## Medicare Monthly Review

Issue No. MMR 2014-09

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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).
National Government Services Articles for Part A & B Providers

Local Coverage Determinations and Article Revisions and Updates for August and September 2014

August 2014 Updates

Posterior Tibial Nerve Stimulation for Voiding Dysfunction (L31391)
The "Abstract", "Indications and Limitations", "current procedural terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) Codes", "International Classification of Diseases, Clinical Modification, 9th Revision (ICD-9-CM) Codes that Support Medical Necessity", "Documentation Requirements", "Utilization Guidelines" and the "Sources of Information and Basis for Decision" sections were revised to allow posterior tibial nerve stimulation (PTNS) coverage for beneficiaries with overactive bladder syndrome (OBS) as a less invasive “third-line treatment” for selected patients who meet the criteria outlined in the American Urological Association’s (AUA) Guideline effective for dates of service on or after 08/10/14. Minor formatting and template changes were made.

Transcranial Magnetic Stimulation (L32038)
The "Abstract", "Indications and Limitations", "CPT/HCPCS Codes", "ICD-9-CM Codes that Support Medical Necessity", "Documentation Requirements", "Utilization Guidelines" and the "Sources of Information and Basis for Decision" sections were revised to allow TMS coverage in adults who have a confirmed diagnosis of major depressive disorder (MDD), single or recurrent episode who meet the criteria in the local coverage determination (LCD) effective for dates of service on or after 08/15/14.

Retired Articles

Posterior Tibial Nerve Stimulation for Voiding Dysfunction – Supplemental Instructions Article (SIA) (A50267)
The above listed SIA will no longer be in effect for services performed after 08/09/14. All local policy rules, requirements, and limitations within this policy will no longer be applied on a prepay basis, but as with any billed service, claims may be subject to postpay review. All Centers for Medicare & Medicaid Services (CMS) national policy rules, requirements and limitations remain in effect.

Transcranial Magnetic Stimulation – SIA (A50991)
The above listed SIA will no longer be in effect for services performed after 08/14/14. All local policy rules, requirements, and limitations within this policy will no longer be applied on a prepay basis, but as with any billed service, claims may be subject to postpay review. All CMS national policy rules, requirements and limitations remain in effect.

September 2014 Updates

Bone Mass Measurement – Medical Policy Article
Article revised 09/01/14 to remove this statement under Limitations: "It is not medically necessary to have both peripheral and axial bone mass measurement (BMM) tests performed on the same day."

Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L25820)
The following article has been retired and removed from the LCD: A46756 - Oxaliplatin (e.g., Eloxatin®). No comment and notice period required and none given.

Noninvasive Vascular Studies (L27355)
Revised effective 09/01/14, credentialing requirements have been revised for transcutaneous oxygen tension measurements to clarify that appropriate credentialing bodies are not limited to those listed.

In addition, ICD-9 code 785.9 was added as payable for extremity arterial evaluation for suspected popliteal artery aneurysm.
Outpatient Physical and Occupational Therapy Services (L26884)
Based on a reconsideration request, effective 08/11/14, vestibular ocular reflex training (VOR) was removed from the list of "Miscellaneous Noncovered Services" and added to the "Indications" section for CPT code 97112. References supporting this change were added to the Sources of Information section.

In addition, CMS Internet-Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 10: (580 KB) was added to the CMS National Coverage Policy section.

Ranibizumab (e.g., Lucentis™) and Aflibercept (e.g., Eylea™) – Related to LCD L25820 (A46091)
Article published September 2014: The "Indications" section has been revised to add diabetic macular edema (DME) as a payable indication for aflibercept effective for dates of service on or after 07/29/2014. The "Utilization" section has been revised to add the recommended dose and frequency of treatment for aflibercept for DME. ICD-9-CM code 362.07 has been added to the Group 3: Codes in the "Covered ICD-9 Code" section. Outdated information has been removed.

Retired Articles
Oxaliplatin (e.g., Eloxatin®) – Related to LCD L25820 – A46756
This article will no longer be in effect for services performed after 08/31/14. All local policy rules, requirements, and limitations within this article will no longer be applied on a prepay basis, but as with any billed service, claims will be subject to postpay review. All CMS national policy rules, requirements and limitations remain in effect.
In September 2012, the Centers for Medicare & Medicaid Services (CMS) announced the availability of a new electronic mailing list for those who refer Medicare beneficiaries for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Referral agents play a critical role in providing information and services to Medicare beneficiaries. To ensure you give Medicare patients the most current DMEPOS Competitive Bidding Program information, CMS strongly encourages you to review the information sent from this new electronic mailing list. In addition, please share the information you receive from the mailing list and the link to the “mailing list for referral agents” subscriber webpage with others who refer Medicare beneficiaries for DMEPOS. Thank you for signing up!

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

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

Note: This article was revised on August 1, 2014, to show the new ICD-10 implementation date of October 1, 2015. While the Change Request may not reflect the new date, CMS has made the date change. All other information is unchanged.

Provider Types Affected

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

Provider Action Needed

CR8494, from which this article is taken, provides that the Laboratory National Coverage Determination (NCD) Edit Software will be updated to accommodate the processing of the
International Classification of Diseases, Tenth Revision (ICD-10) diagnosis codes. This is a follow-up to CR8202 Changes to the Laboratory National Coverage Determination (NCD) Software for ICD-10 (dated February 1, 2013), that extended the ICD-9 to ICD-10 implementation date to October 1, 2015. (You can find this CR at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1174OTN.pdf on the CMS website.)

Background

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

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

Additional Information

The official instruction, CR 8494 issued to your A/B MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2865CP.pdf on the CMS Website.

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

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New product from the Medicare Learning Network® (MLN)

- "Provider Compliance Tips for Computed Tomography (CT Scans)" - Fact sheet (ICN 907793) EPUB, QR

MLN Matters® Number: MM8711 Revised Related Change Request (CR) #: CR 8711
Related CR Release Date: August 8, 2014 Effective Date: September 2, 2014
Related CR Transmittal #: R1418OTN Implementation Date: September 2, 2014

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE - July 1, 2014 Version 3.1.1

Note: This article was revised on August 12, 2014, to reflect the revised CR8711 issued on August 8, 2014. The CR revised the CAQH CORE version number and the publication date. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are changed. 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.

What You Need to Know

This article is based on Change Request (CR) 8711, which instructs the MACs to update the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule. If you use Medicare's PC Print or Medicare Remit Easy Print (MREP) software, you...
will need to obtain the new version after it is updated on October 6, 2014. Make sure that your billing staffs are aware of these changes.

**Background**

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the Affordable Care Act.

Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

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

CAQH CORE will publish the next version of the Code Combination List on or about July 1, 2014. This update is based on March 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website. (Visit [http://www.wpc-edi.com/reference](http://www.wpc-edi.com/reference) for CARC and RARC updates and [http://www.caqh.org/CORECodeCombinations.php](http://www.caqh.org/CORECodeCombinations.php) for CAQH CORE defined code combination updates.)

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

**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)


MLN Matters® Number: MM8735 Related Change Request (CR) #: CR 8735
Related CR Release Date: August 22, 2014 Effective Date: January 1, 2015
Related CR Transmittal #: R3043CP Implementation Date: January 5, 2015

Claim Status Category and Claim Status Codes Update

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8735 which informs MACs about the changes to Claim Status Category Codes and Claim Status Codes. Make sure your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (e.g. previous HIPAA

Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the September/October 2014 committee meeting shall be posted on that site on or about November 1, 2014. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 8735.

These code changes are to be used in the editing of all X12 276 transactions processed on or after the date of implementation and are to be reflected in X12 277 transactions issued on and after the date of implementation of CR 8735.

All MACs must comply with the requirements contained in the versions 004010X093A1 and 005010X212 of ASC X12 276/277 Implementation Guide as well as the 005101X214 of the ASC X12 277 Health Care Claim Acknowledgement Implementation Guide (inclusive of any published Errata documents) and must use valid Claim Status Category Codes and Claim Status Codes when sending 277 responses.

**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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MLN Matters® Number: MM8808  Related Change Request (CR) #: CR 8808
Related CR Release Date: August 22, 2014  Effective Date: September 23, 2014
Related CR Transmittal #: R3050CP  Implementation Date: September 23, 2014

New Manual Correction for Extracorporeal Photopheresis

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8808 which clarifies certain requirements for providers that are effective for claims with dates of service on or after April 30, 2012, the Centers for Medicare & Medicaid Services (CMS) covers extracorporeal photopheresis for the treatment of bronchiolitis obliterans syndrome (BOS) following lung allograft transplantation only when provided under a clinical research study that meets specific requirements to assess the effect of extracorporeal photopheresis for the treatment of BOS following lung allograft transplantation. Make sure your billing staffs are aware of the changes.

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Background


Accordingly, Chapter 32, Section 190.3, of the "Medicare Claims Processing Manual" is reformatted to clearly state that:

- Medicare coverage for extracorporeal photopheresis is restricted to the inpatient or outpatient hospital settings specifically for BOS, and not for the other covered diagnosis (including chronic graft versus hosts disease) which remain covered in the hospital inpatient, hospital outpatient, and non-facility (physician-directed clinic or office settings) settings.

- MACs will deny claims for extracorporeal photopheresis for BOS when the service is not rendered to an inpatient or outpatient setting of a hospital, including critical access hospitals using the following codes:
  
  o Claim Adjustment Reason Code (CARC) 96 – Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;
  
  o CARC 171 – Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;
  
  o Remittance Advice Remark Code (RARC) N428 – Not covered when performed in this place of service. (A/MACs only) ; and
  
  o Group Code CO (Contractual Obligations) or PR (Patient Responsibility) dependent on liability.

- MACs will return to provider/return as unprocessable claims for BOS containing HCPCS procedure code 36522 along with one of the following ICD-9-CM diagnosis codes: 996.84, 491.9, 491.20, 491.21, and 496 but is missing diagnosis code V70.7 (as primary/secondary diagnosis, institutional only), condition code 30 (institutional claims only), clinical trial modifier Q0/Q1, and value code D4 with an 8-digit clinical trial identifier number (A/MACs only). In doing so, MACs will use the following messages:

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CARC 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

RARC N517 – Resubmit a new claim with the requested information.

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.
NEW product from the Medicare Learning Network® (MLN)

- "ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets"
  Educational Tool (ICN 900943), downloadable

MLN Matters® Number: MM8818  Related Change Request (CR) #: CR 8818
Related CR Release Date: August 1, 2014  Effective Date: September 2, 2014
Related CR Transmittal #: R192BP  Implementation Date: September 2, 2014

Clarification of the Confined to the Home Definition in Chapter 15, Covered Medical and Other Health Services, of the Medicare Benefit Policy Manual

Provider Types Affected

This MLN Matters® Article is intended for physicians, home health agencies, and other providers that submit claims to Medicare Administrative Contractors (MACs) related to certifying or providing home health services to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You
This article is based on Change Request (CR) 8818 which clarifies the definition of the patient as being "confined to the home" to more accurately reflect the definition as articulated in the Social Security Act (Sections 1814(a) and 1835(a)).

CAUTION – What You Need to Know
In addition to clarifying the definition of the patient as being "confined to the home", vague terms, such as "generally speaking", have been removed from Medicare's manual.

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instructions to ensure clearer and more specific requirements of the definition. These changes present the requirements first and more closely align the Medicare Benefit Policy manual with the Social Security Act. This will help prevent confusion, promote a clearer enforcement of the statute, and provide more definitive guidance to Home Health Agencies (HHAs) in order to foster compliance.

GO – What You Need to Do
See the Background and Additional Information Sections of this article for further details regarding these changes, and make sure that your billing staffs are aware of these changes.

Background

In the calendar year (CY) 2012 Home Health Prospective Payment System (HH PPS) proposed rule published on July 12, 2011, the Centers for Medicare & Medicaid Services (CMS) proposed its intent to provide clarification to the "Medicare Benefit Policy Manual" language regarding the definition of "confined to the home". In the CY 2012 HH PPS final rule published on November 4, 2011 (FR 76 68599-68600; see http://www.gpo.gov/fdsys/pkg/FR-2011-11-04/pdf/2011-28416.pdf), this proposal was finalized. This clarification was recommended by the Office of Inspector General (OIG).

CR 8818 revises the Medicare Benefit Policy Manual (Pub 100-02), Chapter 15 (Covered Medical and Other Health Services), Section 60.4.1 (Definition of Homebound Patient Under the Medicare Home Health (HH) Benefit), and it includes revised Section 60.4.1 as an attachment. The revised Section 60.4.1 is summarized as follows:

For a patient to be eligible to receive covered home health services, the law requires that a physician certify in all cases that the patient is confined to his/her home. For purposes of the statute, an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:

1. Criteria-One:
   The patient must either:
   
   Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence
   
   OR
   
   Have a condition such that leaving his or her home is medically contraindicated.
   
   **If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet two additional requirements defined in Criteria-Two below.**

2. Criteria-Two:
   There must exist a normal inability to leave home;
AND

Leaving home must require a considerable and taxing effort.

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.

Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited to furnish adult day-care services in a State, shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of an infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health care treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

The aged person who does not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of this reimbursement unless they meet one of the above conditions above.

The complete portion on the revised manual is attached to CR8818.

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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MLN Matters® Number: MM8838  Related Change Request (CR) #: CR 8838
Related CR Release Date: August 22, 2014  Effective Date: January 1, 2015
Related CR Transmittal #: R3038CP  Implementation Date: January 5, 2015

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8838 deals with the regular update in Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of CARCs and RARCs (835) Rule. CAQH CORE will publish the next version of the Code Combination List on or about October 1, 2014. This update is based on July 1, 2014 CARC and RARC updates as posted at the Washington Publishing Company (WPC) website. Visit http://www.wpc-edi.com/reference for CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php for CAQH CORE defined code combination updates.

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The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014 under the Patient Protection and Affordable Care Act of 2010. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended the Social Security Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to Electronic Data Interchange (EDI) from paper has been slow and disappointing. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

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

**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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MLN Matters® Number: MM8853 Related Change Request (CR) #: CR 8853
Related CR Release Date: August 15, 2014 Effective Date: January 1, 2015
Related CR Transmittal #: R1421OTN Implementation Date: January 5, 2015

Revised Modification to the Medically Unlikely Edit (MUE) Program

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8853 informs MACs about additional modifications being updated in the Medically Unlikely Edit (MUE) Program. The updates include clarifications, general processing instructions, and detailed explanations of MUE requirements and specifications. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) implemented the Medically Unlikely Edit (MUE) program on January 1, 2007, to reduce the Medicare Part B paid claims error rate. At the onset or implementation of the MUE Program, regarding the adjudication process, the MUE value for a Healthcare Common Procedure Coding System (HCPCS) code was only adjudicated against the units of service (UOS) reported on each line of a claim. On April 1, 2013, CMS modified the MUE program so that some MUE values would
be date of service edits rather than claim line edits. At that time, CMS introduced a new data field to the MUE edit table termed “MUE adjudication indicator” or “MAI”. CMS is currently assigning a MAI to each HCPCS code. CR8853 contains current and updated background information for these modifications, including general processing instructions.

**MUEs for HCPCS codes with a MAI of “1”**

MUEs for HCPCS codes with a MAI of “1” will continue to be adjudicated as a claim line edit.

**MUEs for HCPCS codes with a MAI of “2”**

MUEs for HCPCS codes with a MAI of “2” are absolute date of service edit. These are “per day edits based on policy”. HCPCS codes with an MAI of “2” have been rigorously reviewed and vetted within CMS and obtain this MAI designation because UOS on the same date of service (DOS) in excess of the MUE value would be considered impossible because it was contrary to statute, regulation, or subregulatory guidance. This subregulatory guidance includes clear correct coding policy that is binding on both providers and the MACs.

Limitations created by anatomical or coding limitations are incorporated in correct coding policy, both in the Health Insurance Portability & Accountability Act of 1996 (HIPAA) mandated coding descriptors and CMS approved coding guidance as well as specific guidance in CMS and National Correct Coding Initiatives (NCCI) manuals. For example, it would be contrary to correct coding policy to report more than one unit of service for Current Procedural Terminology (CPT) 94002 "ventilation assist and management . . . initial day" because such usage could not accurately describe two initial days of management occurring on the same DOS as would be required by the code descriptor.

