophagus</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Head and Neck (not thyroid, CNS)</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Non-small cell lung</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Ovary</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Brain</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Cervix</td>
<td>Cover with exceptions *</td>
<td>Cover</td>
</tr>
<tr>
<td>Small cell lung</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Soft tissue sarcoma</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Pancreas</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Testes</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Prostate</td>
<td>Non-cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Thyroid</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Breast (male and female)</td>
<td>Cover with exceptions *</td>
<td>Cover</td>
</tr>
<tr>
<td>Melanoma</td>
<td>Cover with exceptions *</td>
<td>Cover</td>
</tr>
<tr>
<td>All other solid tumors</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Myeloma</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>All other cancers not listed</td>
<td>Cover</td>
<td>Cover</td>
</tr>
</tbody>
</table>

*Cervix: Nationally non-covered for the initial diagnosis of cervical cancer related to initial anti-tumor treatment strategy. All other indications for initial anti-tumor treatment strategy for cervical cancer are nationally covered.

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

*Melanoma: Nationally non-covered for initial staging of regional lymph nodes. All other indications for initial anti-tumor treatment strategy for melanoma are nationally covered.
Additional Information


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2015 GEMs, Reimbursement Mappings, and ICD-10 Files Now Available - The 2015 General Equivalence Mappings (GEMs), Reimbursement Mappings, ICD-10-CM files, and ICD-10-PCS files are now available on the 2015 ICD-10-CM and GEMs web page and 2015 ICD-10-PCS and GEMs web page. The mappings can be used to convert policies from ICD-9-CM to ICD-10 codes. The GEMs provide both forward (ICD-9-CM to ICD-10) and backward (ICD-10 to ICD-9-CM) mappings. There are no new, revised, or deleted ICD-10-CM or ICD-10-PCS codes.

MLN Matters® Number: MM8775  Related Change Request (CR) #: CR 8775
Related CR Release Date: June 20, 2014  Effective Date: September 23, 2014
ICD-10: Upon Implementation of ICD-10
Related CR Transmittal #: R2977CP  Implementation Date: September 23, 2014
ICD-10: Upon Implementation of ICD-10

Clarification of Billing Instructions Related to the Home Health Benefit

Provider Types Affected

This MLN Matters® Article is intended for physicians, home health agencies, and suppliers of Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) submitting claims to Medicare Administrative Contractors (MACs) for services and supplies to Medicare beneficiaries in a home health period of coverage.

Provider Action Needed

This article is based on Change Request (CR) 8775, which updates the "Medicare Claims Processing Manual," to specify the physician specialty codes that are excluded from home health consolidated billing, to make conforming changes related to the retirement of the home health advance beneficiary notice, and to make miscellaneous changes to conform term and code usage to national standards. This CR contains no new policy. Make sure your billing staffs are aware of these updates.

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Background

CR 8775 makes a variety of small changes to the "Medicare Claims Processing Manual". These changes do not reflect any new policy. These changes fall into one of three categories.

1. **Clarification to Home Health Consolidated Billing (HH CB) Instructions:** In 2003, CR 2705 made changes to Medicare systems to bypass services from Home Health Consolidated Billing (HH CB) editing when provided by a physician. CR 2705 provided a list of physician specialty codes that are used in this bypass, but the list was never included in the "Medicare Claims Processing Manual". CR8775 adds the list to the HH CB section of Chapter 10 of the manual. It also makes some wording clarifications to better reflect how Medicare system edits currently enforce HH CB. The modifications to the manual are attached to CR8775, and you will find a link to that CR in the "Additional Information" section of this article.

2. **Removal of References to the Home Health Advance Beneficiary Notice (HHABN):** CR 8404 described the use of the Advance Beneficiary Notice of Noncoverage (ABN) as a replacement for the HH ABN. CR8775 makes conforming changes to Chapter 10 to remove references to the HHABN.

3. **Conforming to National Standards:** CR8775 makes detailed changes throughout many sections of Chapter 10 to ensure that references to type of bill and revenue code values mirror the way these values are used in the National Uniform Billing Committee's Official UB-04 Data Specifications Manual. Additionally, one remittance advice code pair is updated to comply with the Council for Affordable Quality Healthcare’s Committee on Operating Rules for Information Exchange (CAQH CORE) operating rules for code usage on remittance advices.

**Note:** MACs use claim adjustment reason code 97 when rejecting or denying claims due to HH CB.

Additional Information


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

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Changes to the Laboratory National Coverage Determination (NCD) Software

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8797 which informs MACs that the Laboratory National Coverage Determination (NCD) Edit Software will be updated to continue the processing of ICD-9 diagnosis codes. Make sure your billing staffs are aware of these changes.

Background

The Laboratory NCD Edit Software will be updated to continue the processing of the ICD-9 diagnosis codes. On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary of Health and Human Services may not adopt ICD-10 codes prior to October 1, 2015. This requires Health
Insurance Portability & Accountability Act of 1996 (HIPAA) covered entities to continue to use ICD-9-CM at least through September 30, 2015. Also, CR8797 announces there are no updates to the laboratory NCD code lists for this quarter.

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.
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- “Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 3]” Educational Tool, ICN 909006, downloadable

MLN Matters® Number: SE1418 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

Proper Use of Modifier 59

Note: This article was revised on June 2, 2014, to correct a code in Example 8 on page 7 and to make an editorial change to Example 11 on page 8. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to clarify the proper use of Modifier 59. The article only clarifies existing policy. Make sure that your billing staffs are aware of the proper use of Modifier 59.

Background

The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/

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Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations.

For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of “0,” the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied.

For PTP edits that have a CCMI of “1,” the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. (Refer to the National Correct Coding Initiative Policy Manual for Medicare Services, Chapter 1, for general information about the NCCI program, PTP edits, CCMIs, and NCCI-associated modifiers. This manual can be retrieved from the download section at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html on the Centers for Medicare & Medicaid Services (CMS) website.)

One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are “separate and distinct.” Modifier 59 is an important NCCI-associated modifier that is often used incorrectly.

The CPT Manual defines modifier 59 as follows:

“Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.”

Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.

1. Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or
encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

One of the common uses of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed at different anatomic sites, are not ordinarily performed or encountered on the same day, and that cannot be described by one of the more specific anatomic NCCI-associated modifiers – i.e., RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI. (See examples 1, 2, and 3.) From an NCCI perspective, the definition of different anatomic sites includes different organs or, in certain instances, different lesions in the same organ. However, NCCI edits are typically created to prevent the inappropriate billing of lesions and sites that should not be considered to be separate and distinct. Modifier 59 should only be used to identify clearly independent services that represent significant departures from the usual situations described by the NCCI edit. The treatment of contiguous structures in the same organ or anatomic region does not constitute treatment of different anatomic sites. For example:

- Treatment of the nail, nail bed, and adjacent soft tissue (See example 4.)
- Treatment of posterior segment structures in the eye (See example 5.)
- Arthroscopic treatment of structures in adjoining areas of the same shoulder (See example 6.)

2. Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day.

Another common use of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed during different patient encounters on the same day and that cannot be described by one of the more specific NCCI-associated modifiers – i.e., 24, 25, 27, 57, 58, 78, 79, or 91. (See example 7) As noted in the CPT definition, modifier 59 should only be used if no other modifier more appropriately describes the relationship of the two procedure codes.

3. Modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two codes is different.

One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe a “different procedure or surgery.” The code descriptors of the two codes of a code pair edit usually represent different procedures, even though they may be overlapping. The edit indicates that the two procedures should not be reported together if performed at the same anatomic site and same patient encounter as those procedures would not be considered to be “separate and distinct.” The provider should not use modifier 59 for such an edit.
based on the two codes being “different procedures.” (See example 8.) However, if the two procedures are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier 59 may be appended to indicate that they are different procedures on that date of service.

4. Other specific appropriate uses of modifier 59

There are three other limited situations in which two services may be reported as separate and distinct because they are separated in time and describe non-overlapping services even though they may occur during the same encounter, i.e.:

A. Modifier 59 is used appropriately for two services described by timed codes provided during the same encounter only when they are performed sequentially. There is an appropriate use for modifier 59 that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two timed services are provided in time periods that are separate and distinct and not interspersed with each other (i.e., one service is completed before the subsequent service begins), modifier 59 may be used to identify the services. (See example 9.)

B. Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure. When a diagnostic procedure precedes a surgical procedure or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical procedure is made, that diagnostic test may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention. (See example 10.) If the diagnostic procedure is an inherent component of the surgical procedure, it should not be reported separately.