**Note:** Although the Qualified Independent Contractors (QICs) and the Administrative Law Judges (ALJs) are not bound by sub-regulatory guidance, they do give deference to it and are being made aware that CMS considers all edits with an MAI of 2 to be firm limits based on subregulatory guidance, while some MUE edits with an MAI “2” may be based directly on regulation or statute.

**MUEs for HCPCS codes with a MAI of “3”**

MUEs for HCPCS codes with a MAI of “3” are date of service edits. These are “per day edits based on clinical benchmarks”. If claim denials based on these edits are appealed, MACs may pay UOS in excess of the MUE value if there is adequate documentation of medical necessity of correctly reported units. If MACs have pre-payment evidence (e.g. medical review) that UOS in excess of the MUE value were actually provided, were correctly coded, and were medically necessary, the MACs may bypass the MUE for a
HCPCS code with an MAI of “3” during claim processing, reopening, or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.

**General Processing Instructions**

- Since ambulatory surgical center (ASC) providers (specialty code 49) cannot report modifier 50, the MUE value used for editing will be doubled for HCPCS codes with an MAI of “2” or “3” if the bilateral surgery indicator for the HCPCS code is “1”.
- CMS will continue to set the units of service for each MUE high enough to allow for medically likely daily frequencies of services provided in most settings. Because MUEs are based on current coding instructions and practices, MUEs are prospective edits applicable to the time period for which the edit is effective. A change in an MUE is not retroactive and has no bearing on prior services unless specifically updated with a retroactive effective date. In the unusual case of a retroactive MUE change, MACs are not expected to identify claims but should reopen impacted claims that you bring to their attention.
- Since MUEs are auto-deny edits, denials may be appealed. Appeals shall be submitted to your MAC not the NCCI/MUE contractor. MACs adjudicating an appeal for a claim denial for a HCPCS code with an MAI of “1” or “3” may pay correctly coded correctly counted medically necessary UOS in excess of the MUE value.
- Finally, a denial of services due to an MUE is a coding denial, not a medical necessity denial. The presence of an Advance Beneficiary Notice (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE. If during reopening or redetermination medical records are provided with respect to an MUE denial for an edit with an MAI of “3”, MACs will review the records to determine if the provider actually furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary. If the units were actually provided but one of the other conditions is not met, a change in denial reason may be warranted (for example, a change from the MUE denial based on incorrect coding to a determination that the item/service is not reasonable and necessary under section 1862(a)(1)). This may also be true for certain edits with an MAI of “1.” CMS interprets the notice delivery requirements under Section1879 of the Social Security Act (the Act) as applying to situations in which a provider expects the initial claim determination to be a reasonable and necessary denial. Consistent with NCCI guidance, denials resulting from MUEs are not based on any of the statutory provisions that give liability protection to beneficiaries under section 1879 of the Social Security Act. Thus, ABN issuance based on an MUE is NOT appropriate.
- CMS reminds providers to report bilateral surgical procedures on a single claim line with modifier 50 and one (1) UOS. When modifier -50 is required by manual or coding instructions, claims submitted with two lines or two units and anatomic modifiers will be denied for incorrect coding. MACs may reopen or allow...
resubmission of those claims in accordance with their policies and with the policy in Chapter 34, Section 10.1, of the "Medicare Claims Processing Manual" at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf) on the CMS website. Clerical errors (which includes minor errors and omissions) may be treated as reopenings.

- CMS encourages providers to change and resubmit their own claims where possible and to change their coding practices, but during reopening MACs may, when necessary, correct the claim to modifier -50 from an equivalent 2 units of bilateral anatomic modifiers. The original submitted version of the claim is retained in the Medicare IDR.

- CMS also reminds providers to use anatomic modifiers (e.g. RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) and report procedures with differing modifiers on individual claim lines when appropriate. Many MUEs are based on the assumption that correct modifiers are used.

- On your Remittance Advice, MACs will continue to use Group Code CO (contractual obligation), and remark codes N362 and MA01 for claims that fail the MUE edits, when the UOS on the claim exceed the MUE value, and deny the entire claim line(s) for the relevant HCPCS code.

**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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MLN Matters® Number: MM8858 Related Change Request (CR) #: CR 8858

Related CR Release Date: August 22, 2014 Effective Date: 30 Days From Issuance (See test dates)

Related CR Transmittal #: R1423OTN Implementation Date: November 17 through 21, 2014, for the November Testing Week; March 2 through 6, 2015 for the March Testing Week; June 1 through 5, 2015, for the June Testing Week;

International Classification of Diseases, 10th Revision (ICD-10) Testing - Acknowledgement Testing with Providers

Provider Types Affected

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

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Provider Action Needed

Change Request (CR) 8858 instructs MACs to promote three specific acknowledgement testing weeks with providers, and provide data and statistics to the Centers for Medicare & Medicaid Services (CMS) to demonstrate readiness for the International Classification for Disease 10th Edition Clinical Modification (ICD-10) transition. Make sure that your billing staffs are aware of these ICD-10 testing opportunities.

Background

The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing ICD-10. All covered entities must be fully compliant on October 1, 2015.

CR8858 instructs all MACs and the DME MAC Common Electronic Data Interchange (CEDI) contractor to promote ICD-10 Acknowledgement Testing with trading partners during three separate testing weeks, and to collect data about the testing. These testing weeks will be:

- November 17 – 21, 2014
- March 2 – 6, 2015
- June 1 – 5, 2015

The concept of trading partner testing was originally designed to validate the trading partners’ ability to meet technical compliance and performance processing standards during the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 5010 implementation. While submitters may acknowledgement test ICD-10 claims at any time through implementation, the ICD-10 testing weeks have been created to generate awareness and interest, and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

These testing weeks will allow trading partner’s access to MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on the CMS website, the CEDI website and each MAC’s website.

Key Points of the Testing Process for CR8858

- Test claims with ICD-10 codes must be submitted with current dates of service since testing does not support future dates of service.
- Claims will be subject to existing NPI validation edits.
- MACs and CEDI will be staffed to handle increased call volume during this week.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected by Medicare.
- Test claims will be subject to all existing EDI front-end edits, including Submitter authentication and NPI validation.
• Testing will not confirm claim payment or produce a remittance advice.
• MACs and CEDI will be appropriately staffed to handle increased call volume on their Electronic Data Interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during this week.
• Your MAC will announce and promote these testing weeks via their listserv messages and their website.

Additional Information


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- “Medicare Learning Network® (MLN) Suite of Products & Resources for Compliance Officers”, Educational Tool, ICN 908525, Downloadable only

MLN Matters® Number: MM8863
Related Change Request (CR) #: CR 8863
Related CR Release Date: August 15, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R1422OTN
Implementation Date: January 5, 2015

Specific Modifiers for Distinct Procedural Services

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You
New coding requirements related to Healthcare Common Procedure Coding System (HCPCS) modifier -59 could impact your reimbursement.

WARNING – What You Need to Know
Change Request (CR) 8863 notifies MACs and providers that the Centers for Medicare & Medicaid Services (CMS) is establishing four new HCPCS modifiers to define subsets of the -59 modifier, a modifier used to define a “Distinct Procedural Service.”

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GO – What You Need to Do

Make sure your billing staffs are aware of the coding modifier changes.

Background

The Medicare National Correct Coding Initiative (NCCI) has Procedure to Procedure (PTP) edits to prevent unbundling of services, and the consequent overpayment to physicians and outpatient facilities. The underlying principle is that the second code defines a subset of the work of the first code. Reporting the codes separately is inappropriate. Separate reporting would trigger a separate payment and would constitute double billing.

CR8863 discusses changes to HCPCS modifier -59, a modifier which is used to define a “Distinct Procedural Service.” Modifier -59 indicates that a code represents a service that is separate and distinct from another service with which it would usually be considered to be bundled.

The -59 modifier is the most widely used HCPCS modifier. Modifier -59 can be broadly applied. Some providers incorrectly consider it to be the “modifier to use to bypass (NCCI).” This modifier is associated with considerable abuse and high levels of manual audit activity; leading to reviews, appeals and even civil fraud and abuse cases.

The primary issue associated with the -59 modifier is that it is defined for use in a wide variety of circumstances, such as to identify:

- Different encounters;
- Different anatomic sites; and
- Distinct services.

The -59 modifier is

- Infrequently (and usually correctly) used to identify a separate encounter;
- Less commonly (and less correctly) used to define a separate anatomic site; and
- More commonly (and frequently incorrectly) used to define a distinct service.

The -59 modifier often overrides the edit in the exact circumstance for which CMS created it in the first place. CMS believes that more precise coding options coupled with increased education and selective editing is needed to reduce the errors associated with this overpayment.

CR8863 provides that CMS is establishing the following four new HCPCS modifiers (referred to collectively as -X{EPSU} modifiers) to define specific subsets of the -59 modifier:

- XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter,
XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure,

XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner, and

XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

CMS will continue to recognize the -59 modifier, but notes that Current Procedural Terminology (CPT) instructions state that the -59 modifier should not be used when a more descriptive modifier is available. While CMS will continue to recognize the -59 modifier in many instances, it may selectively require a more specific - X{EPSU} modifier for billing certain codes at high risk for incorrect billing. For example, a particular NCCI PTP code pair may be identified as payable only with the -XE separate encounter modifier but not the -59 or other -X{EPSU} modifiers. The -X{EPSU} modifiers are more selective versions of the -59 modifier so it would be incorrect to include both modifiers on the same line.

The combination of alternative specific modifiers with a general less specific modifier creates additional discrimination in both reporting and editing. As a default, at this time CMS will initially accept either a -59 modifier or a more selective - X{EPSU} modifier as correct coding, although the rapid migration of providers to the more selective modifiers is encouraged.

However, please note that these modifiers are valid even before national edits are in place. MACs are not prohibited from requiring the use of selective modifiers in lieu of the general -59 modifier, when necessitated by local program integrity and compliance needs.

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

REVISED product from the Medicare Learning Network® (MLN)

- “The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation”, Fact Sheet, ICN 905710, Downloadable only

MLN Matters® Number: MM8865 Related Change Request (CR) #: CR 8865
Related CR Release Date: August 1, 2014 Effective Date: October 1, 2014
Related CR Transmittal #: R3011CP Implementation Date: October 6, 2014

October Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Hospice & Home Health MACs, and Durable Medical Equipment MACs (DME MACs) for DMEPOS items or services paid under the DMEPOS fee schedule.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8865 to alert providers and suppliers that CMS issued instructions updating the DMEPOS fee schedule payment amounts, effective October 1, 2014. Make sure your billing staffs are aware of these changes.

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Background

CMS updates DMEPOS fee schedules on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the “Medicare Claims Processing Manual,” Chapter 23, Section 60, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance_Manuals/downloads/clm104c23.pdf on the CMS website.

Key Points of CR8865

Splints, Casts, and Certain Intraocular Lenses (IOLs)

As part of this update, the splint and cast (SC) payment category indicator will be added to the file for the following SC Healthcare Common Procedure Coding System (HCPCS) codes reflecting payment calculated in accordance with the regulations at 42 CFR, Section 414.106 for splints and casts:

A4565, Q4001, Q4002, Q4003, Q4004, Q4005, Q4006, Q4007, Q4008, Q4009, Q4010, Q4011, Q4012, Q4013, Q4014, Q4015, Q4016, Q4017, Q4018, Q4019, Q4020, Q4021, Q4022, Q4023, Q4024, Q4025, Q4026, Q4027, Q4028, Q4029, Q4030, Q4031, Q4032, Q4033, Q4034, Q4035, Q4036, Q4037, Q4038, Q4039, Q4040, Q4041, Q4042, Q4043, Q4044, Q4045, Q4046, Q4047, Q4048, Q4049

The “IL” payment category indicator will be added to the file for V2630, V2631, and V2632 HCPCS codes for IOLs inserted in a physician’s office reflecting payment calculated in accordance with the IOL payment regulations at 42 CFR, Section 414.108.

You may want to review MLN Matters® Article MM8645, “April Quarterly Update for 2014 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule” at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8645.pdf, which includes additional discussion on the establishment of national fee schedule amounts for codes for splints, casts, and IOLs.

Off-the-Shelf (OTS) Orthotics

Effective October 1, 2014, the following two new codes are added to the HCPCS file to describe prefabricated knee orthoses that are furnished OTS:

1. K0901- Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf; and

2. K0902- Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf.
Since these two orthotic OTS codes represent a coding explosion of the prefabricated knee orthosis codes L1843 and L1845, the fees for the above codes will be added to the DMEPOS fee schedule file and established by applying the fees for codes L1843 and L1845 to the new OTS codes K0901 and K0902, respectively. The cross walking of fee schedule amounts for a single code that is exploded into two codes for distinct complete items is in accordance with the instructions found in the "Medicare Claims Processing Manual," Chapter 23, Section 60.3.1. at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website.

Further information on the development of new OTS orthotic codes can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html on the CMS website.

Specific Coding and Pricing Issues

1. This update also notifies that HCPCS codes K0734, K0735, K0736, and K0737 found in Attachment B of Change Request 6270, were discontinued; and
2. Cross walked to HCPCS codes E2622, E2623, E2624, and E2625, respectively, effective January 1, 2011.

Billing instructions for these wheelchair seat cushion items may refer to any of these codes.

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

REVISED product from the Medicare Learning Network® (MLN)

- “Medicare Overpayment Collection Process” Fact Sheet, ICN 006379, downloadable

**Healthcare Provider Taxonomy Codes (HPTC) Update, October 2014**

**Provider Types Affected**

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

**What You Need to Know**

Change Request (CR) 8866 implements the National Uniform Claim Committee (NUCC) Healthcare Provider Taxonomy Codes (HPTC) code set that is effective on October 1, 2014, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

**Background**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include

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implementation guides which dictate when and how data must be sent, including specifying
the code sets which must be used.

Both the current Accredited Standards Committee (ASC) X12 837 institutional and
professional Technical Report Type 3 (TR3s) require the NUCC HPTC set be used to
identify provider specialty information on a health care claim. The standards do not mandate
the reporting of provider specialty information via a HPTC on every claim, nor for every
provider to be identified by specialty.

The standard implementation guides state this information is:

- "Required when the payer’s adjudication is known to be impacted by the provider
taxonomy code," and
- If not required by this implementation guide, do not send."

Note: Medicare does not use HPTCs to adjudicate its claims. It would not expect to see
these codes on a Medicare claim. However, currently, it validates any HPTC that a provider
happens to supply against the NUCC HPTC code set.

The Transactions and Code Sets Final Rule, published on August 17, 2000, establishes that
the maintainer of the code set determines its effective date. This rule also mandates that
covered entities must use the nonmedical data code set specified in the standard
implementation guide that is valid at the time the transaction is initiated. For implementation
purposes, Medicare generally uses the date the transaction is received for validating a
particular nonmedical data code set required in a standard transaction.

The HPTC set is maintained by the NUCC for standardized classification of health care
providers. The NUCC updates the code set twice a year with changes effective April 1 and
October 1. The HPTC set is available for view or for download from the Washington

When reviewing the HPTC set online, revisions made since the last release can be identified
by the color code:

- New items are green;
- Modified items are orange; and
- Inactive items are red.

Additional Information

The official instruction, CR8866 issued to your MAC regarding this change is available at
http://www.cms.gov/Regulations-and-

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 under - How Does It Work.
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- "Swing Bed Services", Fact sheet (ICN 006951)

MLN Matters® Number: MM8873
Related Change Request (CR) #: CR 8873
Related CR Release Date: August 1, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R3012CP
Implementation Date: October 6, 2014

October 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 & Hospice (HH&H) MACs for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8873 describes changes to and billing instructions for various payment policies implemented in the October 2014 hospital Outpatient Prospective Payment System (OPPS) update. Make sure your billing staff are aware of these changes.

Background

The October 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 CR8873.
The October 2014 revisions to I/OCE data files, instructions, and specifications are provided in the October 2014 I/OCE (CR8879). The MLN Matters® Article related to CR8879 will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8879.pdf as soon as that CR is released.