C. Modifier 59 is used appropriately for a diagnostic procedure which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure. When a diagnostic procedure follows the surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise
been required during the therapeutic intervention. (See example 11.) If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it should not be reported separately.

Use of Modifier 59 does not require a different diagnosis for each HCPCS/CPT coded procedure. Conversely, different diagnoses are not adequate criteria for use of modifier 59. The HCPCS/CPT codes remain bundled unless the procedures are performed at different anatomic sites or separate patient encounters or meet one of the other three scenarios described above.

Examples of Modifier 59 Usage

Following are some examples developed to help guide physicians and providers on the proper use of Modifier 59 (Please remember that Medicare policy is that Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.):

Example 1: Column 1 Code / Column 2 Code - 17000/11100
- CPT Code 17000 – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion
- CPT Code 11100 – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

Modifier 59 may be reported with code 11100 if the procedures are performed at different anatomic sites on the same side of the body and a specific anatomic modifier is not applicable. If the procedures are performed on different sides of the body, modifiers RT and LT or another pair of anatomic modifiers should be used, not modifier 59.

Example 2: Column 1 Code/Column 2 Code 47370/76942
- CPT Code 47370 – Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency
- CPT Code 76942 – Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

CPT code 76942 should not be reported and Modifier 59 should not be used if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure. Code
76942 may be reported with modifier 59 if the ultrasonic guidance for needle placement is unrelated to the laparoscopic liver tumor ablation procedure.

**Example 3:** Column 1 Code/Column 2 Code 93453/76000
- CPT Code 93453 – Combined right and left heart catheterization including intraprocedural injections(s) for left ventriculography, imaging supervision and interpretation, when performed
- CPT Code 76000 – Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)

CPT code 76000 should not be reported and Modifier 59 should not be used for fluoroscopy that is used in conjunction with a cardiac catheterization procedure. Modifier 59 may be reported with code 76000 if the fluoroscopy is performed for a procedure unrelated to the cardiac catheterization procedure.

**Example 4:** Column 1 Code/Column 2 Code - 11055/11720
- CPT Code 11055 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
- CPT Code 11720 – Debridement of nail(s) by any method(s); one to five

CPT code 11720 should not be reported and Modifier 59 should not be used if a nail is debrided on the same toe from which a hyperkeratotic lesion has been removed. Modifier 59 may be reported with code 11720 if multiple nails are debrided and a corn that is on the same foot and that is not adjacent to a debrided toenail is pared.

**Example 5:** Column 1 Code/Column 2 code - 67210/67220
- CPT Code 67210 – Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation
- CPT Code 67220 – Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions

CPT code 67220 should not be reported and Modifier 59 should not be used if both procedures are performed during the same operative session because the retina and choroid are contiguous structures of the same organ.

**Example 6:** Column 1 Code/Column 2 Code - 29827/29820
- CPT Code 29827 – Arthroscopy, shoulder, surgical; with rotator cuff repair
- CPT Code 29820 – Arthroscopy, shoulder, surgical; synovectomy, partial

CPT code 29820 should not be reported and Modifier 59 should not be used if both procedures are performed on the same shoulder during the same operative session because
the shoulder joint is a single anatomic structure. If the procedures are performed on different shoulders, modifiers RT and LT should be used, not Modifier 59.

**Example 7:** Column 1 Code / Column 2 Code - 93015/93040
- CPT Code 93015 – Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
- CPT Code 93040 – Rhythm ECG, one to three leads; with interpretation and report

Modifier 59 may be reported if the rhythm ECG is performed at a different encounter than the cardiovascular stress test. If a rhythm ECG is performed during the cardiovascular stress test encounter, CPT code 93040 should not be reported and Modifier 59 should not be used. **In this case, the procedures are performed in different encounters on the same day.**

**Example 8:** Column 1 Code/Column 2 code - 34833/34820
- CPT code 34833 - Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral
- CPT code 34820 - Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral

CPT code 34833 is followed by a *CPT Manual* instruction that states: "(Do not report 34833 in addition to 34820)." Although the CPT code descriptors for 34833 and 34820 describe different procedures, they should not be reported together for the same side. Modifier 59 should not be appended to either code to report the two procedures for the same side of the body. If the two procedures were performed on different sides of the body, they may be reported with modifiers LT and RT as appropriate. **However, the use is inappropriate if the basis for its use is that the narrative description of the two codes is different.**

**Example 9:** Column 1 Code / Column 2 Code - 97140/97530
- CPT Code 97140 – Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
- CPT Code 97530 – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Modifier 59 may be reported if the two procedures are performed in distinctly different 15 minute intervals. CPT code 97530 should not be reported and Modifier 59 should not be used if the two procedures are performed during the same 15 minute time interval. **In this case, the procedures are performed in different encounters on the same day.**

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Example 10: Column 1 Code / Column 2 Code - 37220/75710

- CPT Code 37220 – Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
- CPT Code 75710 – Angiography, extremity, unilateral, radiological supervision and interpretation

Modifier 59 may be reported with CPT code 75710 if a diagnostic angiography has not been previously performed and the decision to perform the revascularization is based on the result of the diagnostic angiography. The CPT Manual defines additional circumstances under which diagnostic angiography may be reported with an interventional vascular procedure on the same artery. Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.

Example 11: Column 1 Code / Column 2 Code - 32551/71020

- CPT Code 32551 – Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open
- CPT Code 71020 – Radiologic examination, chest, 2 views, frontal and lateral

Modifier 59 may be reported if, later in the day following the insertion of a chest tube, the patient develops a high fever and a chest x-ray is performed to rule out pneumonia. CPT code 71020 should not be reported and Modifier 59 should not be used for a chest x-ray that is performed following insertion of a chest tube in order to verify correct placement of the tube. Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.

Additional Information

- The CMS webpage on the National Correct Coding Initiative Edits is available at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html on the CMS website.
- The CPT Manual includes the definition of Modifier 59, as well as CPT codes used with Modifier 59. The manual is available at http://www.ama-assn.org/ama on the American Medical Association (AMA) website.

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2015 GEMs, Reimbursement Mappings, and ICD-10 Files Now Available - The 2015 General Equivalence Mappings (GEMs), Reimbursement Mappings, ICD-10-CM files, and ICD-10-PCS files are now available on the 2015 ICD-10-CM and GEMs web page and 2015 ICD-10-PCS and GEMs web page. The mappings can be used to convert policies from ICD-9-CM to ICD-10 codes. The GEMs provide both forward (ICD-9-CM to ICD-10) and backward (ICD-10 to ICD-9-CM) mappings. There are no new, revised, or deleted ICD-10-CM or ICD-10-PCS codes.

MLN Matters® Number: SE1421  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

How to Access Updates to ICD-10 Local Coverage Determinations in the CMS Medicare Coverage Database

Provider Types Affected

This article is intended for all physicians, providers, and suppliers who submit 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

This MLN Matters® Special Edition article is intended to convey information on how to access updates to International Classification of Diseases, 10th Edition (ICD-10) Local Coverage Determinations (LCDs) in the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Database (MCD).

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Background

MACs may develop an LCD to further define a National Coverage Determination (NCD) or in the absence of a specific NCD. An LCD is a coverage decision made at a MAC’s own discretion to provide guidance to the public and the medical community within a specified geographic area. An LCD cannot conflict with an NCD. An LCD is an administrative and educational tool that can assist you in submitting correct claims for payment by:

- Outlining coverage criteria;
- Defining medical necessity; and
- Providing references upon which a policy (LCD) is based and codes that describe covered and/or noncovered services when the codes are integral to the discussion of medical necessity.

The MCD


Use the following steps to access the list of LCDs with ICD-10 codes:

1. On the CMS MCD Homepage, click on the “Indexes” tab at the top of the page;
2. Select “Local Coverage”;
3. Select one of the three display options for LCDs (“LCDs by Contractor,” “LCDs by State,” or “LCDs Listed Alphabetically”);
4. If you choose LCDs by Contractor, click on that link;
5. Select a MAC;
6. In the Document types, checkmark the square for “Future LCDs/Future Contract Number LCDs”;
7. Click the “Submit” button;
8. Click on the Contractor name; and
9. A list of Future Effective LCDs will display. Those LCDs with a 10/01/2014 Effective Date are ICD-10 LCDs.

Notes:

1. The ICD-10 updates are labeled “future” as the policies are not yet in effect. These updates are subject to change as necessitated by code updates and policy revisions.
2. It is expected that the 10/01/2014 Effective Dates will be changed to 10/01/2015 in mid-2014.

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Printing Documents on the CMS MCD

All documents on the CMS MCD may be printed. Use the following steps to print a document:
1. Open the document; and
2. In the upper right-hand corner, click on the “Print” button or use “Control + P”.
   Alternatively, click on the “Need a PDF?” button and click on the “Save a Copy” icon on the bottom of your screen or use “Shift + Control + S”.

Additional Information


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

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2015 GEMs, Reimbursement Mappings, and ICD-10 Files Now Available - The 2015 General Equivalence Mappings (GEMs), Reimbursement Mappings, ICD-10-CM files, and ICD-10-PCS files are now available on the [2015 ICD-10-CM and GEMs](http://www.gpo.gov) web page and [2015 ICD-10-PCS and GEMs](http://www.gpo.gov) web page. The mappings can be used to convert policies from ICD-9-CM to ICD-10 codes. The GEMs provide both forward (ICD-9-CM to ICD-10) and backward (ICD-10 to ICD-9-CM) mappings. There are no new, revised, or deleted ICD-10-CM or ICD-10-PCS codes.

MLN Matters® Number: MM8761
Related Change Request (CR) #: CR 8761
Related CR Release Date: May 12, 2014
Effective Date: July 1, 2014
Related CR Transmittal #: R2951CP
Implementation Date: July 7, 2014

**Off-Cycle Release of the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2014 Pricer**

**Provider Types Affected**

This MLN Matters® article is intended for hospitals who submit claims to Medicare Claims Part A Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

**Provider Action Needed**

Change Request (CR) 8761 updates the Fiscal Year (FY) 2014 Inpatient Prospective Payment System (IPPS) PRICER due to the Protecting Access to Medicare Act of 2014 and due to corrections of some uncompensated care per claim amounts. Make sure that your billing staff are aware of these updates.

**Background**

On April 1, 2014, the Protecting Access to Medicare Act of 2014 was signed into law, and the new law includes the extension of certain provisions of the Affordable Care Act. (See [http://www.gpo.gov](http://www.gpo.gov)).
Specifically, the following Medicare fee-for-service policies have been extended through March 31, 2015:

- **Section 105 - Extension of Medicare Inpatient Hospital Payment Adjustment for Low-Volume Hospitals**
  The Affordable Care Act provided for temporary changes to the low-volume hospital adjustment for Fiscal Years (FYs) 2011 and 2012. To qualify, the hospital must:
  - Have less than 1,600 Medicare discharges, and
  - Be 15 miles or greater from the nearest like hospital.

- **Section 106 - Extension of the Medicare-Dependent Hospital (MDH) Program**
  The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This provision of the Protecting Access to Medicare Act of 2014 extends the MDH program until March 31, 2015. Prior to this legislation, the MDH program expired March 31, 2014, as provided by the Pathway for SGR Reform Act.

In addition, (consistent with the Centers for Medicare & Medicaid Services (CMS) policy finalized in the FY 2014 IPPS Final Rule (78 FR 50638; see [http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/html/2013-18956.htm](http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/html/2013-18956.htm))) CMS is making changes to the FY 2014 Factor 3, the total uncompensated care payments and the uncompensated care per claim amount for 38 providers included in Attachment A of CR8761, whose uncompensated care payments were inadvertently calculated using a cost report that was less than a full year when a cost report that was a full year or closer to being a full year was available.

The updated payments reflect revisions to Factor 3 such that Medicaid days in the numerator and denominator for all affected providers are based on:
  - A full year cost report from 2011,
  - or if not available or if less than 12 months,
  - A full year cost report from 2010, or
  - The cost report from 2011 or 2010 that is closest to 12 months.

In addition, CMS is revising the uncompensated care per claim amount for one provider, whose uncompensated care per claim amount was inadvertently overstated, resulting in large
interim overpayments. This provider is also included in Attachment A of CR8761.

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2014
The Affordable Care Act (Sections 3125 and 10314; 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)) amended the low-volume hospital adjustment in section 1886(d)(12) of the Social Security Act by revising, for FYs 2011 and 2012, the definition of a low-volume hospital and the methodology for calculating the low-volume payment adjustment. These amendments were extended for FY 2013 by the American Taxpayer Relief Act (ATRA; see [http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf](http://www.gpo.gov/fdsys/pkg/BILLS-112hr8enr/pdf/BILLS-112hr8enr.pdf)), and subsequently extended for FY 2014 discharges occurring before April 1, 2014, by the Pathway for SGR Reform Act. Prior to the Protecting Access to Medicare Act of 2014, for FY 2014 discharges occurring on or after April 1, 2014, and subsequent years, the low-volume hospital qualifying criteria and payment adjustment returned to the statutory requirements that were in effect prior to the amendments made by the Affordable Care Act and subsequent legislation.

To implement the extension of the temporary change in the low-volume hospital payment policy for FY 2014 discharges occurring on or after April 1, 2014, provided for by section 105 of the Protecting Access to Medicare Act (quoted above), in accordance with the existing regulations at CFR 412.101(b)(2)(ii) and consistent with current policy, CMS published a notice in the Federal Register (CMS 1599-N).

In that notice, CMS established that for FY 2014 discharges occurring on or after April 1, 2014, through September 30, 2015, the low-volume hospital qualifying criteria and payment adjustment (percentage increase) is determined using FY 2012 Medicare discharge data from the March 2013 update of the MedPAR files (that is, the same discharge data used to identify qualifying low-volume hospitals and calculate the payment adjustment for discharges that occurred during the first half of FY 2014). In Table 14 of the Addendum to that notice, CMS republishes the list of the IPPS hospitals with fewer than 1,600 Medicare discharges based on the March 2013 update of the FY 2012 MedPAR files (originally published in CMS 1599-IFC2). This list of IPPS hospitals with fewer than 1,600 Medicare discharges is not a listing of the hospitals that qualify for the low-volume adjustment for FY 2014 since it does not reflect whether or not the hospital meets the mileage criterion (that is, to qualify for the low-volume adjustment, the hospital must also be located more than 15 road miles from any other IPPS hospital). In order to receive the applicable low-volume hospital payment adjustment (percentage increase) for FY 2014 discharges occurring on or after April 1, 2014, a hospital must meet both the discharge and mileage criteria.

In order to receive a low-volume hospital payment adjustment for FY 2014 discharges occurring on or after April 1, 2014, consistent with the previously established procedure, CMS is continuing to require a hospital to notify and provide documentation to its MAC that it meets the mileage criterion. Specifically, a hospital must make its request for low-volume hospital status in writing to its Medicare Contractor and provide documentation that it meets the mileage criterion, so that the applicable low-volume percentage increase is applied to payments for its discharges occurring on or...
after April 1, 2014. The MAC must be in receipt of the hospital’s written request by June 30, 2014, in order for the effective date of the hospital’s low-volume hospital status to be April 1, 2014. A hospital that qualified for the low-volume payment adjustment for its FY 2014 discharges occurring on or after October 1, 2013, through March 31, 2014, does not need to notify its MAC and will continue to receive the applicable low-volume payment adjustment for FY 2014 discharges occurring on or after April 1, 2014, without reapplying, provided it continues to meet the Medicare mileage criterion.

A hospital that qualified for the low-volume payment adjustment in FY 2013 but failed to make the required notification to its MAC by the deadline for its discharges occurring during the first half of FY 2014 may begin receiving the applicable low-volume payment adjustment for its FY 2014 discharges occurring on or after April 1, 2014, without reapplying, if it meets the Medicare discharge criterion, based on the FY 2012 MedPAR data (shown in Table 14 of that notice) and the distance criterion. However, the hospital must verify in writing to its MAC that it continues to be more than 15 miles from any other “subsection (d)” hospital no later than June 30, 2014. For requests for low-volume hospital status for FY 2014 discharges occurring on or after April 1, 2014, received after June 30, 2014, if the hospital meets the criteria to qualify as a low-volume hospital, the MAC will establish a low-volume hospital status effective date that will be applicable prospectively within 30 days of the date of the MAC’s low-volume status determination, consistent with CMS historical policy. Hospital requests for low-volume hospital status received between the issuance of the Federal Register notice that implements the provisions of section 105 (quoted above) of the Protecting Access to Medicare Act through June 30, 2014, are only applicable for FY 2014 discharges occurring on or after April 1, 2014 (and will not be applied in determining payments for the hospital’s FY 2014 discharges occurring before April 1, 2014, since CMS policy does not provide for retroactive effective dates).