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

**Changes to Device Edits for October 2014**

The most current list of device edits can be found 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 Services**

The new service in Table 1 is assigned for payment under the OPPS, effective October 1, 2014.

<table>
<thead>
<tr>
<th>HCP CS</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>C9741</td>
<td>10/01/2014</td>
<td>T</td>
<td>0319</td>
<td>Impl pressure sensor w/angio</td>
<td>Right heart catheterization with implantation of wireless pressure sensor in the pulmonary artery, including any type of measurement, angiography, imaging supervision, interpretation, and report, includes provision of patient home electronics unit</td>
<td>$15,509.99</td>
<td>$3,102.00</td>
</tr>
</tbody>
</table>

**Billing for Drugs, Biologicals, and Radiopharmaceuticals**

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

In the Calendar Year (CY) 2014 OPPS/ASC final rule with comment period, the Centers for Medicare & Medicaid Services (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 October 2014 release of the OPPS Pricer. The updated payment rates, effective October 1, 2014 will be included in the October 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 on the CMS website.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2014
Four drugs and biologicals have been granted OPPS pass-through status effective October 1, 2014. These items, along with their descriptors and APC assignments, are identified in Table 2.

Table 2 – Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2014

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9023</td>
<td>Injection, testosterone undecanoate, 1 mg</td>
<td>1487</td>
<td>G</td>
</tr>
<tr>
<td>C9025</td>
<td>Injection, ramucirumab, 5 mg</td>
<td>1488</td>
<td>G</td>
</tr>
<tr>
<td>C9026</td>
<td>Injection, vedolizumab, 1 mg</td>
<td>1489</td>
<td>G</td>
</tr>
<tr>
<td>C9135</td>
<td>Factor ix (antihemophilic factor, recombinant), Alprolix, per 10 i.u.</td>
<td>1486</td>
<td>G</td>
</tr>
</tbody>
</table>

c. New HCPCS Codes Effective October 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 2) in the hospital outpatient setting for October 1, 2014. These codes are listed in Table 3, and are effective for services furnished on or after October 1, 2014.

Table 3 – New HCPCS Codes for Certain Drugs and Biologicals Effective October 1, 2014

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator Effective 10/1/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9972</td>
<td>Injection, Epoetin Beta, 1 microgram, (For ESRD On Dialysis)</td>
<td>N/A</td>
<td>E</td>
</tr>
<tr>
<td>Q9973</td>
<td>Injection, Epoetin Beta, 1 microgram, (Non-ESRD use)</td>
<td>N/A</td>
<td>E</td>
</tr>
</tbody>
</table>

d. Revised Status Indicator for HCPCS Codes J9160 and J9300
Effective October 1, 2014, the status indicator for HCPCS codes J9160 (Injection, denileukin diftitox, 300 micrograms) and J9300 (Injection, gemtuzumab ozogamicin, 5 mg) will change from SI=K (Paid under OPPS; separate APC payment) to SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)). Table 4 includes the drugs and biologicals with revised Status Indicators.

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Table 4 – Drugs and Biologicals with Revised Status Indicators

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
<th>Low/High Cost Status</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9160</td>
<td>Injection, denileukin diftitox, 300 micrograms</td>
<td>N/A</td>
<td>E</td>
<td>High</td>
<td>07/01/2014</td>
</tr>
<tr>
<td>J9300</td>
<td>Injection, gemtuzumab ozogamicin, 5 mg</td>
<td>N/A</td>
<td>E</td>
<td>High</td>
<td>07/01/2014</td>
</tr>
</tbody>
</table>

**e. Reassignment of One Skin Substitute Product that was New for CY 2014 from the Low Cost Group to the High Cost Group**

In the CY 2014 OPPS/ASC final rule, CMS finalized a policy to package payment for skin substitute products into the associated skin substitute application procedure. For packaging purposes, CMS created two groups of application procedures: application procedures that use high cost skin substitute products (billed using CPT codes 15271-15278) and application procedures that use low cost skin substitute products (billed using HCPCS codes C5271-C5278).

Assignment of skin substitute products to the high cost or low cost groups depended upon a comparison of the July 2013 payment rate for the skin substitute product to $32, which is the weighted average payment per unit for all skin substitute products using the skin substitute utilization from the CY 2012 claims data and the July 2013 payment rate for each product. Skin substitute products with a July 2013 payment rate that was above $32 per square centimeter are paid through the high cost group and those with a July 2013 payment rate that was at or below $32 per square centimeter are paid through the low cost group for CY 2014.

CMS also finalized a policy that for any new skin substitute products approved for payment during CY 2014, and CMS will use the $32 per square centimeter threshold to determine mapping to the high or low cost skin substitute group. Any new skin substitute products without pricing information were assigned to the low cost category until pricing information becomes available. There is now pricing information available for three of the new skin substitute products. Table 5 shows the new products and the low/high cost status based on the comparison of the price per square centimeter for the products to the $32 square centimeter threshold for CY 2014.

Table 5 – Revised Low/High Cost Status for Certain Skin Substitute Codes

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>Low/High Cost Status</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4137</td>
<td>Amnioexcel or Biodexcel, Per Square Centimeter</td>
<td>N</td>
<td>High</td>
<td>07/01/2014</td>
</tr>
<tr>
<td>Q4138</td>
<td>BioDfence DryFlex, Per Square Centimeter</td>
<td>N</td>
<td>High</td>
<td>10/01/2014</td>
</tr>
<tr>
<td>Q4140</td>
<td>BioDfence, Per Square Centimeter</td>
<td>N</td>
<td>High</td>
<td>10/01/2014</td>
</tr>
</tbody>
</table>

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The payment rate for HCPCS code J9171 was incorrect in the January 2014 OPPS Pricer. The corrected payment rate is listed in Table 6, and has been installed in the October 2014 OPPS Pricer, effective for services furnished on January 1, 2014, through March 31, 2014. Your MAC will not automatically adjust claims already processed with the incorrect rate, but they will adjust such claims that you bring to the MAC’s attention.

Table 6 – Updated Payment Rate for HCPCS Code J9171, 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>J9171</td>
<td>K</td>
<td>0823</td>
<td>Docetaxel injection</td>
<td>$4.63</td>
<td>$0.93</td>
</tr>
</tbody>
</table>

g. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2014 through June 30, 2014
The payment rate for three HCPCS codes were incorrect in the April 2014 OPPS Pricer. The corrected payment rates are listed in Table 7, and have been installed in the October 2014 OPPS Pricer, effective for services furnished on April 1, 2014 through June 30, 2014. Your MAC will not automatically adjust claims already processed with the incorrect rates, but they will adjust such claims that you bring to the MAC's attention.

Table 7 – Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2014 through June 30, 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>J7335</td>
<td>K</td>
<td>9268</td>
<td>Capsaicin 8% patch</td>
<td>$25.49</td>
<td>$5.10</td>
</tr>
<tr>
<td>J8700</td>
<td>K</td>
<td>1086</td>
<td>Temozolomide</td>
<td>$6.94</td>
<td>$1.39</td>
</tr>
<tr>
<td>J9171</td>
<td>K</td>
<td>1086</td>
<td>Docetaxel injection</td>
<td>$4.35</td>
<td>$0.87</td>
</tr>
</tbody>
</table>

h. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2014 through September 30, 2014
The payment rate for two HCPCS codes were incorrect in the July 2014 OPPS Pricer. The corrected payment rates are listed in Table 8, and have been installed in the October 2014 OPPS Pricer, effective for services furnished on July 1, 2014, through September 30, 2014. Your MAC will not automatically adjust claims already processed with the incorrect rate, but they will adjust such claims that you bring to the MAC's attention.

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Table 8 – Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2014, through September 30, 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>J9047</td>
<td>G</td>
<td>9295</td>
<td>Injection, carfilzomib, 1 mg</td>
<td>$29.67</td>
<td>$5.93</td>
</tr>
<tr>
<td>J9315</td>
<td>K</td>
<td>9265</td>
<td>Romidepsin injection</td>
<td>$270.24</td>
<td>$54.05</td>
</tr>
</tbody>
</table>

Incorrect National Unadjusted Copayment for APC 0066 (Level I Stereotactic Radiosurgery) in the CY 2014 OPPS Final Rule

CMS incorrectly calculated the National Unadjusted Copayment for APC 0066 (Level I Stereotactic Radiosurgery) in the CY 2014 OPPS final rule. The National Unadjusted Copayment for APC 0066 was set to an explicit value, but it should have been set to the Minimum Unadjusted Copayment equivalent to a coinsurance percentage of 20 percent. CMS corrected this error in the July 2014 Pricer, and CMS is making the change for the copayment associated with APC 0066 retroactive to January 1, 2014. The correct copayment is included in the July 2014 update of the OPPS Addendum A and Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html on the CMS website.

Providers should refer to the recent edition of the MLN Connects Provider eNews which instructs

1. contractors to reprocess claims, and
2. providers to reimburse beneficiaries for any overpayment of beneficiary copayment created by correcting the National Unadjusted Copayment associated with APC 0066.


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, MACs determine that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment.

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Additional Information


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October Update to the 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 & Hospice (HH&H) MACs, for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8888 informs MACs about changes to payment files that were originally issued to contractors based upon the CY 2014 Medicare Physician Fee Schedule (MPFS) Final Rule. This change request amends those payment files, effective October 1, 2014. Make sure that your billing staffs are aware of these changes.

Background

Payment files were issued to MACs based upon rates in the Calendar Year (CY) 2014 Medicare Physician Fee Schedule (MPFS) Final Rule, published in the Federal Register on

In order to reflect appropriate payment policy as included in the CY 2014 MPFS Final Rule, the Medicare Physician Fee Schedule Database (MPFSDB) has been updated with October changes. These rates are effective through December 31, 2014.

The table below summarizes the addition of Federally Qualifying Health Centers (FQHCs) Healthcare Common Procedure Coding System (HCPCS) codes G0466, G0467, G0468, G0469, and G0470.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>Procedure Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0466</td>
<td>FQHC visit, new patient</td>
<td>X</td>
</tr>
<tr>
<td>G0467</td>
<td>FQHC visit, estab pt</td>
<td>X</td>
</tr>
<tr>
<td>G0468</td>
<td>FQHC visit, IPPE or AWV</td>
<td>X</td>
</tr>
<tr>
<td>G0469</td>
<td>FQHC visit, MH new pt</td>
<td>X</td>
</tr>
<tr>
<td>G0470</td>
<td>FQHC visit, MH estab pt</td>
<td>X</td>
</tr>
</tbody>
</table>

In addition, note the following changes:

- For HCPCS Codes 55970 and 55980, CMS will change their Procedure Status Codes from “N”= “Noncovered service by Medicare” to “C”= “Carrier Priced”, and their Global Surgery Codes from “XXX” to “YYY”, effective May 30, 2014 (All other indicators should remain the same.).
- For HCPCS Code A9586, CMS will change its Procedure Status Code changed from “N”= “Noncovered service by Medicare” to “C”= “Carrier Priced”, and its Global Surgery Code from “XXX” to “YYY”, effective September 27, 2013 (All other indicators should remain the same. See CR8526.).
- HCPCS Code 0275T “Perq lamot/lam lumbar“ is revised to the 2014 Physician Fee Schedule with a procedure status code of “N”=”Noncovered by Medicare”, effective January 9, 2014 (See CR 8757).
- CMS is changing the short descriptor for G9361 to read “Med Ind for induction”, effective January 1, 2014.
Note that MACs need not search their files to either retract payment for claims already paid or to retroactively pay claims and which were impacted by the above changes. However, they will adjust claims that you bring to their attention

**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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Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8890, which informs MACs about the availability of payment allowances for seasonal influenza virus vaccines. These payment allowances are updated on an annual basis effective August 1st of each year. Make sure that your billing staffs are aware of these changes.

Background

This recurring update notification provides the payment allowances for the following seasonal influenza virus vaccines, when payment is based on 95 percent of the Average Wholesale Price (AWP).

CPT 90655 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015
CPT 90656 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015
CPT 90657 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015
CPT 90661 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015
CPT 90685 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015
CPT 90686 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015
CPT 90687 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015
CPT 90688 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015
HCPCS Q2035 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015
HCPCS Q2036 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015
HCPCS Q2037 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015
HCPCS Q2038 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015

Payment for the following CPT or HCPCS codes may be made if your MAC determines its use is reasonable and necessary for the beneficiary, during the effective dates indicated below:

CPT 90654 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015
CPT 90662 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015
CPT 90672 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015
CPT 90673 Payment allowance is pending. Effective dates: 8/1/2014 - 7/31/2015
HCPCS Q2039 Flu Vaccine Adult - Not Otherwise Classified payment allowance is to be determined by the local claims processing contractor with effective dates of 8/1/2014 - 7/31/2015.

Payment allowances for codes for products that have not yet been approved will be provided when the products have been approved and pricing information becomes available to CMS.

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the Quarterly Average Sales Price (ASP) Drug Pricing Files.

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

**Note:** MACs will not search their files either to retract payment for claims already paid or to retroactively pay claims prior to the implementation date of CR8890. However, they will adjust claims that you bring to their attention.
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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REVISED products from the MLN
• “ICD-10-CM/PCS The Next Generation of Coding.” Fact Sheet, ICN 901044, Downloadable only.

MLN Matters® Number: MM8893 Related Change Request (CR) #: CR 8893
Related CR Release Date: August 22, 2014 Effective Date: January 1, 2015
Related CR Transmittal #: R3035CP Implementation Date: January 5, 2015

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

Provider Types Affected
This MLN Matters® Article is intended for Home Health Agencies (HHAs) and other providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

Provider Action Needed
CR8893, from which this article is taken, provides annual home health (HH) consolidated billing updates, effective January 1, 2015. It announces that Healthcare Common Procedure Coding System (HCPCS) code A4459 (Manual Pump Enema System, Includes Balloon, Catheter And All Accessories, Reusable, Any Type) is added to the HH consolidated billing non-routine supply code list. You should make sure that your billing personnel are aware of this update.

Background
The HH consolidated billing code list is updated annually, to reflect the annual changes to the HCPCS code set itself, and additional updates may occur as often as quarterly in order to

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reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. These updates are required by changes to the coding system itself, not because the services subject to HH consolidated billing are being redefined. Therefore you should note that the new codes identified in each update describe the same services that were used to determine the applicable HH PPS payment rates; and that the updates do not add any additional services.

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

CR8893 provides annual home health (HH) consolidated billing updates, effective January 1, 2015. It announces that Healthcare Common Procedure Coding System (HCPCS) code A4459 (Manual Pump Enema System, Includes Balloon, Catheter And All Accessories, Reusable, Any Type) is added to the HH consolidated billing non-routine supply code list. Code A4459 is added because of its similarity to code A4458, which has been subject to HH consolidated billing since 2003.

There are no changes to the HH consolidated billing therapy code list in this update.

**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.
Partial Code Freeze Prior to ICD-10 Implementation

Note: This article was revised on August 1, 2014, to make changes as a result of the delay of ICD-10 implementation until October 1, 2015.

Provider Types Affected

This MLN Matters® Special Edition Article affects all Medicare Fee-For-Service (FFS) physicians, providers, suppliers, and other entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health setting.

What You Need to Know

At a meeting on September 14, 2011, the ICD-9-CM Coordination & Maintenance (C&M) Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10 which would end one year after the implementation of ICD-10. The implementation of ICD-10 was delayed from October 1, 2014 to October 1, 2015 by final rule CMS-0043-F issued on July 31, 2014. This final rule is available at https://www.federalregister.gov/articles/2014/08/04/2014-18347/change-to-the-compliance-date-for-the-international-classification-of-diseases-10th-revision on the Internet.

There was considerable support for this partial freeze. The partial freeze will be implemented as follows:

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on October 1, 2011.
• On October 1, 2012 and October 1, 2013 there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173.

• On October 1, 2014 and October 1, 2015, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173.

• On October 1, 2016, regular updates to ICD-10 will begin. There will be no updates to ICD-9-CM, as it will no longer be used for reporting.

The ICD-9-CM Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze. At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on and after October 1, 2016 once the partial freeze has ended.

The code freeze was initially discussed at the September 15, 2010, meeting of the committee. To view the transcript of that meeting, go to: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html on the CMS website. From there, select the September 15-16, 2010, meeting documents and transcripts from the Downloads section, and then from the ZIP files, select the ‘091510_Morning_Transcript’ file. This section appears on page 4 of the 78-page document.


**Additional Information**

The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources to help Medicare FFS providers understand and prepare for the transition to ICD-10. General information about ICD-10 is available at http://www.cms.gov/Medicare/Coding/ICD10/index.html on the CMS website.

In addition, the following CMS resources are available to assist in your transition to ICD-10:

- **Medicare Fee-for-Service Provider Resources Web Page** - This site links Medicare Fee-For-Service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this web page. Bookmark http://www.cms.gov/Medicare/Coding/ICD10/index.html and check back regularly for access to ICD-10 implementation information of importance to you. Note: Use the links on
the left side of the web page to navigate to ICD-10 and 5010 information applicable to your specific interest.

**• CMS Sponsored National Provider Conference Calls** - During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit [http://www.cms.gov/Medicare/Coding/ICD10/index.html](http://www.cms.gov/Medicare/Coding/ICD10/index.html) on the CMS website.


**• Frequently Asked Questions (FAQs)** - To access FAQs related to ICD-10, please visit the CMS ICD-10 web page at [http://www.cms.gov/Medicare/Coding/ICD10/index.html](http://www.cms.gov/Medicare/Coding/ICD10/index.html), select the Medicare Fee-for-Service Provider Resources link from the menu on the left side of the page, scroll down the page to the “Related Links Inside CMS” section and select “ICD-10 FAQs”. Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

The following organizations offer providers and others ICD-10 resources:

**• Workgroup for Electronic Data Interchange (WEDI) [http://www.wedi.org](http://www.wedi.org); and**

**• Health Information and Management Systems Society (HIMSS) [http://www.himss.org/icd10](http://www.himss.org/icd10) on the Internet.**
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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

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

Note: This article was revised on August 1, 2014, to show the new ICD-10 implementation date of October 1, 2015. While the Change Request may not reflect the new date, CMS has made the date change. All other information is unchanged.

Provider Types Affected

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

Provider Action Needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2015. As a result of CR7492 (and related MLN Matters® Article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013, implementation date for ICD-10. This article updates MM7492

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to reflect the October 1, 2015, implementation date. Make sure your billing and coding staffs are aware of these changes.

**Key Points of SE1408**

**General Reporting of ICD-10**

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to [http://www.cms.gov/Medicare/Coding/ICD10/index.html](http://www.cms.gov/Medicare/Coding/ICD10/index.html) for more information on the format of ICD-10 codes. In addition, ICD-10 Procedure Codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

**General Claims Submissions Information**

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be Returned to Provider (RTP) as unprocessable. Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2015, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP all claims that are billed with **both** ICD-9 and ICD-10 **diagnosis codes** on the same claim. For dates of service prior to October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP all claims that are billed with **both** ICD-9 and ICD-10 **procedure codes** on the same claim. For claims with dates of service prior to October 1, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2015. Institutional claims containing ICD-10 codes for services prior to October 1, 2015, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

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

The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2015, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2015, and later. In some cases, depending upon the policies associated with those services, there cannot be a
break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2015. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A – Institutional Providers

<table>
<thead>
<tr>
<th>Bill Type(s)</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>11X</td>
<td>Inpatient Hospitals <em>(incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)</em></td>
<td>If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>12X</td>
<td>Inpatient Part B Hospital Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>13X</td>
<td>Outpatient Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>14X</td>
<td>Non-patient Laboratory Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>18X</td>
<td>Swing Beds</td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>21X</td>
<td>Skilled Nursing (Inpatient Part A)</td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>22X</td>
<td>Skilled Nursing Facilities (Inpatient Part B)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>23X</td>
<td>Skilled Nursing Facilities (Outpatient)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>32X</td>
<td>Home Health (Inpatient Part B)</td>
<td>Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>Bill Type(s)</td>
<td>Facility Type/Services</td>
<td>Claims Processing Requirement</td>
<td>Use FROM or THROUGH Date</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>3X2</td>
<td>Home Health – Request for Anticipated Payment (RAPs)*</td>
<td>* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.</td>
<td>*See Note</td>
</tr>
<tr>
<td>34X</td>
<td>Home Health – (Outpatient)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>71X</td>
<td>Rural Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>72X</td>
<td>End Stage Renal Disease (ESRD)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>73X</td>
<td>Federally Qualified Health Clinics (prior to 4/1/10)</td>
<td>N/A – Always ICD-9 code set.</td>
<td>N/A</td>
</tr>
<tr>
<td>74X</td>
<td>Outpatient Therapy</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>75X</td>
<td>Comprehensive Outpatient Rehab facilities</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>76X</td>
<td>Community Mental Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>77X</td>
<td>Federally Qualified Health Clinics (effective 4/4/10)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>Bill Type(s)</td>
<td>Facility Type/Services</td>
<td>Claims Processing Requirement</td>
<td>Use FROM or THROUGH Date</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>81X</td>
<td>Hospice- Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>82X</td>
<td>Hospice – Non hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>83X</td>
<td>Hospice – Hospital Based</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>85X</td>
<td>Critical Access Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
</tbody>
</table>

Table B - Special Outpatient Claims Processing Circumstances

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-day /1-day Payment Window</td>
<td>Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2015, the claim must be billed with ICD-10 for those bundled outpatient services.</td>
<td>THROUGH</td>
</tr>
</tbody>
</table>

Table C – Professional Claims

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>All anesthesia claims</td>
<td>Anesthesia procedures that begin on 9/30/2015 but end on 10/1/2015 are to be billed with ICD-9 diagnosis codes and use 9/30/2015 as both the FROM and THROUGH date.</td>
<td>FROM</td>
</tr>
</tbody>
</table>
### Table D – Supplier Claims

<table>
<thead>
<tr>
<th>Supplier Type</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH/TO Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMEPOS</td>
<td>Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/2015 (i.e., the FROM date of service occurs prior to 10/1/2015 and the TO date of service occurs after 10/1/2015).</td>
<td>FROM</td>
</tr>
</tbody>
</table>

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

MLN Matters® Number: SE1409 Revised  Related Change Request (CR) #: N/A
Related CR Release Date: N/A  Effective Date: October 1, 2015
Related CR Transmittal #: N/A  Implementation Date: N/A

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

Note: This article was revised on July 31, 2014, to show the new ICD-10 implementation date of October 1, 2015. In addition, the portions of the article that discuss ICD-10 acknowledgement testing and end-to-end testing are updated as a result of the new implementation date.

Provider Types Affected

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

Provider Action Needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which International Classification of Diseases, 10th Edition (ICD-10) codes must be used for dates of service on and after October 1, 2015. Be sure you are ready. This MLN Matters® Special Edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.
Background

The implementation of ICD-10 represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2015, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing for ICD-10 to ensure that CMS as well as the FFS provider community is ready.

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

The four-pronged approach includes:

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

Each approach is discussed in more detail below.

CMS Internal Testing of Its Claims Processing Systems

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

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

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

Provider-Initiated Beta Testing Tools

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

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


Acknowledgement Testing

Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the October 1, 2015, implementation date. In addition, CMS will be highlighting this testing by offering three separate weeks of ICD-10 acknowledgement testing. These special acknowledgement testing weeks give submitters access to real-time help desk support and allows CMS to analyze testing data. Registration is not required for these virtual events.

All MACs and the DME MAC Common Electronic Data Interchange (CEDI) contractor will promote this ICD-10 acknowledgement testing with trading partners. This testing allows all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A) that confirms whether the submitted test claims were accepted or rejected.

MACs and CEDI will be appropriately staffed to handle increased call volume on their Electronic Data Interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during these testing weeks. The testing weeks will occur in November 2014, March 2015, and June 2015. For more information about acknowledgement testing, refer to the information on your MAC’s website.

End-to-End Testing

During 2015, CMS plans to offer three separate end-to-end testing opportunities. Each opportunity will be open to a limited number of providers that volunteer for this testing. As
planned, approximately 2,550 volunteer submitters will have the opportunity to participate over the course of the three testing periods. End-to-end testing includes the submission of test claims to Medicare with ICD-10 codes and the provider’s receipt of a Remittance Advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

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

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

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

Claims Submission Alternatives

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2015, you should investigate downloading the free billing software that CMS offers via their MAC websites. The software has been updated to support ICD-10 codes and requires an internet connection. This billing software only works for submitting FFS claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance. Alternatively, all MACs offer provider internet portals, and a subset of these MAC portals offer claims submission; providers submitting to this subset of MACs may choose to use the portal for submission of ICD-10 compliant claims. Register in the portals that offer claims submission to ensure that you have the flexibility to submit professional claims this way as a contingency. More information may be found on your MAC’s website.

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. In addition to showing the toll-free numbers, you will find your MAC’s website address at this site in the event you want more information on the free billing software or the MAC’s provider internet portals mentioned above.

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Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers

Provider Types Affected

This MLN Matters® Article is intended for Home Health Agencies, Home Health Agency Sub-units, and Part B ambulance suppliers in parts of Florida, Illinois, Michigan, Texas and New Jersey that provide services to Medicare, Medicaid and CHIP beneficiaries.

Provider Action Needed

Effective July 30, 2014, the temporary moratoria on new Home Health Agencies, Home Health Agency Sub-units, and Part B ambulance suppliers are being extended for an additional 6 months in certain geographic locations.
CAUTION – What You Need to Know

During the 6-month temporary moratorium, initial provider enrollment applications and change of information applications to add additional practice locations, received from Home Health Agencies, Home Health Agency Sub-Units and Part B Ambulance suppliers in the listed counties will be denied. Application fees that are paid for applications that are denied due to this temporary moratorium will be refunded.

GO – What You Need to Do

Effective July 30, 2014, Home Health Agencies, Home Health Agency Sub-units, and Part B Ambulance suppliers should not submit initial enrollment applications or change of information applications to add additional practice locations until the 6-month moratoria has expired. CMS will announce in the Federal Register when the moratorium has been lifted or if it will be extended.

Background

In accordance with 42 CFR §424.570(c), the Centers for Medicare & Medicaid Services (CMS) may impose a moratorium on the enrollment of new Medicare providers and suppliers of a specific type or the establishment of new practice locations in a particular geographic area.


Moratoria Extension

Effective July 30, 2014, the temporary moratoria on new Home Health Agencies and Home Health Agency Sub-units is being extended for an additional 6 months in the areas stated in Table 1, below.

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Table 1: Home Health Agencies and Home Health Agency Sub-units under Temporary Moratorium

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<tr>
<th>City and State</th>
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<td>Fort Lauderdale, FL</td>
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<td>Miami-Dade</td>
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In addition, the temporary moratorium on new Part B ambulance suppliers is being extended for an additional 6 months in the areas stated in Table 2, below.
Table 2: Part B Ambulance Suppliers Under 6-month Temporary Moratoria

<table>
<thead>
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<th>City and State</th>
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<td>Gloucester (NJ)</td>
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</table>

Initial provider enrollment applications and change of information applications to add additional practice locations received from Home Health Agencies, Home Health Agency Sub-Units and Part B Ambulance suppliers in the above listed counties will be denied in accordance with 42 CFR §424.570(c). Application fees that are paid for applications that are denied due to this temporary moratorium will be refunded.

**Note:** Home Health Agencies, Home Health Agency Sub-Units and Part B Ambulance suppliers are afforded appeal rights. However, the scope of review will be limited to whether the temporary moratorium applies to the provider or supplier appealing the denial. CMS’ basis for imposing a temporary moratorium is not subject to review.

### Additional Information


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

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Fingerprint-based Background Check Begins August 6, 2014

Provider Types Affected

This MLN Matters® Special Edition article is intended for providers and suppliers subject to fingerprint-based background check, submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

Fingerprint-based background checks will be required for all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls into the high risk category and is currently enrolled in Medicare or has submitted an initial enrollment application.

CAUTION – What You Need to Know

The fingerprint-based background requirement was implemented on August 6, 2014, and will be conducted in phases. Providers or suppliers will receive notification of the
fingerprints requirements from their MAC. Initially, not all providers and suppliers in the “high” screening category will be a part of the first phase of the fingerprint-based background check requirement. See the Background section below for more details.

GO – What You Need to Do

If you receive notification of the fingerprint requirements, you will have 30 days from the date of the letter to be fingerprinted. Make sure that your staffs are aware of these requirements.

Background

The Centers for Medicare & Medicaid Services (CMS) awarded the Fingerprint-based Background Check contract to Accurate Biometrics located in Chicago, Illinois on July 8, 2014. Fingerprint-based background checks will be required for all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls into the high risk category and is currently enrolled in Medicare or has submitted an initial enrollment application. The fingerprint-based background requirement was implemented on August 6, 2014, and will be conducted in phases. Initially, not all providers and suppliers in the “high” screening category will be included in the first phase of the fingerprint-based background check requirement.

Applicable providers or suppliers will receive notification of the fingerprint requirements from their MAC. The MAC will send a letter to the applicable providers or suppliers listing all 5 percent or greater owners who are required to be fingerprinted. The letter will be mailed to the provider or supplier’s correspondence address and the special payments address on file with Medicare.

Generally the relevant individual will be required to be fingerprinted only once, but CMS reserves the right to request additional fingerprints if needed. The relevant individuals will have 30 days from the date of the letter to be fingerprinted.

If the provider or supplier finds a discrepancy in the ownership listing, the provider or supplier should contact their MAC immediately to communicate the discrepancy and take the appropriate action to update the enrollment record to correctly reflect the ownership information.

The relevant individuals should contact Accurate Biometrics prior to being fingerprinted to ensure the fingerprint results are accurately submitted to the Federal Bureau of Investigation (FBI) and properly returned to CMS. Accurate Biometrics may be contacted by phone (866-361-9944) or by accessing their website at www.cmsfingerprinting.com if you have any questions.

If an initial enrollment application is received by the MAC and the provider or supplier is required to obtain a fingerprint-based background check, the MAC will not begin processing
the application until the fingerprint-based background check has been completed and the results are received. The effective date of enrollment will be determined by the date the fingerprint results are received.

**Additional Information**


REVISED products from the MLN

- “Medicare Learning Network® (MLN) Suite of Products & Resources for Inpatient Hospitals”, Educational Tool, ICN 905704, Downloadable only

MLN Matters® Number: SE1428 Revised  Related Change Request (CR) #: NA
Related CR Release Date: NA  Effective Date: NA
Related CR Transmittal #: NA  Implementation Date: NA

Comprehensive Error Rate Testing (CERT): Skilled Nursing Facility (SNF) Certifications and Recertifications

Note: This article was revised on August 25, 2014, to delete a sentence in the "Provider Action Needed" section that referenced outpatient therapy. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians and non-physician practitioners (NPPs) who bill for services provided to Medicare beneficiaries in SNFs.

Provider Action Needed

This MLN Matters® Special Edition (SE) 1428 alerts providers that a major reason for claims being denied is failure to obtain certification and recertification statements from physicians or NPPs. The routine admission order established by a physician is not a certification of the necessity for post hospital extended care services for purposes of the program. Your billing staff needs to be aware of the requirements outlined below.
Background

The SNF inpatient improper payment rate increased from 4.8 percent during the 2012 reporting period to 7.7 percent during the 2013 report period. A major source of improper payments stems from SNFs failure to obtain certification and recertification statements from physicians or NPPs.

What is an Acceptable Certification Statement?

An acceptable certification statement must contain the following information:

- The individual needs skilled nursing care (furnished directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services;
- Such services are required on a daily basis;
- Such services can only practically be provided in a SNF or swing-bed hospital on an inpatient basis;
- Such services are for an ongoing condition for which the individual received inpatient care in a hospital; and
- A dated signature of the certifying physician or NPP.

What is an Acceptable Re-certification Statement?

An acceptable recertification statement must contain the following information:

- The reasons for the continued need for post hospital SNF care;
- The estimated time the individual will need to remain in the SNF;
- Plans for home care, if any;
- If the reason for continued need for services is a condition that arose after admission to the SNF (and while being treated for an ongoing condition for which the individual received inpatient care in a hospital) this must be indicated; and
- A dated signature of the recertifying physician or NPP.