MACs will verify that the hospital meets the discharge criteria by using the Medicare discharges based on the March 2013 update of the FY 2012 MedPAR files as shown in Table 14 of the Federal Register Notice (CMS-1599-N) and available on the Acute Inpatient PPS webpage at http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp (click on the link on the left side of the screen titled, “FY 2014 IPPS Final Rule Home Page”). CMS notes that in order to facilitate administrative implementation, the only source that CMS and the MACs will use to determine the number of Medicare discharges for purposes of the low-volume payment adjustment for FY 2014 discharges occurring on or after April 1, 2014, is the data from the March 2013 update of the FY 2012 MedPAR file.) The Medicare discharge count includes any billed Medicare Advantage claims in the MedPAR file but excludes any claims serviced in non-IPPS units.

In order to implement this policy for FY 2014, the Pricer will continue to include the table containing the provider number and discharge count determined from the March 2013 update of the FY 2012 MedPAR file. The table in the Pricer includes IPPS providers with fewer than 1,600 Medicare discharges but does not consider whether the IPPS hospital meets the mileage criterion (that is, located more than 15 road miles from the nearest IPPS hospital).
The applicable low-volume payment adjustment (percentage increase) is based on and in addition to all other IPPS per discharge payments, including capital, Disproportionate Share Hospital (DSH), uncompensated care, Indirect Medical Education (IME) and outliers. For Sole-Community Hospitals (SCHs) and MDHs, the applicable low-volume percentage increase is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

Reinstatement of Medicare Dependent Hospital (MDH) Status
Under the Affordable Care Act (Section 3124), the MDH program authorized by the Social Security Act (Section 1886(d)(5)(G)) was set to expire at the end of FY 2012. These amendments were extended for FY 2013 by section 606 of the American Taxpayer Relief Act, and from October 1, 2013, through March 31, 2014, by the Pathway for SGR Reform Act. As part of the Protecting Access to Medicare Act, Congress reinstated the MDH program through March 31, 2015.

CMS implemented the extension of the MDH program provided by the Affordable Care Act and subsequent legislation in:

- The regulations at 42 CFR 412.108 (see http://www.ecfr.gov/cgi-bin/text-idx?SID=cb24df348324f83565afefe0ef321163&node=42:2.0.1.2.12&rgn=div5#42:2.0.1.2.12.7.50.13);
- The FY 2011 IPPS/LTCH PPS final rule (75 FR 50287; see http://www.gpo.gov/fdsys/pkg/FR-2010-08-16/html/2010-19092.htm);
- The FY 2014 IPPS/LTCH PPS final rule (78 FR 50647 through 50649; see http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/html/2013-18956.htm); and

Consistent with the CMS implementation of previous MDH program extensions, generally, providers that were classified as MDHs as of the date of expiration of the MDH provision will be reinstated as MDHs effective April 1, 2014, with no need to reapply for MDH classification. There are the following two exceptions:

a. MDHs that classified as Sole-Community Hospitals (SCHs) on or after April 1, 2014
In anticipation of the expiration of the MDH provision, CMS allowed MDHs that applied for classification as an SCH by March 1, 2014, to be granted such status effective with the expiration of the MDH program. Hospitals that applied in this manner and were approved for SCH classification received SCH status as of April 1, 2014. Additionally, some hospitals that had MDH status as of the March 31, 2014, expiration of the MDH program may have missed the March 1, 2014, application deadline. These hospitals applied for SCH status in the usual manner instead and may have been approved for SCH status effective 30 days from the date of approval resulting in an effective date later than April 1, 2014.

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b. MDHs that requested a cancellation of their rural classification under 42 CFR 412.103(b)

In order to meet the criteria to become an MDH, a hospital must be located in a rural area. To qualify for MDH status, some MDHs may have reclassified as rural under the regulations at 42 CFR 412.103. With the expiration of the MDH provision, some of these providers may have requested a cancellation of their rural classification. You can review 42 CFR 412.103 at http://www.ecfr.gov/cgi-bin/text-idx?SID=cb24df348324f83565afefe0ef321163&node=42:2.0.1.2.12&rgn=div5#42:2.0.1.2.12.7.50.8 on the Internet.

Any provider that falls within either of the two exceptions listed above will not have its MDH status automatically reinstated retroactively to April 1, 2014. All other former MDHs will be automatically reinstated as MDHs effective April 1, 2014. Providers that fall within either of the two exceptions will have to reapply for MDH classification in accordance with the regulations at 42 CFR 412.108(b) and meet the classification criteria at 42 CFR 412.108(a). Specifically, the regulations at 412.108(b) require that:

1. The hospital submit a written request along with qualifying documentation to its contractor to be considered for MDH status (412.108(b)(2)).
2. The contractor make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification (412.108(b)(3)).
3. The determination of MDH status be effective 30 days after the date of the contractor's written notification to the hospital (412.108(b)(4)).


Cancellation of MDH Status

As required by the regulations at 42 CFR 412.108(b)(5), MACs must “evaluate on an ongoing basis” whether or not a hospital continues to qualify for MDH status. Therefore, as required by the regulations at 412.108(b)(5) and (6), the MACs will ensure that the hospital continues to meet the MDH criteria at 412.108(a) and will notify any MDH that no longer qualifies for MDH status. The cancellation of MDH status will become effective 30 days after the date the contractor provides written notification to the hospital.

It is important to note that despite the fact some providers might no longer meet the criteria necessary to be classified as MDHs, these providers could qualify for automatic reinstatement of MDH status retroactive to October 1, 2013, (unless they meet either of the two exceptions for automatic reinstatement as explained above) and would subsequently lose their MDH status prospectively.

Attachment B of CR8761 outlines the various possible actions to be followed for each former MDH and the corresponding examples for each scenario.
Hospital Specific (HSP) Rate Update for MDHs
For the payment of FY 2014 discharges occurring on or after April 1, 2014, the Hospital Specific (HSP) amount for MDHs in the Provider Specific File will continue to be entered in FY 2012 dollars (just as was done for SCHs as instructed in CR 8241 (Transmittal 2778; August 30, 2013)). PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2013 of 0.9480 and make all updates to the HSP amount for FY 2013 and beyond.

Uncompensated Care Payment
There is no change to the existing policy.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.
2015 GEMs, Reimbursement Mappings, and ICD-10 Files Now Available - The 2015 General Equivalence Mappings (GEMs), Reimbursement Mappings, ICD-10-CM files, and ICD-10-PCS files are now available on the 2015 ICD-10-CM and GEMs web page and 2015 ICD-10-PCS and GEMs web page. The mappings can be used to convert policies from ICD-9-CM to ICD-10 codes. The GEMs provide both forward (ICD-9-CM to ICD-10) and backward (ICD-10 to ICD-9-CM) mappings. There are no new, revised, or deleted ICD-10-CM or ICD-10-PCS codes.

MLN Matters® Number: MM8773 Related Change Request (CR) #: CR8773
Related CR Release Date: June 6, 2014 Effective Date: July 1, 2014
Related CR Transmittal #: R2974CP Implementation Date: July 7, 2014

July Update to the Calendar Year (CY) 2014 Medicare Physician Fee Schedule Database (MPFSDB)

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice (HHH) MACs, for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8773 which amends the payment files that were issued to MACs based upon the CY 2014 MPFS, Final Rule as modified by the "Pathway for SGR Reform Act of 2013" (Section 101) passed on December 18, 2013, and further modified by section 101 of the “Protecting Access to Medicare Act of 2014” on April 1, 2014. Make sure your billing staffs are aware of these changes.
Background

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

In order to reflect appropriate payment policy based on current law and the Calendar Year (CY) 2014 Medicare Physician Fee Schedule (MPFS) Final Rule, the MPFS Database (MPFSDB) has been updated using the 0.5 percent update conversion factor, effective January 1, 2014, to December 31, 2014.

Payment files were issued to MACs based upon the CY 2014 MPFS Final Rule, published in the Federal Register on December 10, 2013, which is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html, and as modified by section 101 of the "Pathway for SGR Reform Act of 2013" passed on December 18, 2013, and further modified by section 101 of the “Protecting Access to Medicare Act of 2014” on April 1, 2014, for MPFS rates to be effective January 1, 2014, to December 31, 2014.

The summary of Healthcare Common Procedure Coding System (HCPCS) Code additions for the July 2014 update are shown in the following table:

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>Procedure Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9970</td>
<td>Inj Ferric Carboxymaltos 1mg</td>
<td>E</td>
</tr>
<tr>
<td>Q9974</td>
<td>Morphine epidural/intratheca</td>
<td>E</td>
</tr>
<tr>
<td>S0144</td>
<td>Inj, Propofol, 10mg</td>
<td>I</td>
</tr>
<tr>
<td>S1034</td>
<td>Art pancreas system</td>
<td>I</td>
</tr>
<tr>
<td>S1035</td>
<td>Art pancreas inv disp sensor</td>
<td>I</td>
</tr>
<tr>
<td>S1036</td>
<td>Art pancreas ext transmitter</td>
<td>I</td>
</tr>
<tr>
<td>S1037</td>
<td>Art pancreas ext receiver</td>
<td>I</td>
</tr>
<tr>
<td>0347T</td>
<td>Ins bone device for rsa</td>
<td>C</td>
</tr>
<tr>
<td>0348T</td>
<td>Rsa spine exam</td>
<td>C</td>
</tr>
<tr>
<td>0349T</td>
<td>Rsa upper extr exam</td>
<td>C</td>
</tr>
<tr>
<td>0350T</td>
<td>Rsa lower extr exam</td>
<td>C</td>
</tr>
<tr>
<td>0351T</td>
<td>Intraop oct brst/node spec</td>
<td>C</td>
</tr>
<tr>
<td>0352T</td>
<td>Oct brst/node i&amp;r per spec</td>
<td>C</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>Procedure Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>0353T</td>
<td>Intraop oct breast cavity</td>
<td>C</td>
</tr>
<tr>
<td>0354T</td>
<td>Oct breast surg cavity i&amp;r</td>
<td>C</td>
</tr>
<tr>
<td>0355T</td>
<td>Gi tract capsule endoscopy</td>
<td>C</td>
</tr>
<tr>
<td>0356T</td>
<td>Instr drug device for iop</td>
<td>C</td>
</tr>
<tr>
<td>0358T</td>
<td>Bia whole body</td>
<td>C</td>
</tr>
<tr>
<td>0359T</td>
<td>Behavioral id assessment</td>
<td>C</td>
</tr>
<tr>
<td>0360T</td>
<td>Observ behav assessment</td>
<td>C</td>
</tr>
<tr>
<td>0361T</td>
<td>Observ behav assess addl</td>
<td>C</td>
</tr>
<tr>
<td>0362T</td>
<td>Expose behav assessment</td>
<td>C</td>
</tr>
<tr>
<td>0363T</td>
<td>Expose behav assess addl</td>
<td>C</td>
</tr>
<tr>
<td>0364T</td>
<td>Behavior treatment</td>
<td>C</td>
</tr>
<tr>
<td>0365T</td>
<td>Behavior treatment addl</td>
<td>C</td>
</tr>
<tr>
<td>0366T</td>
<td>Group behavior treatment</td>
<td>C</td>
</tr>
<tr>
<td>0367T</td>
<td>Group behav treatment addl</td>
<td>C</td>
</tr>
<tr>
<td>0368T</td>
<td>Behavior treatment modified</td>
<td>C</td>
</tr>
<tr>
<td>0369T</td>
<td>Behav treatment modify addl</td>
<td>C</td>
</tr>
<tr>
<td>0370T</td>
<td>Fam behav treatment guidance</td>
<td>C</td>
</tr>
<tr>
<td>0371T</td>
<td>Mult fam behav treat guide</td>
<td>C</td>
</tr>
<tr>
<td>0372T</td>
<td>Social skills training group</td>
<td>C</td>
</tr>
<tr>
<td>0373T</td>
<td>Exposure behavior treatment</td>
<td>C</td>
</tr>
<tr>
<td>0374T</td>
<td>Expose behav treatment addl</td>
<td>C</td>
</tr>
</tbody>
</table>

All the additional codes listed in the above table are effective as of July 1, 2014. For full details on the above codes, including on descriptors, place of service codes, co-surgery indicators, etc. see the tables in CR8773. The Web address for CR8773 is in the “Additional Information” section below.

In addition to the codes that were added, codes J2271 (Morphine SO4 injection 100mg) and J2275 (Morphine sulfate injection) have a change in their procedure status code from E to I, effective July 1, 2014.

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Also, Section 651 of Medicare Modernization Act (MMA) required the Secretary of Health and Human Services to conduct a demonstration for up to 2 years to evaluate the feasibility and advisability of expanding coverage for chiropractic services under Medicare. The demonstration expanded Medicare coverage to include: “(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and (B) diagnostic and other services that a chiropractor is legally authorized to perform by the state or jurisdiction in which such treatment is provided.” The demonstration, which ended on March 31, 2007, was required to be budget neutral as section 651(f)(1)(B) of MMA mandates the Secretary to ensure that “the aggregate payments made by the Secretary under the Medicare program do not exceed the amount which the Secretary would have paid under the Medicare program if the demonstration projects under this section were not implemented.” The costs of this demonstration were higher than expected and CMS has been recovering costs by deducting 2 percent from payments for chiropractic services. Since CMS has determined that the costs are fully recovered, the July update eliminates the 2 percent reduction for CPT codes 98940, 98941, and 98942 that was utilized for the first half of CY 2014, effective July 1, 2014.

Additional Information


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

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MLN Matters® Number: MM8776  Related Change Request (CR) #: CR 8776
Related CR Release Date: May 23, 2014  Effective Date: July 1, 2014
Related CR Transmittal #: R2971CP  Implementation Date: July 7, 2014

July 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Home Health and Hospices MACs for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8776 which describes changes to and billing instructions for various payment policies implemented in the July 2014 Outpatient Prospective Payment System (OPPS) update. Make sure your billing staffs are aware of these changes.

Background

Change Request (CR) 8776 describes changes to and billing instructions for various payment policies implemented in the July 2014 OPPS update. The July 2014 Integrated
Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, Status Indicator (SI), and Revenue Code additions, changes, and deletions identified in CR 8776.


Key changes to and billing instructions for various payment policies implemented in the July 2014 OPPS update are as follows:

Changes to Device Edits for July 2014

The most current list of device edits is available under "Device and Procedure Edits" at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/ on the CMS website. Failure to pass these edits will result in the claim being returned to the provider.

New Brachytherapy Source Payment

The Social Security Act (Section 1833(t)(2)(H); see http://www.socialsecurity.gov/OPHome/ssact/title18/1833.htm) mandates the creation of additional groups of covered outpatient department (OPD) services that classify devices of brachytherapy consisting of a seed or seeds (or radioactive source) (“brachytherapy sources”) separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the brachytherapy sources furnished. Cesium-131 chloride solution is a new brachytherapy source.

The HCPCS code assigned to this source as well as payment rate under OPPS are listed in Table 1 below.

Table 1—New Brachytherapy Source Code Effective July 1, 2014

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Effective date</th>
<th>SI</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Long descriptor</th>
<th>Payment</th>
<th>Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2644</td>
<td>7/01/2014</td>
<td>U</td>
<td>2644</td>
<td>Brachytx cesium-131 chloride</td>
<td>Brachytherapy source, cesium-131 chloride solution, per millicurie</td>
<td>$18.97</td>
<td>$3.80</td>
</tr>
</tbody>
</table>

The American Medical Association (AMA) releases Category III CPT codes twice per year: 1.) in January, for implementation beginning the following July, and 2.) in July, for implementation beginning the following January.

For the July 2014 update, CMS is implementing in the OPPS 27 Category III CPT codes that the AMA released in January 2014 for implementation on July 1, 2014. Of the 27 Category III CPT codes shown in Table 2 below, 17 of the Category III CPT codes are separately payable under the hospital OPPS. The SIs and APCs for these codes are shown in Table 2 below. Payment rates for these services can be found in Addendum B of the July 2014 OPPS Update that is posted at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html) on the CMS website.