How and When to Document the Certification and Recertification Statements

- There is no specific format or procedure for documentation of the certification or recertification statement(s) but they must include the content listed above. For example (if appropriate) the physician or NPP could sign and date a statement that:
  1. All of the required information is included in the individual’s medical record; and
  2. Continued post hospital extended care services are medically necessary.

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The following are the required timeframes for physicians or NPPs to document the certification or recertification statement(s):

1. The certification must be obtained at the time of admission or as soon thereafter as is reasonable and practicable.

2. The first recertification is required no later than the 14th day of post hospital SNF care.

3. Subsequent recertifications are required at least every 30 days after the first recertification.

Note: SNFs are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an isolated oversight or lapse. Delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the SNF considers relevant for purposes of explaining the delay.

Examples of CERT Findings

Below are examples of CERT review findings of incorrect certifications and recertifications:

- A physician order dated the day of admission to the SNF stated “resident certified as skilled (Medicare).” There was no indication of the need for daily skilled care, for inpatient services or for services for an ongoing condition for which the individual received inpatient care in a hospital care. Therefore the certification was not complete.

- A record selected by CERT for medical review did not have a certification or recertification statement. In response to a request for additional documentation, the facility submitted an initial certification and a recertification dated after the dates of service for the claim. There was no explanation of the reason(s) for the delayed certification. Therefore, the medical record did not meet Medicare requirements.

- A SNF medical record contained a 30-day recertification dated prior to the claim’s dates of service. There was no initial certification. A request for further documentation resulted in an initial certification and a 14-day recertification, both signed six months after the claim’s dates of service. In addition, the 30-day recertification was returned with a new date, also well after the claim dates of services. There was no explanation of the reason(s) for the delayed certification. This documentation did not meet the requirements for SNF certification and recertification.

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**Additional Information**

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


You may also want to review the following documents:


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Centers for Medicare & Medicaid Services
Articles for Part A Providers
REVISED products from the Medicare Learning Network® (MLN)

- “Medicare Physician Fee Schedule,” Fact Sheet, ICN 006814 Downloadable only.

MLN Matters® Number: MM8350 Revised  Related Change Request (CR) #: CR 8350
Related CR Release Date: August 16, 2013  Effective Date: January 1, 2014
Related CR Transmittal #: R2765CP  Implementation Date: January 6, 2014

Diagnosis Code Reporting on Religious Nonmedical Health Care Institution Claims

Note: This article was revised on August 1, 2014, to show the new ICD-10 implementation date of October 1, 2015. While the Change Request may not reflect the new date, CMS has made the date change. All other information is unchanged.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8350 which informs Medicare contractors about enforcement in Medicare systems of longstanding diagnosis coding instructions on Religious Nonmedical Health Care Institution (RNHCI) claims. It also clarifies diagnosis code reporting on RNHCI claims for the ICD-10 transition. Make sure that your billing staffs are aware of these changes.
Background

While coding of diagnoses is not consistent with the nonmedical nature of Religious Nonmedical Health Care Institution (RNHCI) services, the presence of diagnosis codes is a requirement for standard claims transactions. Longstanding instructions in the “Medicare Claims Processing Manual,” Chapter 3, Section 170, direct RNHCIs to use the following pair of ICD-9 diagnosis codes to satisfy the claim requirement:

- Principal diagnosis: 799.9 "other unknown and unspecified cause"
- Other diagnosis: V62.6 "refusal of treatment for reasons of religion or conscience"

RNHCI claims received on or after January 1, 2014 (with any claim “through” date prior to October 1, 2015), will be returned to the provider if they do not contain the above ICD-9 Principal Diagnosis and first Other Diagnosis codes.

The implementation of ICD-10 effective October 2015 will require RNHCI to instead report the following pair of ICD-10 diagnosis codes to satisfy the claim requirement:

- Principal diagnosis: R69 "illness, unspecified"
- Other diagnosis: Z53.1 "procedure and treatment not carried out because of patient's decision for reasons of belief"

RNHCI claims received with a claim “through” date on or after October 1, 2015, will be returned to the provider if they do not contain the above ICD-10 Principal Diagnosis and first Other Diagnosis codes or if they contain any ICD-9 code.

Additional Information


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

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NEW product from the Medicare Learning Network® (MLN)
- “Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 4]”, Educational Tool, ICN 909012, downloadable

MLN Matters® Number: MM8581 Related Change Request (CR) #: CR 8581
Related CR Release Date: August 8, 2014 Effective Date: Claims received on or after January 1, 2015
Related CR Transmittal #: R3022CP Implementation Date: April 6, 2015

Automation of the Request for Reopening Claims Process

Note: To assist providers with coding a request to reopen claims that are beyond the filing timeframes a Special Edition Article, SE1426, has been developed. That article contains some additional information on this process as well as condition codes and billing scenarios. The article may be reviewed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1426.pdf on the CMS website.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8581 which informs A/MACs about changes that will allow providers and their vendors to electronically request reopenings of claims. Make sure your billing staffs are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.

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Background

When a provider needs to correct or supplement a claim, and the claim remains within timely filing limits, providers may submit an adjustment claim to remedy the error. When the need for a correction is discovered beyond the claims timely filing limit, an adjustment bill is not allowed and a provider must utilize the reopening process to remedy the error.

Generally, reopenings are written requests for corrections that include supporting documentation. However, a standard process across all A/MACs has not been available. In an effort to streamline and standardize the process for providers to request reopenings, CMS petitioned the National Uniform Billing Committee (NUBC) for a “new” bill type frequency code to be used by providers indicating a Request for Reopening and a series of Condition Codes that can be utilized to identify the type of Reopening being requested. These institutional reopenings must be submitted with a “Q” frequency code to identify them as a Reopening. The NUBC adopted these new codes and bill type frequency change effective with claims received on or after January 1, 2015.

A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are different from adjustment bills in that adjustment bills are subject to normal claims processing timely filing requirements (i.e., filed within one year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (e.g., claim determinations may be reopened within one year of the date of receipt of the initial determination for any reason, or within one to four years of the date of receipt of the initial determination upon a showing of good cause). Reopenings are also separate and distinct from the appeals process. A reopening will not be granted if an appeal decision is pending or in process.

Decisions to allow reopenings are discretionary actions on the part of your A/MAC. An A/MAC’s decision to reopen a claim determination, or refusal to reopen a claim determination, is not an initial determination and is therefore not appealable. Requesting a reopening does not guarantee that request will be accepted and the claim determination will be revised, and does not extend the timeframe to request an appeal. If an A/MAC decides not to reopen an initial determination, the A/MAC will Return To Provider (RTP) the reopening request indicating that the A/MAC is not allowing this discretionary action. In this situation, the original initial determination stands as a binding decision, and appeal rights are retained on the original initial determination. New appeal rights are not triggered by the refusal to reopen, and appeal filing timeframes on the original initial determination are not extended following a contractor’s refusal to reopen. However, when an A/MAC reopen and revises initial determination, that revised determination is a new determination with new appeal rights.

Providers are reminded that submission of adjustment bills or reopening requests in response to claim denials resulting from review of medical records (including failure to
submit medical records in response to a request for records) is not appropriate. Providers must submit appeal requests for such denials.

Additionally, many A/MACs allow re-openings to be submitted hardcopy (by mail or fax) or through a provider online portal. The creation of this new process does not eliminate or negate those processes. Contact your MAC about other ways re-openings may be submitted.

Additional Information

The official instruction, CR 8581, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3022CP.pdf on the CMS website.

For additional information regarding the distinction between adjustment bills, which are subject to normal claims processing timely filing limits, and re-openings, which may be requested beyond timely filing limitations, review Chapter 1, Section 70.5 of the "Medicare Claims Processing Manual" (IOM 100-4). That manual chapter is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf on the CMS website.


Attachment 1 will assist providers with coding claim’s request for reopening.

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**Coding Requirements:**

These claims must be submitted with an “Q” in the 4th position of the Type of Bill (TOB xxxQ) to identify them as a Reopening.

### Condition Code Definitions for Reopening

<table>
<thead>
<tr>
<th>Condition Code</th>
<th>Title</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1</td>
<td>Request for Reopening Reason Code - Mathematical or Computational Mistakes</td>
<td>Mathematical or computational mistakes</td>
</tr>
<tr>
<td>R2</td>
<td>Request for Reopening Reason Code - Inaccurate Data Entry</td>
<td>Inaccurate data entry, e.g., mis-keyed or transposed provider number, referring NPI, date of service, procedure code, etc.</td>
</tr>
<tr>
<td>R3</td>
<td>Request for Reopening Reason Code - Misapplication of a Fee Schedule.</td>
<td>Misapplication of a fee schedule</td>
</tr>
<tr>
<td>R5</td>
<td>Request for Reopening Reason Code - Incorrectly Identified Duplicate</td>
<td>Claim Claims denied as duplicates which the party believes were incorrectly identified as a duplicate.</td>
</tr>
<tr>
<td>R6</td>
<td>Request for Reopening Reason Code - Other Clerical Errors or Minor Errors and Omissions not Specified in R1-R5 above</td>
<td>Other clerical errors or minor errors and omissions not specified in R1-R5 above.</td>
</tr>
<tr>
<td>R7</td>
<td>Request for Reopening Reason Code - Corrections other than Clerical Errors</td>
<td>Claim corrections other than clerical errors within one year of the date of initial determination.</td>
</tr>
<tr>
<td>R8</td>
<td>Request for Reopening Reason Code - New and Material Evidence</td>
<td>A reopening for good cause (one to four years from the date of the initial determination) due to new and material evidence that was not available or known at the time of the determination or decision and may result in a different conclusion.</td>
</tr>
<tr>
<td>R9</td>
<td>Request for Reopening Reason Code - Faulty Evidence</td>
<td>A reopening for good cause (one to four years from the date of the initial determination) because the evidence that was considered in making the determination or decision clearly shows that an obvious error was made at the time of the determination or decision.</td>
</tr>
</tbody>
</table>

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Preventing Duplicate Payments When Overlapping Inpatient and Home Health (HH) Claims Are Received Out of Sequence

Provider Types Affected

This MLN Matters® Article is intended for Home Health Agencies (HHAs) who bill Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8699 which improves safeguards to prevent payment of HH services when a beneficiary is an inpatient of a hospital or Skilled Nursing Facility (SNF). Make sure that your billing personnel are on the alert for overlapping claims dates.

Background

In August 2012, the Office of Inspector General (OIG) issued report OEl-04-00240, entitled "Inappropriate and Questionable Billing by Medicare Home Health Agencies." One recommendation of this report was to improve existing edits to prevent inappropriate payments.
payments on HH claims that overlap claims for inpatient hospital stays or SNF stays. The Centers for Medicare & Medicaid Services (CMS) requested and received example claims from the OIG in order to research ways to improve the edits in Original Medicare claims systems that identify such overlaps. This review identified two gaps in current Medicare edits:

1. The edit that rejects HH claims when they have dates overlapping an inpatient stay (other than the admission date, discharge date, or a date during an occurrence span code 74 period indicating a leave of absence) does not consider inpatient stays in a swing bed (Type of Bill 018x); and

2. Medicare systems only identify overlaps with inpatient stays when the inpatient hospital or SNF claim was received before the HH claim.

Key Points

CR8699 contains no new policy but revises the Medicare systems to close gaps to prevent inappropriate payments on HH claims. The “Medicare Claims Processing Manual,” Chapter 10 (Home Health Agency Billing) will be changed to state the following:

- Beneficiaries cannot be institutionalized and receive home health care simultaneously. Claims for institutional inpatient services (inpatient hospital, SNF, and swing bed claims), have priority in Medicare claims editing over claims for HH services.

- If an HH Prospective Payment System (PPS) claim is received, and Medicare's Common Working File (CWF) finds dates of service on the HH claim that fall within the dates of an inpatient, SNF, or swing bed claim (not including the dates of admission and discharge and the dates of any leave of absence), Medicare systems will reject the HH claim. The HHA may submit a new claim removing any dates of service within the inpatient stay that were billed in error.

- If the HH PPS claim is received first and the inpatient hospital, SNF, or swing bed claim comes in later, but contains dates of service duplicating dates of service within the HH PPS episode period, Medicare systems will adjust the previously paid HH PPS claim to non-cover the duplicated dates of service.

The following remittance advice codes will be used for any HH visits non-covered as a result of CR8699:

- Group code: CO
- Claim Adjustment Reason Code: 96 (Non-covered charge(s))
• Remittance Advice Remark Code: M80 (Not covered when performed during the same session/date as a previously processed service for the patient.)

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.

For a comprehensive list of CMS HH educational products and information you may visit [http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html](http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html) on the CMS website.

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Preventing Payment on Requests for Anticipated Payment (RAPs) When Home Health Beneficiaries are Enrolled in Medicare Advantage (MA) Plans

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8710 which informs HH&H MACs about the changes to Original Medicare systems to ensure Requests for Anticipated Payments (RAPs) are not paid when the final claim for a home health episode will not be payable due to a Medicare Advantage (MA) enrollment. Make sure that your billing staffs are aware of these changes.

Background

Original Medicare claims for home health services are not payable when the home health episode dates fall entirely within a Medicare Advantage enrollment period. Current Medicare systems edits prevent claims for such episodes from receiving payment. However,
RAPs for such episodes are currently being paid. Since these RAP payments will be recovered in full when the final claim is received and rejected or when no final claim is received after 120 days, the RAP payments create an avoidable 'pay and chase' situation.

The requirements of CR8710 revise Original Medicare systems to ensure that RAPs with "From" dates falling within Medicare Advantage enrollment periods are processed but are paid at zero percent. This will allow the final claim to be received and rejected appropriately, but will prevent any program vulnerability. Additionally, the requirements add remittance advice coding to distinguish between Medicare Advantage related zero-paid RAPs and zero-paid RAPs processed in Medicare Secondary Payer (MSP) situations.

RAPs will be rejected when:

- The RAP contains a payment amount greater than zero, and
- The RAP "From" date falls on or after the start date of a MA enrollment period, and
- The RAP "From" date falls before the end date of that MA enrollment period.

The following remittance advice coding will apply when processing zero-paid RAPs due to MSP involvement:

- Remittance Advice Remarks Code N360 - Alert: Coordination of benefits has not been calculated when estimating benefits for this pre-determination. Submit payment information from the primary payer with the secondary claim.

**Additional Information**


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

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

Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2015

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8788 which provides updated rates used to correctly pay IRF PPS claims for FY 2015. A new IRF PRICER software package will be released prior to October 1, 2014, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2014, through September 30, 2015. Make sure your billing staffs are aware of these changes.
Background

The Centers for Medicare & Medicaid Services (CMS) published a final rule in the Federal Register (see [http://www.gpo.gov/fdsys/pkg/FR-2001-08-07/pdf/01-19313.pdf](http://www.gpo.gov/fdsys/pkg/FR-2001-08-07/pdf/01-19313.pdf)), that established the IRF PPS, as authorized under the Social Security Act (Section 1886(j)); see [http://www.ssa.gov/OP_Home/ssact/title18/1886.htm](http://www.ssa.gov/OP_Home/ssact/title18/1886.htm). In that final rule, CMS set forth per discharge Federal rates for Federal Fiscal Year (FY) 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002. Annual updates to the IRF PPS rates are required by the Social Security Act (Section 1886(j)(3)(C)). Additionally, Section 1886(j)(7)(A)(i) of the Social Security Act requires application of a 2 percentage point reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements which CMS implemented for FY 2014 IRF PPS payments. The updates for FY2015 are in the following table.

### PRICER Updates for IRF PPS FY 2015
**(October 1, 2014 – September 30, 2015)**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Federal Rate</td>
<td>$15,198</td>
</tr>
<tr>
<td>Adjusted Standard Federal Rate</td>
<td>$14,901</td>
</tr>
<tr>
<td>Fixed Loss Amount</td>
<td>$8,848</td>
</tr>
<tr>
<td>Labor-related Share</td>
<td>0.69294</td>
</tr>
<tr>
<td>Non-labor Related Share</td>
<td>0.30706</td>
</tr>
<tr>
<td>Urban National Average Cost-to-Charge Ratio (CCR)</td>
<td>0.443</td>
</tr>
<tr>
<td>Rural National Average CCR</td>
<td>0.569</td>
</tr>
<tr>
<td>Low Income Patient (LIP) Adjustment</td>
<td>0.3177</td>
</tr>
<tr>
<td>Teaching Adjustment</td>
<td>1.0163</td>
</tr>
<tr>
<td>Rural Adjustment</td>
<td>1.149</td>
</tr>
</tbody>
</table>

The Social Security Act (Section 1886(j)(7)(A)(i)) requires application of a 2 percentage point reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. FY 2015 is the second year that the mandated reduction will be applied for IRFs that failed to comply with the data submission requirements during the data collection period January 1, 2013, through December 31, 2013.