Table 2 – 27 Category III CPT Codes Implemented as of July 1, 2014

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0347T</td>
<td>Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)</td>
<td>Q2</td>
<td>0420</td>
</tr>
<tr>
<td>0348T</td>
<td>Radiologic examination, radiostereometric analysis (RSA); spine, (includes, cervical, thoracic and lumbosacral, when performed)</td>
<td>X</td>
<td>0261</td>
</tr>
<tr>
<td>0349T</td>
<td>Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow and wrist, when performed)</td>
<td>X</td>
<td>0261</td>
</tr>
<tr>
<td>0350T</td>
<td>Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee and ankle, when performed)</td>
<td>X</td>
<td>0261</td>
</tr>
<tr>
<td>0351T</td>
<td>Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real time intraoperative</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0352T</td>
<td>Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real time or referred</td>
<td>B</td>
<td>N/A</td>
</tr>
<tr>
<td>0353T</td>
<td>Optical coherence tomography of breast, surgical cavity; real time intraoperative</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0354T</td>
<td>Optical coherence tomography of breast, surgical cavity; interpretation and report, real time or referred</td>
<td>B</td>
<td>N/A</td>
</tr>
<tr>
<td>0355T</td>
<td>Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), colon, with interpretation and report</td>
<td>T</td>
<td>0142</td>
</tr>
<tr>
<td>0356T</td>
<td>Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into</td>
<td>S</td>
<td>0698</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------------------</td>
<td>--------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>0358T</td>
<td>Bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report</td>
<td>Q1 0340</td>
<td></td>
</tr>
<tr>
<td>0359T</td>
<td>Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report</td>
<td>V 0632</td>
<td></td>
</tr>
<tr>
<td>0360T</td>
<td>Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient</td>
<td>V 0632</td>
<td></td>
</tr>
<tr>
<td>0361T</td>
<td>Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)</td>
<td>N N/A</td>
<td></td>
</tr>
<tr>
<td>0362T</td>
<td>Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient</td>
<td>V 0632</td>
<td></td>
</tr>
<tr>
<td>0363T</td>
<td>Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)</td>
<td>N N/A</td>
<td></td>
</tr>
<tr>
<td>0364T</td>
<td>Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time</td>
<td>S 0322</td>
<td></td>
</tr>
<tr>
<td>0365T</td>
<td>Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each</td>
<td>N N/A</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------</td>
<td>---------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>additional 30 minutes of technician time (List separately in addition to code for primary procedure)</td>
<td>0366T</td>
<td>Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time</td>
<td>S</td>
</tr>
<tr>
<td>0367T</td>
<td>Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0368T</td>
<td>Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time</td>
<td>S</td>
<td>0322</td>
</tr>
<tr>
<td>0369T</td>
<td>Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>0370T</td>
<td>Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)</td>
<td>S</td>
<td>0324</td>
</tr>
<tr>
<td>0371T</td>
<td>Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)</td>
<td>S</td>
<td>0324</td>
</tr>
<tr>
<td>0372T</td>
<td>Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients</td>
<td>S</td>
<td>0325</td>
</tr>
<tr>
<td>0373T</td>
<td>Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient</td>
<td>S</td>
<td>0323</td>
</tr>
<tr>
<td>0374T</td>
<td>Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Billing for Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2014

In the CY 2014 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2014 release of the OPPS Pricer. The updated payment rates, effective July 1, 2014, will be included in the July 2014 update of the OPPS Addendum A and Addendum B, which will be posted at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html) on the CMS website.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2014

Three drugs and biologicals have been granted OPPS pass-through status effective July 1, 2014. These items, along with their descriptors and APC assignments, are identified below in Table 3.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9022*</td>
<td>Injection, elosulfase alfa, 1mg</td>
<td>1480</td>
<td>G</td>
</tr>
<tr>
<td>C9134*</td>
<td>Factor XIII (antihemophilic factor, recombinant), Tretten, per 10 i.u.</td>
<td>1481</td>
<td>G</td>
</tr>
<tr>
<td>J1446</td>
<td>Injection, tbo-filgrastim, 5 micrograms</td>
<td>1447</td>
<td>G</td>
</tr>
</tbody>
</table>

Note: The HCPCS codes identified with an “*” indicate that these are new codes effective July 1, 2014.

c. New HCPCS Codes Effective July 1, 2014, for Certain Drugs and Biologicals

Two new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biological listed in Table 4) in the hospital outpatient setting for July 1, 2014. These codes are listed below in Table 4, and they are effective for services furnished on or after July 1, 2014.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator Effective 7/1/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9970*</td>
<td>Injection, ferric carboxymaltose, 1 mg</td>
<td>9441</td>
<td>G</td>
</tr>
<tr>
<td>Q9974**</td>
<td>Injection, Morphine Sulfate, Preservative-Free For Epidural Or Intrathecal Use, 10 mg</td>
<td>N/A</td>
<td>N</td>
</tr>
</tbody>
</table>
HCPCS code C9441 (Injection, ferric carboxymaltose, 1 mg) will be deleted and replaced with HCPCS code Q9970 effective July 1, 2014.

**HCPCS code J2275 (Injection, morphine sulfate (preservative-free sterile solution), per 10 mg) and will be replaced with HCPCS code Q9974 effective July 1, 2014. The SI for HCPCS code J2275 will change to E, “Not Payable by Medicare,” effective July 1, 2014.

d. Revised SIs for HCPCS Codes J2271 and Q2052

Effective July 1, 2014, the SI for HCPCS code J2271 (Injection, morphine sulfate, 100mg) will change:

1) From SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.),
2) To SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

Effective April 1, 2014, the SI for HCPCS code Q2052 (Services, supplies, and accessories used in the home under the Medicare intravenous immune globulin (IVIG) demonstration) will change:

1) From SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.)
2) To SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

e. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2013, through December 31, 2013

The payment rate for one HCPCS code was incorrect in the October 2013 OPPS Pricer. The corrected payment rate is listed in Table 5 below, and it has been installed in the July 2014 OPPS Pricer, effective for services furnished on October 1, 2013, through December 31, 2013. Your MAC will adjust any claims incorrectly processed if you bring those claims to the attention of your MAC.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Corrected Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>J2788</td>
<td>K</td>
<td>9023</td>
<td>Rho d immune globulin 50 mcg</td>
<td>$25.15</td>
<td>$5.03</td>
</tr>
</tbody>
</table>

f. Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2014, through March 31, 2014

The payment rate for one HCPCS code was incorrect in the January 2014 OPPS Pricer. The corrected payment rate is listed below in Table 6, and it has been installed in the July 2014 OPPS
Pricer, effective for services furnished on January 1, 2014, through March 31, 2014. Your MAC will adjust any claims incorrectly processed if you bring those claims to the attention of your MAC.

Table 6 – Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2014, through March 31, 2014

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Corrected Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0775</td>
<td>K</td>
<td>1340</td>
<td>Collagenase, clost hist inj</td>
<td>$38.49</td>
<td>$7.70</td>
</tr>
</tbody>
</table>

Operational Change to Billing Lab Tests for Separate Payment
As delineated in MLN Matters Special Edition Article (SE)1412, issued on March 5, 2014, (see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1412.pdf), effective July 1, 2014, OPPS hospitals should begin using modifier L1 on type of bill (TOB) 13X when seeking separate payment for outpatient lab tests under the Clinical Laboratory Fee Schedule (CLFS) in the following circumstances:

1) A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or
2) A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day.

“Unrelated” means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis. Hospitals should no longer use TOB 14X in these circumstances.

CMS is providing related updates to the "Medicare Claims Processing Manual" (Publication 100-04; Chapter 2, Section 90; and Chapter 16, Sections 30.3, 40.3, and 40.3.1) which are included as an attachment to CR 8766.

Clarification of Payment for Certain Hospital Part B Inpatient Labs
As recently provided in Change Request (CR) 8445, Transmittal 2877, published on February 7, 2014 (see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8445.pdf on the CMS website), and CR 8666, Transmittal 182, published on March 21, 2014 (see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8666.pdf on the CMS website), hospitals may only bill for a limited set of Part B inpatient services when beneficiaries who have Part B coverage are treated as hospital inpatients, and:

1) They are not eligible for or entitled to coverage under Part A, or
2) They are entitled to Part A but have exhausted their Part A benefits.
CMS is clarifying its general payment policy that, for hospitals paid under the OPPS, these Part B inpatient services are separately payable under Part B, and are excluded from OPPS packaging, if the primary service with which the service would otherwise be bundled is not a payable Part B inpatient service.

CMS has adjusted its claims processing logic to make separate payment for Laboratory services paid under the CLFS pursuant to this policy that would otherwise be OPPS-packaged beginning in 2014. Hospitals should consult their MAC for reprocessing of any 12X TOB claims with dates of service on or after January 1, 2014 that were denied and should be paid under this policy.

**Coverage Determinations**

The fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program.

MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, Medicare Contractors determine that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment.