In compliance with Section 1886(j)(7)(A)(i) of the Social Security Act, CMS will apply a 2 percentage point reduction to the applicable FY 2015 market basket increase factor (2.2 percent) in calculating an adjusted FY 2015 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements.

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Application of the 2 percentage point reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Also, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

The adjusted FY 2015 standard payment conversion factor that will be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the period from January 1, 2013, through December 31, 2013, will be $14,901.

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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**Diagnosis Reporting on Home Health Claims**

**Provider Types Affected**

This MLN Matters® Article is intended for Home Health Agencies (HHAs) that submit claims to Home Health and Hospice Medicare Administrative Contractors (HH&H MACs)) for services provided to Medicare beneficiaries.

**Provider Action Needed**

This article is based on Change Request (CR) 8813 which adds editing for principal diagnoses that are not appropriate for reporting on the home health claim. CR8813 instructs that the principal diagnosis reported on the home health claim should be the ICD-9-CM code that is most related to the current home health plan of care. HHAs should not submit manifestation codes as the primary diagnosis. Make sure that your billing staffs are aware of these changes.

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Background

HHAs are to report diagnosis coding on the home health claim, as required by the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Coding Guidelines. Adherence to ICD-9-CM coding guidelines when assigning diagnosis codes is required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient’s primary diagnosis is defined as the diagnosis most related to the current home health plan of care. An analysis of Outcome and Assessment Information Set (OASIS) records and claims for Calendar Year (CY) 2011 revealed that some HHAs were not complying with the coding guidelines when reporting the primary diagnosis, in particular with regards to certain codes that require the underlying condition be sequenced first, followed by the manifestation. Given the concerns regarding compliance with coding guidelines, Medicare is adopting edits to ensure greater compliance of coding guidelines for primary diagnosis codes.

The principal diagnosis reported on the home health claim should be the ICD-9-CM code that is most related to the current home health plan of care. HHAs should not submit manifestation codes as the primary diagnosis.

Change Request (CR) 8813 instructs that, given the concerns regarding compliance with coding guidelines, the Centers for Medicare & Medicaid Services (CMS) is adopting edits to ensure greater compliance of coding guidelines for primary diagnosis codes.

Effective January 1, 2015, home health claims (including Requests for Anticipated Payments) reporting a manifestation code as principal diagnosis will be returned to the provider.

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 product from the Medicare Learning Network® (MLN)

- "Medicare Billing: 837I and Form CMS-1450" Web-based Training (WBT)

MLN Matters® Number: MM8820
Related Change Request (CR) #: CR 8820
Related CR Release Date: August 1, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R1412OTN
Implementation Date: January 5, 2015

Modifying FISS Part B Claims Overlap Edits Related to CMS-1599-F

Provider Types Affected

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

What You Need to Know

Change Request (CR) 8820 directs MACs to use modified Fiscal Intermediary Shared System (FISS) overlap edits for outpatient Type of Bill (TOB) 013x overlapping an inpatient TOB 012x. Effective January 1, 2015, Medicare’s FISS system will use modified Part B duplicate claims edit logic to bypass the duplicate claims edits of the TOB 013x and TOB 012x claims if the "Through" date of the TOB 013x is equal to the "From" date of the TOB 012x. Make sure your billing staffs are aware of these changes.

Background


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A hospital may also be paid for Part B inpatient services if it determines under Medicare's utilization review requirements that a beneficiary should have received hospital outpatient rather than hospital inpatient services, and the beneficiary has already been discharged from the hospital (commonly referred to as hospital self-audit). Hospitals may bill for the Part B inpatient services specified in the “Medicare Benefit Policy Manual,” Chapter 6, Section 10, which is available at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf) on the CMS website.

When beneficiaries treated as hospital inpatients are either not entitled to Part A at all, or are entitled to Part A but have exhausted their Part A benefits, hospitals may only bill for the limited set of Part B inpatient services specified in the “Medicare Benefit Policy Manual,” Chapter 6, Section 10, which is available at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf) on the CMS website.

**Additional Information**


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MLN Matters® Articles Index: Have you ever tried to search MLN Matters® articles for information regarding a certain issue, but you did not know what year it was published? To assist you next time in your search, try the CMS article indexes that are published at [http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/MLNMattersArticles/](http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/MLNMattersArticles/) on the CMS website. These indexes resemble the index in the back of a book and contain keywords found in the articles, including HCPCS codes and modifiers. These are published every month. Just search on a keyword(s) and you will find articles that contained those word(s). Then just click on one of the related article numbers and it will open that document. Give it a try.

MLN Matters® Number: MM8876 Related Change Request (CR) #: CR 8876
Related CR Release Date: August 11, 2014 Effective Date: October 1, 2014
Related CR Transmittal #: R3023CP Implementation Date: October 6, 2014

Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, Quality Reporting Program and the Hospice Pricer for Fiscal Year (FY) 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8876 informs MACs about changes that update the hospice payment rates, hospice wage index, and Pricer for FY 2015, and that update the hospice cap amount for the cap year ending October 31, 2014. Make sure your billing staffs are aware of these changes.

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Background

Payment rates for hospice care, the hospice aggregate cap amount, and the hospice wage index are updated annually. The law governing the payment for hospice care requires annual updates to the hospice payment rates. Section 1814(i)(1)(C)(ii) of the Social Security Act (the Act) stipulates that the payment rates for hospice care for fiscal years after 2002 will increase by the market basket percentage increase for the fiscal year (FY). This payment methodology has been codified in regulations found at 42 CFR §418.306(a)-(b).

The Affordable Care Act of 2010 (ACA) requires that beginning in FY 2013, the market basket update be reduced by a productivity adjustment. Additionally, ACA requires that in FY 2013, the market basket update also be reduced by 0.3 percentage point. These ACA changes are now part of the Act at section 1814(i)(1)(C)(iv).

Hospice Aggregate Cap

The Hospice Aggregate Cap amount is updated annually in accordance with §1814(i)(2)(B) of the Act and provides for an increase (or decrease) in the hospice cap amount. Specifically, the cap amount is increased or decreased for accounting years after 1984 by the same percentage as the percentage increase or decrease, respectively, in the Medical Care expenditure category of the Consumer Price Index for all Urban Consumers.

Hospice Wage Index

The Hospice Wage Index is used to adjust payment rates to reflect local differences in wages according to the revised wage index. The Hospice Wage Index is updated annually as required by 42 CFR §418.306(c) and as discussed in hospice rulemaking. The August 6, 2009, FY 2010 Hospice Wage Index final rule finalized a provision to phase out the Budget Neutrality Adjustment Factor (BNAF) over seven years, with a 10 percent reduction in the BNAF in FY 2010, and an additional 15 percent reduction in each of the next six years, with complete phase out in FY 2016.

Quality Reporting Program

Section 3004 of the Affordable Care Act amended the Act to authorize a quality reporting program for hospices. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and in each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data submission requirements with respect to that FY.

The annual hospice payment updates will be implemented through the Hospice Pricer software found in the intermediary standard systems. The new Pricer module will apply the existing calculation to the updated payment rates shown below. An updated table will be installed in the module, to reflect the FY 2015 hospice wage index.
**FY 2015 Hospice Payment Rates**

The FY 2015 payment rates will be the FY 2014 payment rates, increased by 2.1 percent, which is the final hospital market basket update for FY 2015 (2.9 percent) less a productivity adjustment of 0.5 percentage point, less 0.3 percentage point. The FY 2015 hospice payment rates are effective for care and services furnished on or after October 1, 2014, through September 30, 2015.


**Table 1: FY 2015 Hospice Payment Rates Updated by the Estimated Hospice Payment Update Percentage**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2014 Payment Rates</th>
<th>Increase by the FY 2015 final hospice payment update of 2.1 percent</th>
<th>FY 2015 final Payment Rate</th>
<th>Labor Share of the final payment rate</th>
<th>Non-Labor share of the final payment rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care</td>
<td>$156.06</td>
<td>x1.021</td>
<td>$159.34</td>
<td>$109.48</td>
<td>$49.86</td>
</tr>
<tr>
<td>652</td>
<td>Continuous Home Care: Full rate applies to 24 hours of care. Hourly rate = $38.75</td>
<td>$910.78</td>
<td>x1.021</td>
<td>$929.91</td>
<td>$638.94</td>
<td>$290.97</td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$161.42</td>
<td>x1.021</td>
<td>$164.81</td>
<td>$89.21</td>
<td>$75.60</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$694.19</td>
<td>x1.021</td>
<td>$708.77</td>
<td>$453.68</td>
<td>$255.09</td>
</tr>
</tbody>
</table>
Beginning in FY 2014, hospices which fail to report quality data will have their market basket update reduced by two percentage points. Table 2 shows the rates for these hospices.

Table 2: Hospice Payment Update Percentage for Hospices That DO NOT Submit the Required Quality Data

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2014 Payment Rates</th>
<th>Increase by the FY 2015 hospice payment update percentage of 2.1 percent minus 2 percentage points =0.1</th>
<th>FY 2015 Payment Rate</th>
<th>Labor Share of the final payment rate</th>
<th>Non-Labor share of the final payment rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home care</td>
<td>$156.06</td>
<td>x1.001</td>
<td>$156.22</td>
<td>$107.34</td>
<td>$48.88</td>
</tr>
<tr>
<td>652</td>
<td>Continuous Home Care: Full rate applies to 24 hours of care. Hourly rate = $37.99</td>
<td>$910.78</td>
<td>x1.001</td>
<td>$911.69</td>
<td>$626.42</td>
<td>$285.27</td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$161.42</td>
<td>x1.001</td>
<td>$161.58</td>
<td>$87.46</td>
<td>$74.12</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$694.19</td>
<td>x1.001</td>
<td>$694.88</td>
<td>$444.79</td>
<td>$250.09</td>
</tr>
</tbody>
</table>

**Hospice Cap**
The latest hospice cap amount for the cap year ending October 31, 2014, is $26,725.79. In computing the cap, CMS used the March 2014 Consumer Price Index for All Urban Consumers (CPI-U) from the Medical Care expenditure category, published by the Bureau of Labor Statistics (http://www.bls.gov/cpi/home.htm), which was 233.369. The hospice cap is discussed further in the "Medicare Claims Processing Manual," Chapter 11, Processing Hospice Claims, Section 80.2.

**Hospice Wage Index**
The FY 2015 Hospice Wage Index final rule will be effective October 1, 2014, and published on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Regulations-and-Notices-Items/CMS-1609-F.html before that date. The

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revised wage index and payment rates will be incorporated in the hospice Pricer and forwarded to the intermediaries following publication of the wage index final rule.

**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.
Hospice Manual Update for Diagnosis Reporting and Filing Hospice Notice of Election (NOE) and Termination or Revocation of Election. This CR Rescinds and Fully Replaces CR8777

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

New editing instructions for hospice primary diagnoses and newly required timeframes for submitting information to your MAC might impact your reimbursement.

CAUTION – What You Need to Know

Change Request (CR) 8877provides:

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MLN Matters® Number: MM8877  Related Change Request Number: 8877

- Education for providers regarding new editing instructions for diagnoses that are not appropriate for reporting as principal diagnoses on hospice claims;
- Provider education for newly required timeframes for filing a hospice Notice of Election (NOE) and Notice of Termination/Revocation of Election (NOTR), and also for the exceptions process available when a hospice NOE is filed late; and
- A clarification of the differences between Healthcare Common Procedure Coding System (HCPCS) site of service codes Q5003 and Q5004.

GO – What You Need to Do
Make sure your billing staffs are aware of these changes.

Background

Principal Diagnosis Coding Instructions
International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Coding Guidelines require you to report diagnosis coding on your hospice claim. The principal diagnosis reported on the claim should be the diagnosis most contributory to the terminal prognosis. The coding guidelines state that when the provider has established, or confirmed, a related definitive diagnosis, codes listed under the classification of Symptoms, Signs, and Ill-defined Conditions are not to be used as principal diagnoses. Hospice providers may not report diagnosis codes that cannot be used as the principal diagnosis according to ICD-9-CM/ICD-10-CM Coding Guidelines and that require further compliance with various ICD-9-CM/ICD-10-CM coding conventions, such as those that have principal diagnosis code sequencing or etiology/manifestation guidelines. According to the ICD-9CM/ICD-10-CM Coding Guidelines both “debility” and “adult failure to thrive” are considered nonspecific, symptom diagnoses. Specifically, you should not use ICD-9-CM codes 799.3 (Debility, unspecified) and 780.79 (Other malaise and fatigue), ICD-10-CM code R53.81 (Other malaise); and ICD-9-CM code 783.7 and ICD-10-CM code R62.7 (adult failure to thrive) as principal hospice diagnoses on a hospice claim form. When any of these diagnoses are reported as a principal diagnosis, the claim will be returned to the provider for a more definitive hospice diagnosis based on ICD-9-CM/ICD-10-CM Coding Guidelines.

Additionally, there are several dementia diagnosis codes that cannot be used as the principal diagnosis, and require further compliance with various ICD-9-CM/ICD-10-CM coding conventions, such as those that are classified as unspecified or which have principal diagnosis code sequencing guidelines. These dementia codes (most of which are those found under the ICD-9-CM/ICD-10-CM classification, “Mental, Behavioral, and Neurodevelopmental Disorders”) are typically manifestations from an underlying physiological condition; and are not appropriate as principal diagnoses because of etiology.

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/manifestation guidelines or sequencing conventions. You must code the underlying condition as the principal diagnosis, and the aforementioned dementia conditions would be appropriate as secondary diagnoses.

ICD-9-CM/ICD-10-CM diagnosis codes 294.10/F02.80 (Dementia in diseases classified elsewhere without behavioral disturbance), and 294.11/F02.81 (Dementia in diseases classified elsewhere with behavioral disturbance) are included in an existing Medicare Code Editor edit, which does not allow these diagnoses to be coded as principal. This Medicare Code Editor edit will be implemented as a “Manifestation code as principal diagnosis” edit in the Integrated Outpatient Code Editor (IOCE). Additionally, new edits for the codes in CR8877’s Attachment A will be implemented, as these codes are part of sequencing or other coding convention in the coding guidelines.

You should only use unspecified codes when the medical record documentation (at the time of the encounter) is insufficient to assign a more specific code. However, if the underlying neurologic condition causing dementia may be difficult to code because the medical record may not provide sufficient information, and there are codes listed under “Diseases of the Nervous System” that do provide for appropriate principal code selection under those circumstances, you are encouraged to look at the coding conventions under that classification for coding dementia conditions on hospice claims.

You should be aware that if you report any of these diagnoses, mentioned above, as a principal diagnosis, the claim will be returned to you for a more definitive hospice diagnosis based on ICD-9-CM/ICD-10-CM Coding Guidelines.

Newly Required Timeframes for Information to MACs

When electing hospice care, the beneficiary waives the right to Medicare payment for any Medicare services related to the terminal illness, and related conditions, during a hospice election; except when those services are provided by:

- The designated hospice;
- Another hospice under arrangements made by the designated hospice; or
- The individual’s attending physician, who is not an employee of the designated hospice;

as noted in 42 CFR 418.24(d) which is available at http://www.gpo.gov/fdsys/granule/CFR-2012-title42-vol3/CFR-2012-title42-vol3-sec418-24/content-detail.html on the Internet. Prompt filing of the NOE with the MAC is required to properly enforce this waiver, and prevent inappropriate payments to non-hospice providers. The effective date of hospice election is the same as the hospice admission date.

Upon discharge from hospice or revocation of hospice care, the beneficiary immediately resumes the Medicare coverage that had previously been waived by the hospice election. As such, hospices should record the beneficiary’s discharge or revocation in the claims.
processing system promptly. Doing so protects the beneficiary from experiencing possible delays in accessing needed care.