**Additional Information**


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

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Submission of Community Mental Health Center (CMHC) Certifications of Compliance with Section 485.918(b)(1)

Provider Types Affected

This MLN Matters® Article is intended for Community Mental Health Centers (CMHCs) submitting institutional claims to Medicare Administrative Contractors (MACs) for CMHC services to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8784, which informs MACs about the processing of CMHC certifications of compliance.

Background

Effective October 29, 2014, under 42 CFR 485.918(b)(1) a CMHC must provide at least 40 percent of its items and services to individuals who are not eligible for benefits under title XVIII of the Social Security Act, as measured by the total number of CMHC clients treated by the CMHC for whom services are not paid by Medicare, divided by the total number of clients treated by the CMHC in the applicable timeframe. Pursuant to this requirement, a newly enrolling or revalidating CMHC must submit to the Centers for Medicare & Medicaid

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Services (CMS), via its MAC, a certification statement provided by an independent entity (such as an accounting technician). The document must certify that:

- The entity has reviewed the CMHC’s client care data; and
- For:
  - Initial enrollments: The CMHC meets the 40 percent requirement for the prior 3 months.
  - Revalidations: The CMHC meets the 40 percent requirement for each of the intervening 12-month periods between initial enrollment and revalidation.

The statement must be submitted as part of any initial enrollment or revalidation (including off-cycle revalidations).

Special Guidelines

1. An appropriate official of the certifying entity must sign the document. (Notarization is not required unless CMS requests it.) Such persons may include accounting technicians, CEOs, officers, directors, etc.

2. The certification should be on the certifying entity’s letterhead or should otherwise indicate that the document is clearly from the entity.

Additional Information


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

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As a result of the Affordable Care Act, claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. For full details, see the MLN Matters® article, MM6960, at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6960.pdf on the Centers for Medicare & Medicaid Services website.

MLN Matters® Number: SE1039  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

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing Guide

Note: At the time this article was first published in 2010, the information reflected Medicare policy correctly at that time. Since then, more current information is available and new articles have been released. This article was updated on June 5, 2014, to refer to some of the key new articles.

Provider Types Affected

This article is for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

What You Need to Know

This Special Edition article is based on Change Request (CR) 7038, CR 7208, and CR 8743; and it provides a billing guide for FQHCs and RHCs. It describes the information FQHCs are required to submit in order for the Centers for Medicare & Medicaid Services (CMS) to develop and implement a Prospective Payment System (PPS) for Medicare FQHCs. It also explains how RHCs should bill for certain preventive services under the Affordable Care Act. Effective for dates of service on or after January 1, 2011, coinsurance and deductible are not applicable for the Initial Preventive Physical Examination (IPPE) provided by RHCs. However, to ensure coinsurance and deductible are not applied, detailed Healthcare Common Procedure Coding System (HCPCS)
coding must be provided for preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. The Affordable Care Act also waives the deductible for planned colorectal cancer screening tests that become diagnostic.

Background

Historically, RHCs and FQHCs billing instructions have been the same. However, effective January 1, 2011, the billing requirements will be different for each of these facilities’ types.

As outlined in CR 7208, transmittal 2122, RHCs are only required to submit detailed HCPCS codes for preventive services with a United States Preventive Services Task Force (USPSTF) grade of A or B in order to waive coinsurance and deductible. As outlined in CR 7038 (see the related MLN Matters® article, MM7038 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7038.pdf on the CMS website), FQHCs are required to submit detailed HCPCS code(s) for all services rendered during the encounter. As outlined in CR 8743 (see the related MLN Matters® article, MM8743 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8743.pdf on the CMS website) and effective for cost reporting periods beginning on or after October 1, 2014, FQHCs are required to implement a prospective payment system (PPS). FQHCs will remain under the all-inclusive rate (AIR) system until their first cost reporting period beginning on or after October 1, 2014. Listed below is a summary of the billing requirements for each facility that you need to know when submitting claims for either RHCs or FQHCs.

RHCs (71X Types of Bills (TOBs):

The professional components of preventive services are part of the overall encounter, and for TOB 71x, these services have always been billed on revenue lines with the appropriate site of service revenue code in the 052x series. In previous requirements, HCPCS codes have only been required to report certain preventive services subject to frequency limits.

Effective for dates of service on or after January 1, 2011, coinsurance and deductible are waived for the IPPE, the annual wellness visit, and other Medicare covered preventive services recommended by the USPSTF with a grade of A or B. Detailed HCPCS coding is required to ensure that coinsurance and deductible are not applied to these preventive services.

Payment for the professional component of allowable preventive services is made under the all-inclusive rate when all of the program requirements are met. Lab and technical components should continue to be billed as non RHC services.
Basic RHC Billing for Preventive Services:

When one or more preventive service that meets the specified criteria is provided as part of an RHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary coinsurance and deductible. For example, if the total charge for the visit is $150, and $50 of that is for a qualified preventive service, the beneficiary coinsurance and deductible is based on $100 of the total charge.

To ensure coinsurance and deductible are waived for qualified preventive services, RHCs must report an additional revenue line with the appropriate site of service revenue code in the 052X series with the approved preventive service HCPCS code and the associated charges. For example, the service lines should be reported as follows:

<table>
<thead>
<tr>
<th>Line</th>
<th>Revenue Code</th>
<th>HCPCS code</th>
<th>Date of Service</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>052X</td>
<td></td>
<td>01/01/2011</td>
<td>100.00</td>
</tr>
<tr>
<td>2</td>
<td>052X</td>
<td>Preventive Service Code</td>
<td>01/01/2011</td>
<td>50.00</td>
</tr>
</tbody>
</table>

The services reported without the HCPCS code will receive an encounter/visit payment. Payment will be based on the all-inclusive rate, and the coinsurance and deductible will be applied. The qualified preventive service will not receive payment, as payment is made under the all-inclusive rate for the services reported on the first revenue line. Coinsurance and deductible are not applicable to the service line with the preventive service.

Exceptions:

If the only service provided is a preventive service (such as the IPPE or Annual Wellness Visit (AWV)), report only one line with the appropriate site of service revenue code (052X) and the preventive service HCPCS code. The services will be paid based on the all inclusive rate. Coinsurance and deductible are not applicable.

NOTE: An additional visit may be paid for IPPE when billed with another qualified encounter/visit, as outlined with CR6445 (see the related MLN Matters® article, MM6445, at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6445.pdf on the CMS website).

RHCs are not required to report separate revenue lines for influenza virus or pneumococcal pneumonia vaccines on the 71x claims as the cost for these services are not included in the encounter. Costs for the influenza virus or pneumococcal pneumonia vaccines.
vaccines are included in the cost report and no line items are billed. Coinsurance and deductible do not apply to either of these vaccines.

The hepatitis B vaccine is included in the encounter rate. The charges of the vaccine and its administration shall be carved out of the office visit and reported on a separate line as outlined in the above example. An encounter cannot be billed if vaccine administration is the only service the RHC provides. For additional information on incident to services, please see the “Medicare Benefit Policy Manual” (Chapter 13, Section 60) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf on the CMS website.

RHCs do not receive any reimbursement on TOBs 71x for the technical component of services provided by clinics. This is because the technical component of services are not within the scope of Medicare-covered RHC services. The associated technical component of services furnished by the clinic/center are billed on other types of claims that are subject to strict editing to enforce statutory frequency limits.

**FQHCs (77X TOBs):**

The Affordable Care Act (Section 10501(i)(3)(A) amended the Social Security Act (Section 1834; see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm) by adding a new subsection (o) titled “Development and Implementation of Prospective Payment System.”

This subsection provides the statutory framework for development and implementation of a Prospective Payment System (PPS) for Medicare FQHCs. The Social Security Act (Section 1834(o)(1)(B)) as amended by the Affordable Care Act, addresses collection of data necessary to develop and implement the new Medicare FQHC PPS. Specifically, the Affordable Care Act grants the Secretary of Health and Human Services the authority to require FQHCs to submit such information as may be required in order to develop and implement the Medicare FQHC PPS, including the reporting of services using HCPCS codes. The Affordable Care Act requires that the Secretary impose this data collection submission requirement no later than January 1, 2011.

Beginning with dates of service on or after January 1, 2011, when billing Medicare, FQHCs must report all services provided during the encounter/visit by listing the appropriate HCPCS code. The additional revenue lines with detailed HCPCS code(s) are for information and data gathering purposes in order to develop the FQHC PPS set to be implemented in 2014. The additional data will not be utilized to determine current Medicare payment to FQHCs. The Medicare claims processing system will continue to make payments under the current FQHC interim per-visit payment rate methodology.
**Basic FQHC Billing Requirements:**
For dates of service on or after January 1, 2011, all valid UB04 revenue codes except the following may be used to report the additional services that are needed for data collection and analysis purposes only:

- 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x.

Medicare will make one payment at the all-inclusive rate for each date of service that contains a valid HCPCS code for professional services when one of the following revenue codes is present:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Clinic visit by member to RHC/FQHC</td>
</tr>
<tr>
<td>0522</td>
<td>Home visit by RHC/FQHC practitioner</td>
</tr>
<tr>
<td>0524</td>
<td>Visit by RHC/FQHC practitioner to a member in a covered Part A stay at a Skilled Nursing Facility (SNF)</td>
</tr>
<tr>
<td>0525</td>
<td>Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility</td>
</tr>
<tr>
<td>0527</td>
<td>RHC/FQHC Visiting Nurse Service(s) to a member’s home when in a Home Health Shortage Area</td>
</tr>
<tr>
<td>0528</td>
<td>Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident)</td>
</tr>
</tbody>
</table>

**Payments for Encounter/Visits:**
Medicare will make an additional encounter payment at the all-inclusive rate on the same claim when:

- Effective January 1, 2011, two services lines are submitted with a 052X revenue code and one line contains modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the...
day, e.g., treatment for an ear infection in the morning and treatment for injury to a limb in the afternoon;

- Services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900;
- Diabetes Self Management Training (DSMT) is billed under revenue code 052x and HCPCS code G0108 and Medical Nutrition Therapy (MNT) is billed under revenue code 052x and HCPCS code 97802, 97803, or G0270; and
- The Initial Preventive Physical Examination (IPPE) billed under revenue code 052X and HCPCS code G0402. This is a once in a lifetime benefit. HCPCS coding is required.

Note: Modifier 59 is not required for DSMT, MNT, or IPPE in order to receive an additional encounter payment.

When reporting multiple services on FQHC claims, the 052X revenue line should include the total charges for all of the services provided during the encounter. For preventive services with a grade of A or B from the USPSTF, the charges for these services must be deducted from the total charge for purposes of calculating beneficiary coinsurance correctly. For example, if the total charge for the visit is $350.00, and $50.00 of that is for a qualified preventive service, the beneficiary coinsurance and deductible is based on $300.00 of the total charge.

**Example A:**

<table>
<thead>
<tr>
<th>Line</th>
<th>Rev Code</th>
<th>HCPCS code</th>
<th>Date of Service</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0521</td>
<td>Office Visit</td>
<td>01/01</td>
<td>300.00</td>
</tr>
<tr>
<td>2</td>
<td>0636</td>
<td>Penicillin Injection</td>
<td>01/01</td>
<td>125.00</td>
</tr>
<tr>
<td>3</td>
<td>0271</td>
<td>Wound Cleaning</td>
<td>01/01</td>
<td>125.00</td>
</tr>
<tr>
<td>4</td>
<td>0771</td>
<td>Preventive Service Code</td>
<td>01/01</td>
<td>50.00</td>
</tr>
</tbody>
</table>

When reporting multiple services on the same day that are unrelated, modifier 59 must be used to report these services, e.g., treatment for an ear infection in the morning and treatment for injury to a limb in the afternoon.
Example B:

<table>
<thead>
<tr>
<th>Line</th>
<th>Rev Code</th>
<th>HCPCS code</th>
<th>Modifier</th>
<th>Date of Service</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0521</td>
<td>Office Visit</td>
<td></td>
<td>01/01</td>
<td>150.00</td>
</tr>
<tr>
<td>2</td>
<td>0479</td>
<td>Removal of Wax From Ear</td>
<td></td>
<td>01/01</td>
<td>100.00</td>
</tr>
<tr>
<td>3</td>
<td>0521</td>
<td>Office Visit</td>
<td>59</td>
<td>01/01</td>
<td>450.00</td>
</tr>
<tr>
<td>4</td>
<td>0271</td>
<td>Wound Cleaning</td>
<td></td>
<td>01/01</td>
<td>150.00</td>
</tr>
<tr>
<td>5</td>
<td>0279</td>
<td>Bone Setting With Casting</td>
<td></td>
<td>01/01</td>
<td>300.00</td>
</tr>
</tbody>
</table>

When reporting an additional encounter for IPPE, the revenue lines should be reflected as follows:

Example C:

<table>
<thead>
<tr>
<th>Line</th>
<th>Rev Code</th>
<th>HCPCS code</th>
<th>Date of Service</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0521</td>
<td>Office Visit</td>
<td>01/01</td>
<td>75.00</td>
</tr>
<tr>
<td>2</td>
<td>0419</td>
<td>Breathing Treatment</td>
<td>01/01</td>
<td>75.00</td>
</tr>
<tr>
<td>3</td>
<td>0521</td>
<td>IPPE (G0402)</td>
<td>01/01</td>
<td>150.00</td>
</tr>
</tbody>
</table>

As of January 01, 2011, for data collection and analysis for the PPS, FQHCs are required to report separate revenue lines for influenza virus or pneumococcal pneumonia vaccines (PPV) on the 77x claims. The charges of these vaccines and the administration shall be carved out of the office visit and reported on a separate line as outlined in example A. The cost for these services will continue to be reimbursed through cost reporting. Coinsurance and deductible do not apply to either of these vaccines.

Hepatitis B vaccine is included in the encounter rate. The charges for the vaccine and its administration will be carved out of the office visit and reported on a separate line as outlined in example A. An encounter cannot be billed if vaccine administration is the only service the FQHC provides. For additional information on incident to services, please see Chapter 13, Section 60 of the “Medicare Benefit Policy Manual” at [http://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/downloads/bp102c13.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/downloads/bp102c13.pdf) on the CMS website.
Laboratory and technical components should continue to be billed as non FQHC services.

**Summary of Differences**

The chart below displays a list of elements and notes the differences between RHCs and FQHCs:

<table>
<thead>
<tr>
<th>Element</th>
<th>RHCs</th>
<th>FQHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue Codes</strong></td>
<td>052X series</td>
<td>All except: 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096-310x</td>
</tr>
<tr>
<td><strong>HCPCS code</strong></td>
<td>Required for Preventive Services only excluding Flu and PPV</td>
<td>Required for all services rendered during encounter/visit</td>
</tr>
<tr>
<td><strong>Modifier 59</strong></td>
<td>Not applicable at this time</td>
<td>Should be used to report two distinct unrelated visits on the same day</td>
</tr>
<tr>
<td><strong>DSMT and MNT</strong></td>
<td>Not separately payable</td>
<td>All inclusive payment rate</td>
</tr>
</tbody>
</table>

**November 2013 Manual Updates**


**The FQHC PPS**

FQHCs will transition to the FQHC PPS based on their cost reporting periods. For FQHCs with cost reporting periods beginning before October 1, 2014, MACs shall...
continue to pay the FQHCs using the current AIR system. For FQHCs with cost reporting periods beginning on or after October 1, 2014, MACs shall pay the FQHCs using the FQHC PPS.

Under the FQHC PPS, Medicare will pay FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically-necessary, face-to-face FQHC visit is furnished to a Medicare beneficiary. Medicare will allow for an additional payment when an illness or injury occurs subsequent to the initial visit, or when a mental health visit is furnished on the same day as a medical visit.

The PPS rate will be adjusted when a FQHC furnishes care to a patient who is new to the FQHC or to a beneficiary receiving an initial preventive physical examination (IPPE) or an annual wellness visit (AWV). CMS is establishing specific payment codes to be used under the FQHC PPS based on descriptions of services that will correspond to the appropriate PPS rates.

The PPS rates will also be adjusted to account for geographic differences in the cost of inputs by applying FQHC geographic adjustment factors (FQHC GAFs). In calculating the total payment amount, the FQHC GAF will be based on the locality of the site where the services are furnished. For FQHC organizations with multiple sites, the FQHC GAF may vary depending on the location of the FQHC delivery site.

Complete details of the FQHC PPS are available in MLN Matters® article MM8743, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm8743.pdf on the CMS website.

**Additional Information**

Additional information on vaccines can be found in the “Medicare Claims Processing Manual” (Chapter 1, section 10) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf on the CMS website, and additional coverage requirements for the pneumococcal vaccine, hepatitis B vaccine, and influenza virus vaccine can be found in the “Medicare Benefit Policy Manual” (Chapter 15) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf on the CMS website.