You must file Hospice NOEs within 5 calendar days after the effective date of hospice election. A timely-filed NOE is a NOE that is submitted to the Medicare contractor and accepted by the MAC within 5 calendar days after the hospice admission date. If you do not file the NOE within this 5 calendar day period, Medicare will not cover and pay for the days of hospice care from the effective date of election to the date of NOE filing. These days will be a provider liability, and you should not bill the beneficiary for them.

You should report these non-covered days on the claim with an occurrence span code 77, and report the charges related to the level of care for these days as non-covered; or the claim will be returned to you.

**Example:**

Admission date is 10/10/2014 (Fri).

Day 1 = Sat. 10/11/2014
Day 2 = Sun. 10/12/2014
Day 3 = Mon. 10/13/2014
Day 4 = Tues. 10/14/2014
Day 5 = Weds. 10/15/2014

10/15/2014 is the NOE Due Date.

If the NOE Receipt date is 10/16/2014, the hospice reports 10/10 through 10/15 as non-covered days using occurrence span code 77.

If you fail to file a timely NOE, you may request an exception which, if approved, waives the consequences of failing to file a complete and timely NOE. The four circumstances that may qualify the hospice for an exception to the consequences of filing a late NOE are:

1. Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice’s ability to operate;
2. An event that produces a data filing problem due to a CMS or MAC systems issue that is beyond the control of the hospice;
3. A newly Medicare-certified hospice that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its MAC; or,
4. Other circumstances determined by the MAC to be beyond the hospice’s control.

If one of the four circumstances described above prevents you from filing your NOE within the time requirements, you must submit the associated claim with occurrence span code 77 used to identify the non-covered, provider liable days. You must also report a KX modifier with the Q HCPCS code reported on the earliest dated level of care line on the claim.

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KX modifier prompts your MAC to request the documentation supporting your request for an exception.

Your MAC will determine if a circumstance that a hospice encountered qualifies for an exception; and if it approves the request for an exception, it will re-process the claim without the provider liable days for late-filing of the NOE. If, however, it does not approve your request for an exception, your MAC will process the claim as submitted.

If a hospice beneficiary is discharged alive or if a hospice beneficiary revokes the election of hospice care, you must file a NOTR within 5 calendar days after the effective date of a beneficiary’s discharge or revocation, unless you have already filed a final claim. A NOTR (bill type 8XB) contains the same data elements as an NOE (bill type 8XA) and is entered via Direct Data Entry in the same way.

**Clarification of the Differences between HCPCS Codes Q5003 and Q5004**

CR8877 clarifies the differences between site of service HCPCS codes Q5003 (Hospice care provided in nursing Long Term Care (LTC) facility or non-skilled Nursing Facility (NF)) and Q5004 (Hospice care provided in Skilled Nursing Facility (SNF)). This clarification does not represent a change in policy regarding the correct usage of these two codes.

Q5004 should be used for hospice patients in a Skilled Nursing Facility (SNF), or in the SNF portion of a dually-certified nursing facility. There are four situations in which this would occur:

1. If the beneficiary is receiving hospice care in a solely-certified SNF;
2. If the beneficiary is receiving general inpatient care in the SNF;
3. If the beneficiary is in a SNF receiving SNF care under the Medicare SNF benefit for a condition unrelated to the terminal illness and related conditions, and is receiving hospice routine home care; this is uncommon; or
4. If the beneficiary is receiving inpatient respite care in a SNF.

If a beneficiary is in a nursing facility but doesn’t meet the criteria above for Q5004, the site should be coded as Q5003, for a long term care nursing facility.

**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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**MLN Matters® Number:** MM8879  
**Related Change Request (CR) #:** CR 8879  
**Related CR Release Date:** August 8, 2014  
**Effective Date:** October 1, 2014  
**Related CR Transmittal #:** R3018CP  
**Implementation Date:** October 6, 2014

**October 2014 Integrated Outpatient Code Editor (I/OCE) Specifications Version 15.3**

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 8879 informs MACs about the changes to the I/OCE instructions and specifications for the I/OCE that will be utilized under the Outpatient Prospective Payment System (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes.
Background

This instruction informs MACs and the Fiscal Intermediary Shared System (FISS) maintainer that the I/OCE is being updated for October 1, 2014. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, which eliminates the need to update, install, and maintain two separate OCE software packages on a quarterly basis.

The full list of I/OCE specifications is available at http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html on the Centers for Medicare & Medicaid Services (CMS) website. CR8879 includes an attachment with a summary of changes for October 2014 in Appendix N of the attachment with key changes for providers in the following table:

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2014</td>
<td>Modify the software to maintain 28 prior quarters (7 years) of programs in each release. Remove older versions with each release. (The earliest version date included in this October 2014 release is 1/1/2008).</td>
</tr>
<tr>
<td>01/01/2008</td>
<td>Add code 52630 to the male-only procedure list, retroactive to the earliest version of the program.</td>
</tr>
<tr>
<td>10/1/2014</td>
<td>Add logic for processing claims with bill type 77x that do not contain Condition Code 65 under new FQHC PPS logic (see page 10 and new Appendix L).</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2014</td>
<td>Add new values to the following output fields returned in the APC Return Buffer (see Table 7) in support of FQHC processing:</td>
</tr>
<tr>
<td></td>
<td>a) Payment Indicator:</td>
</tr>
<tr>
<td></td>
<td>10 – Paid FQHC encounter payment</td>
</tr>
<tr>
<td></td>
<td>11 – Not paid or not included under FQHC encounter payment</td>
</tr>
<tr>
<td></td>
<td>12 – No additional payment, included in payment for FQHC encounter</td>
</tr>
<tr>
<td></td>
<td>13 – Paid FQHC encounter payment for new patient or IPPE/AWV</td>
</tr>
<tr>
<td></td>
<td>b) Packaging Flag:</td>
</tr>
<tr>
<td></td>
<td>5 – Packaged as part of FQHC encounter payment</td>
</tr>
<tr>
<td></td>
<td>6 – Packaged preventive service as part of FQHC encounter payment, not subject to coinsurance payment</td>
</tr>
<tr>
<td></td>
<td>c) Payment Method Flag</td>
</tr>
<tr>
<td></td>
<td>5 – Payment for service determined under FQHC PPS</td>
</tr>
<tr>
<td></td>
<td>d) Line Item Action Flag</td>
</tr>
<tr>
<td></td>
<td>5 - Non-covered service excluded from payment under FQHC PPS</td>
</tr>
<tr>
<td></td>
<td>e) Composite Adjustment Flag</td>
</tr>
<tr>
<td></td>
<td>01 – FQHC medical clinic visit</td>
</tr>
<tr>
<td></td>
<td>02 – FQHC mental health clinic visit</td>
</tr>
<tr>
<td></td>
<td>03 – Subsequent FQHC clinic visit, medical or mental health (modifier 59 reported)</td>
</tr>
<tr>
<td></td>
<td>Note: The values defined above for Composite Adjustment flag are used only for FQHC claims with bill type 77x when CC 65 is not present.</td>
</tr>
<tr>
<td>10/1/2014</td>
<td>New edit 88 - FQHC payment code not reported for FQHC claim (RTP)</td>
</tr>
<tr>
<td></td>
<td>Criteria: FQHC payment code not reported for a claim with bill type 77x and without Condition Code 65</td>
</tr>
<tr>
<td></td>
<td>Note: If the bill type is 770 (No payment claim), edit 88 is not applicable.</td>
</tr>
<tr>
<td>10/1/2014</td>
<td>New edit 89 - FQHC claim lacks required qualifying visit code (RTP)</td>
</tr>
<tr>
<td></td>
<td>Criteria: FQHC payment code reported for FQHC claim (bill type is 77x without Condition Code 65) without a qualifying visit HCPCS.</td>
</tr>
</tbody>
</table>

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Effective Date | Modification
---|---
10/1/2014 | New edit 90 - Incorrect revenue code reported for FQHC payment code (RTP)  
Criteria: FQHC payment code not reported with revenue code 519, 52X or 900.

10/1/2014 | New edit 91 - Item or service not covered under FQHC PPS (LIR)  
Criteria: A service considered to be non-covered under FQHC PPS is reported.

10/1/2014 | Add edit 6 (Invalid procedure code) and edit 84 (Claim lacks required primary code) to the list of edits to be applied for FQHC PPS claims.

10/1/2014 | Update Appendix F(a) OCE Edits Applied by Bill Type table, to include a new row for edits applicable for FQHC (bill type 77x) effective 10/1/2014. Modified row10 to document the previous bill type 77x applicable versions.

10/1/2014 | Update Appendix E(a) Logic for Assigning Payment Method Flag Values to Status Indicators by Bill type to add new Payment Method Flag value of 5.

10/1/2014 | Make HCPCS/APC/SI changes as specified by CMS (data change files).

10/1/2014 | Implement version 20.3 of the NCCI (as modified for applicable institutional providers).

7/1/2014 | Updated skin substitute product list (Appendix O, List E) to move Q4137 from low cost to high cost (List A to List B).

10/1/2014 | Updated skin substitute product list (Appendix O, List E) to move Q4138 and Q4140 from low cost to high cost (List A to List B).

1/1/2012 | Remove the Deductible/CoInsurance N/A flag from HCPCS code G0448, which was erroneously flagged in the program, retroactively to 1/1/2012.

10/1/2014 | Add new Appendix L (FQHC Processing Logic and Flowchart) and rename OCE Overview to Appendix M, rename the Summary of Modifications to Appendix N, and rename the Code Lists to Appendix O.

10/1/2014 | Create 508-compliant versions of the specifications & Summary of Data Changes documents for publication on the CMS web site.

10/1/2014 | Deliver quarterly software update & all related documentation and files to users via electronic means.

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NEW product from the Medicare Learning Network® (MLN)
  • “Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 4]”, Educational Tool, ICN 909012, downloadable

MLN Matters® Number: MM8889  Related Change Request (CR) #: CR 8889
Related CR Release Date: August 22, 2014  Effective Date: October 1, 2014
Related CR Transmittal #: R3034CP  Implementation October 6, 2014

Update-Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS)
Fiscal Year (FY) 2015

Provider Types Affected

This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs) for services provided to inpatient Medicare beneficiaries and are paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS).

Provider Action Needed

Change Request (CR)8889 identifies changes that are required as part of the annual IPF PPS update from the Fiscal Year (FY) 2015 IPF PPS Final Rule displayed on August 1, 2014. These changes are applicable to IPF discharges occurring during the Fiscal Year October 1, 2014, through September 30, 2015. Make sure your billing staffs are aware of these IPF PPS changes for FY 2015.

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Background

The Centers for Medicare & Medicaid Services (CMS) published a final rule in the Federal Register on November 15, 2004, that established the IPF PPS under the Medicare program in accordance with provisions of the Medicare, Medicaid and SCHIP Balance Budget Refinement Act of 1999 (BBRA; Section 124 of Public Law 106-113).

Payments to IPFs under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (i.e., bad debts, and graduate medical education). CMS is required to make updates to this prospective payment system annually.

CR8889 identifies changes that are required as part of the annual IPF PPS update from the IPF PPS Fiscal Year (FY) 2015 Final Rule. These changes are applicable to IPF discharges occurring during the Fiscal Year (FY) October 1, 2014, through September 30, 2015.

Inpatient Psychiatric Facilities Quality Reporting Program (IPFQR)

Section 1886(s)(4) of the Social Security Act (The Act) requires the establishment of a quality data reporting program for the IPF PPS beginning in FY 2014. CMS finalized new requirements for quality reporting for IPFs in the “Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates” final rule (August 31, 2012) (77 FR 53258, 53644 through 53360). Section 1886(s)(4)(A)(i) of the Act requires that, for FY 2014 and each subsequent fiscal year, the Secretary of Health and Human Services shall reduce any annual update to a standard Federal rate for discharges occurring during the FY by 2 percentage points for any IPF that does not comply with the quality data submission requirements with respect to an applicable year. Therefore, CMS is applying a 2 percentage point reduction to the Federal per diem base rate and the Electroconvulsive Therapy (ECT) base rate as follows:

- For IPFs that fail to submit quality reporting data under the IPF Quality Reporting program, CMS is applying a 0.1 percent annual update (that is 2.1 percent reduced by two percentage points in accordance with section 1886(s)(4)(A)(ii) of the Act) and the wage index budget neutrality factor of 1.0002 to the FY 2014 Federal per diem base rate of $713.19, yielding a Federal per diem base rate of $714.05 for FY 2015.

- Similarly, CMS is applying the 0.1 percent annual update and the 1.0002 wage index budget neutrality factor to the FY 2014 Electroconvulsive Therapy (ECT) base rate of $307.04, yielding an ECT base rate of $307.41 for FY 2015.

Market Basket Update

For FY 2015, CMS used the FY 2008-based Rehabilitation, Psychiatric, and Long Term Care (RPL) market basket to update the IPF PPS payment rates (that is the Federal per diem and ECT base rates).
The Social Security Act (Section 1886(s)(2)(A)(ii); see http://www.ssa.gov/OP_Home/ssact/title18/1886.htm on the Internet), requires the application of an “Other Adjustment” that reduces any update to the IPF PPS base rate by percentages specified in the Social Security Act (Section 1886(s)(3)) for Rate Year (RY) beginning in 2010 through the FY beginning in 2019. For the FY beginning in 2014 (that is, FY 2015), the Act (Section 1886(s)(3)(B)) requires the reduction to be 0.3 percentage point. CMS is implementing that provision in the FY 2015 Final Rule.

In addition, the Act Section 1886(s)(2)(A)(i) requires the application of the Productivity Adjustment described in the Act (Section 1886(b)(3)(B)(xi)(II)) to the IPF PPS for the RY beginning in 2012 (that is, a RY that coincides with a FY), and each subsequent FY. For the FY beginning in 2014 (that is FY 2015), the reduction is 0.5 percentage point. CMS is implementing that provision in the FY 2015 Final Rule.

Specifically, CMS has updated - the IPF PPS base rate for FY 2015 by applying the adjusted market basket update of 2.1 percent (which includes the RPL market basket increase of 2.9 percent, an ACA required 0.3 percent reduction to the market basket update, and an ACA required productivity adjustment reduction of 0.5 percent) and the wage index budget neutrality factor of 1.0002 to the FY 2014 Federal per diem base rate of $713.19 yields a Federal per diem base rate of $728.31 for FY 2015. Similarly, applying the adjusted market basket update of 2.1 percent and the wage index budget neutrality factor of 1.0002 to the FY 2014 ECT rate of $307.04 yields an ECT rate of $313.55 for FY 2015.

**Pricer Updates for FY 2015**

- The Federal per diem base rate is $728.31;
- The Federal per diem base rate is $714.05 (when applying the Two Percentage Point Reduction.);
- The fixed dollar loss threshold amount is $8,755;
- The IPF PPS will use the FY 2014 unadjusted pre-floor, pre-reclassified hospital wage index;
- The labor-related share is 69.294 percent;
- The non-labor related share is 30.706 percent;
- The ECT rate is $313.55; and
- The ECT rate is $307.41 (when applying the Two Percentage Point Reduction).
Cost to Charge Ratio (CCR) for the IPF Prospective Payment System FY 2015

<table>
<thead>
<tr>
<th>Cost to Charge Ratio</th>
<th>Median</th>
<th>Ceiling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>0.4710</td>
<td>1.6582</td>
</tr>
<tr>
<td>Rural</td>
<td>0.6220</td>
<td>1.8590</td>
</tr>
</tbody>
</table>

CMS is applying the national CCRs to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, CMS is using these national ratios until the facility's actual CCR can be computed using the first tentatively settled or final settled cost report, which will then be used for the subsequent cost report period.
- The IPFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the MAC obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

**MS-DRG Update**

- The code set and adjustment factors are unchanged for IPF PPS FY 2015.

**FY 2014 Pre-floor, Pre-reclassified Hospital Wage Index**

- CMS is using the updated wage index and the wage index budget neutrality factor of 1.0002.

**COLA Adjustment for the IPF PPS FY 2015**

The Office of Personal Management (OPM) began transitioning from Cost of Living Adjustment (COLA) factors to a locality payment rate in FY 2010. The 2009 COLA factors were frozen in order to allow this transition. In the FY 2013 IPPS/LTCH final rule (77 FR 53700 through 53701), CMS established a new methodology to update the COLA factors for Alaska and Hawaii. In this FY 2015 IPF PPS update, CMS adopted this new COLA update methodology and is updating the COLA rates (as published in FY 2014 IPPS/LTCH final rule (78 FR 50986), using the new methodology). The COLAs for Alaska and Hawaii are shown in the following tables:
## Alaska

<table>
<thead>
<tr>
<th>Cost of Living Adjustment Factor</th>
<th>1.23</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Anchorage and 80-kilometer (50-mile) radius by road</td>
<td>1.23</td>
</tr>
<tr>
<td>City of Fairbanks and 80-kilometer (50-mile) radius by road</td>
<td>1.23</td>
</tr>
<tr>
<td>City of Juneau and 80-kilometer (50-mile) radius by road</td>
<td>1.23</td>
</tr>
<tr>
<td>Rest of Alaska</td>
<td>1.23</td>
</tr>
</tbody>
</table>

## Hawaii

<table>
<thead>
<tr>
<th>Cost of Living Adjustment Factor</th>
<th>1.25</th>
</tr>
</thead>
<tbody>
<tr>
<td>City and County of Honolulu</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Hawaii</td>
<td>1.19</td>
</tr>
<tr>
<td>County of Kauai</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Maui and County of Kalawao</td>
<td>1.25</td>
</tr>
</tbody>
</table>

### 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.

### Disclaimer

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Revised products from the Medicare Learning Network® (MLN)

- “ICD-10-CM/PCS Myths and Facts”, Fact Sheet, ICN 902143, downloadable.

**MLN Matters® Number: SE1325 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**

**Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims that Span the International Classification of Diseases, 10th Edition (ICD-10) Implementation Date**

**Note:** This article was revised on August 4, 2014, to reflect the new ICD-10 implementation date of October 1, 2015. Other adjustments required for that new date have been made.

**Provider Types Affected**

This Special Edition Article is intended for providers who submit claims to Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

**Provider Action Needed**

SE1325 clarifies the policy for processing claims for certain institutional encounters that span the International Classification of Diseases, 10th Edition (ICD-10) implementation date of October 1, 2015.

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Background

In this Special Edition article, the Centers for Medicare & Medicaid Services (CMS) clarifies the policy for processing split claims for certain institutional encounters that span the ICD-10 implementation date (that is, when ICD-9 codes are effective for that portion of the services rendered on September 30, 2015, and earlier, and when ICD-10 codes are effective for that portion of the services rendered on October 1, 2015, and later)

The following excerpt from a table in MLN Matters® Article SE1408 provides you further guidance for such split claims. (You can find this article at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf) on the CMS website.)

<table>
<thead>
<tr>
<th>Bill Type</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>12X</td>
<td>Inpatient Part B Hospital Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>13X</td>
<td>Outpatient Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>14X</td>
<td>Non-patient Laboratory Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>Bill Type</td>
<td>Facility Type/Services</td>
<td>Claims Processing Requirement</td>
<td>Use FROM or THROUGH Date</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------</td>
<td>-------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>22X</td>
<td>Skilled Nursing Facilities (Inpatient Part B)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>23X</td>
<td>Skilled Nursing Facilities (Outpatient)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>34X</td>
<td>Home Health – (Outpatient)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>71X</td>
<td>Rural Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>72X</td>
<td>End Stage Renal Disease (ESRD)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Bill Type</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>74X</td>
<td>Outpatient Therapy</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>75X</td>
<td>Comprehensive Outpatient Rehab facilities</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>76X</td>
<td>Community Mental Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>77X</td>
<td>Federally Qualified Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>81X</td>
<td>Hospice- Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
</tbody>
</table>
### Important Details

1. Please note that creating multiple/interim claims on a single encounter is not a new concept, and that these instructions will apply to relatively few claims per institution because only claims that span this single implementation date (October 1, 2015) will be impacted.

2. When you split claims for an encounter spanning the ICD-10 implementation date, remember to maintain all charges with the same Line Item Date of Service (LIDOS) on the correct corresponding claim for the encounter.

   - Single item services whose time-frame cross over midnight on September 30, 2015 (e.g., Emergency Room Visits and Observation), **are not split into 2 separate charges**, rather the single item service should be placed in the claim based upon the LIDOS: 1) For ER encounters the LIDOS is the date the patient enters the ER; and 2) for observation encounters it is the date that observation care begins.

      (Please refer to the "Medicare Claims Processing Manual", Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Sections 180.6 Emergency Room (ER) Services That Span Multiple Service Dates and 290.2.2 (Reporting Hours of Observation for observation services); respectively, for more information about Emergency Department and observation claims. You can find this manual at [http://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/clm104c04.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/clm104c04.pdf) on the CMS website.)

<table>
<thead>
<tr>
<th>Bill Type</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>82X</td>
<td>Hospice – Non hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>85X</td>
<td>Critical Access Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
</tbody>
</table>

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• If there is no service for the encounter with a LIDOS on the split claim with an October 2015 date, do not send an October 2015 claim to Medicare for payment.

• If there are services with a LIDOS on the split claim with an October date, but there is no payment allowed on any of the charges (i.e., all charges are packaged), you should maintain a log of these charges for cost reporting purposes.

Claim Examples
Emergency Department and Observation Service encounters are the most common scenarios for which CMS has received requests for clarification about interim billing. The following ED and Observation Service examples are provided to help you better understand the split billing concept. This concept can be applied to any of the encounters that require split billing.
Example 1A: ED Visit Encounter – 1st Claim

<table>
<thead>
<tr>
<th>Claim</th>
<th>Description</th>
<th>HCPCS/RATES/HPPS Code</th>
<th>Serv. Date</th>
<th>Serv. Units</th>
<th>Total Charges</th>
<th>Non-Covered Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>09302015</td>
<td>3</td>
<td>50 00</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td>09302015</td>
<td>3</td>
<td>100 00</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>09302015</td>
<td>1</td>
<td>225 00</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>09302015</td>
<td>1</td>
<td>750 00</td>
<td></td>
</tr>
</tbody>
</table>

Note: On this straddle claim, you would put all the charges from this emergency department encounter with a line item date of service (LIDOS) that occurred with a September date. ICD-9 codes (shown in yellow below) would be displayed on this portion of the claim from the E.D. encounter. Any charge from this encounter with a line item date of service that occurred in October would go on a separate claim that would display ICD-10 codes.

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Example 1B: ED Visit Encounter – 2nd Claim

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>PATIENT ADDRESS</th>
<th>BIRTHDATE</th>
<th>SEX</th>
<th>D</th>
<th>STAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICARE SMITH</td>
<td>abcde</td>
<td>10012015</td>
<td>01</td>
<td>01</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>HCPCS/RATES/HPPS CODE</th>
<th>SERV. DATE</th>
<th>SERV. UNITS</th>
<th>TOTAL CHARGES</th>
<th>NON-COVERED CHARGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>0250</td>
<td>3</td>
<td>10012015</td>
<td>3</td>
<td>75 00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0270</td>
<td>1</td>
<td>10012015</td>
<td>1</td>
<td>50 00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0450</td>
<td>12001</td>
<td>10012015</td>
<td>1</td>
<td>350 00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

On this straddle claim, you would put all the charges from this emergency department encounter with a line item date of service (LIDOS) that occurred with an October date. ICD-10 codes (shown in yellow below) would be displayed on this portion of the claim from the E.D. encounter. Any charge from this encounter with a line item date of service that occurred in September would go on a separate claim that would display ICD-9 codes.

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### Example 2A: Observation Encounter – 1\textsuperscript{st} Claim

| 0250 | 96361 | 09302015 | 3 | 250.00 |
| 0260 | 96362 | 09302015 | 1 | 50.00  |
| 0270 | 71919 | 09302015 | 1 | 100.00 |
| 0324 | 96360 | 09302015 | 1 | 225.00 |
| 0450 | 99284 | 09302015 | 1 | 800.00 |
| 0762 | 00378 | 09302015 | 10 | 500.00 |

ON THIS STRADDLE CLAIM, YOU WOULD PUT ALL THE CHARGES FROM THIS OBSERVATION ENCOUNTER WITH A LINE ITEM DATE OF SERVICE (LIDOS) THAT OCCURRED WITH A SEPTEMBER DATE. ICD-9 CODES (SHOWN IN YELLOW BELOW) WOULD BE DISPLAYED ON THIS PORTION OF THE CLAIM FROM THE OBV. ENCOUNTER. ANY CHARGE FROM THIS ENCOUNTER WITH A LINE ITEM DATE OF SERVICE THAT OCCURRED IN OCTOBER WOULD GO ON A SEPARATE CLAIM THAT WOULD DISPLAY ICD-10 CODES.

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Example 2B Observation Encounter – 2nd Claim

<table>
<thead>
<tr>
<th>Description</th>
<th>0250</th>
<th>0260</th>
<th>0324</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10012015</td>
<td>10012015</td>
<td>10012015</td>
</tr>
<tr>
<td></td>
<td>900.00</td>
<td>900.00</td>
<td>184.00</td>
</tr>
</tbody>
</table>

---

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Please remember to follow the ICD-9-CM and ICD-10-CM Official Coding Guidelines (covering both inpatient and outpatient guidelines), which you can find on the Internet at http://www.cdc.gov/nchs/icd/icd9cm.htm#addenda and http://www.cdc.gov/nchs/icd/icd10cm.htm, respectively.

When coding an encounter that straddles implementation, you should use an ICD-9 code on the September interim claim for the encounter and a corresponding ICD-10 code on the October interim claim for the encounter. You can learn more about the mapping of these codes in the Diagnosis Code Set General Equivalence Mappings, ICD-10-CM to ICD-9-CM and ICD-9-CM to ICD-10-CM, which is available at http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html on the CMS website.

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.

Note: This article was revised on August 1, 2014, to show the new ICD-10 implementation date of October 1, 2015. All other information is unchanged.

Provider Types Affected

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

Provider Action Needed

This MLN Matters® Special Edition (SE) 1410 alerts providers that on October 1, 2015, all Medicare claims submissions of diagnosis codes will change from the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) to the 10th Edition (ICD-10-CM). All entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must make this transition requiring systems changes throughout the entire health care industry.
# Background

In 2011, the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7492, which provided information on reporting guidelines and claims submissions requirements for ICD-10-CM. Particularly, CR 7492 provided instructions regarding claims with service dates that span the ICD-10 effective date. Recently, CMS issued an updated article (SE1408) at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf), which provides special billing instructions for home health agencies (HHAs) to apply to HH claims where the episode begins in August or September 2015 and ends in October 2015. MLN Matters® Article SE1408 also provides details for coding other types of claims for services that span the ICD-10 implementation date of October 1, 2015. This article provides further details regarding HH claims for episodes that span the October 1 date.

# Key Points of This Article

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

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

## Episodes Starting Before October 1, 2015, with OASIS Completion Dates Before October 1, 2015

In the case of initial HH episodes, the OASIS assessment must be completed within 5 days of the start of care. The assessment completion date (M0090 date) determines whether the HH Grouper software that determines the payment group for the episode will apply ICD-9-CM or ICD-10-CM codes to the episode. In the case where the episode start of care date is before October 1, 2015 and the M0090 date is also before October 1, 2015, ICD-9-CM codes will be used on the OASIS and to determine the payment group code (the Health Insurance Prospective Payment System (HIPPS) code).

For HH claims (type of bill 032x), ICD-10-CM reporting is required based on the claim “Through” date. On Requests for Anticipated Payment (RAPs), Medicare billing instructions require that the “From” and “Through” dates are the same. So if the episode begins in September 2015, the “From” and “Through” dates on the RAP would report the same date in September. These RAPs would report ICD-9-CM diagnosis codes using codes matching the OASIS assessment.

If the HH episode spans into October 2015, the corresponding final claim for the episode will be required to report ICD-10-CM codes. HH claims cannot be split into periods before and after October 1, 2015, so these claims will have claim “Through” dates of October 1,
2015, or later. The HIPPS code on the final claim must match the HIPPS code that was reported on the RAP. The HIPPS code on the RAP was based on the ICD-9-CM codes matching the OASIS assessment.

CR 7492 stated that CMS will:

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

This means that HHAs do not have to re-group the episode based the ICD-10-CM codes. But this could result in some inconsistency between the HIPPS code and the ICD-10-CM codes on the claim. CMS will alert medical reviewers at our MACs to ensure that the ICD-10-CM codes on these claims are not used in making determinations. CMS will also alert researchers using CMS data files of this inconsistency. The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes that were used on the RAP and which are stored in the OASIS system.

These same procedures will apply to resumption of care assessments (M0100 = 03) and to recertification (M0100 = 04) and follow-up (M0100 = 05) assessments when the episode start date and the M0090 date on those assessments are both before October 1, 2015 but the episode ends in October 2015 (see table below).

**Episodes Starting Before October 1, 2015, with OASIS Completion Dates in October 2015**

There may be cases where the episode start of care date is before October 1, 2015, and, due to the 5 day completion window, the M0090 date is in October 2015. For example, an initial episode with a start of care date of September 28, 2015, could have an M0090 date of October 2, 2015. In these cases, ICD-10-CM codes will be used on the OASIS and to determine the HIPPS code.

The RAP for this example would have “From” and “Through” dates of September 28, 2015. As a result, these RAPs would need to report ICD-9-CM diagnosis codes even though ICD-10-CM codes were used on the OASIS assessment.

Since RAPs are not subject to medical review and are replaced in Medicare claims history by the final claim, there is no need to account for adverse impacts in these situations. The ICD-9-CM codes are required in order for the RAP to be processed. The corresponding final claim for the episode will report ICD-10-CM codes matching the OASIS assessment.

**Recertification Episodes Beginning in the First Days of October 2015**

In the case of recertification episodes, the M0090 date can be up to 5 days earlier than the episode start date. So, a recertification episode starting on October 2, 2015, could have an M0090 date of September 28, 2015. ICD-9-CM codes are used on the OASIS assessment and will be used to determine the HIPPS code. But in this case, both the RAP and claim will require ICD-10-CM codes since the “Through” date on both will be after October 1, 2015.
The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes which are stored in the OASIS system. In these cases also, CMS will alert medical reviewers at our MACs and researchers using CMS data files to prevent adverse impacts.

The following table summarizes the above scenarios:

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

**Additional Information**


The ICD-10-related implementation date is now October 1, 2015.

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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Scenarios and Coding Instructions for Submitting Requests to Reopen Claims that are Beyond the Claim Filing Timeframes – Companion Information to MM8581: “Automation of the Request for Reopening Claims Process”

Provider Types Affected

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

Provider Action Needed

This article is intended to provide additional information, coding instructions and scenarios for requesting a reopening of a claim that is beyond the filing timeframe. It is a companion article to MLN Matters® Article MM8581 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8581.pdf). MM8581 is based on Change Request (CR) 8581 which informs A MACs about changes that will allow providers and their vendors to electronically request reopening claims. Make sure your billing staffs are aware of these changes.
Background

When a provider needs to correct or supplement a claim, and the claim remains within timely filing limits, providers may submit an adjustment claim to remedy the error. When the need for a correction is discovered beyond the claims timely filing limit, an adjustment bill is not allowed and a provider must utilize the reopening process to remedy the error.

Generally, reopenings are written requests for corrections that include supporting documentation. However, a standard process across all A/MACs has not been available. In an effort to streamline and standardize the process for providers to request reopenings, CMS petitioned the National Uniform Billing Committee (NUBC) for a “new” bill type frequency code to be used by providers indicating a Request for Reopening and a series of Condition Codes that can be utilized to identify the type of Reopening being requested. These institutional reopenings must be submitted with a “Q” frequency code to identify them as a Reopening. The NUBC adopted these new codes and bill type frequency change effective with claims received on or after January 1, 2015.

A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are different from adjustment bills in that adjustment bills are subject to normal claims processing timely filing requirements (i.e., filed within one year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (e.g., claim determinations may be reopened within one year of the date of receipt of the initial determination for any reason, or within one to four years of the date of receipt of the initial determination upon a showing of good cause).

Reopenings are also separate and distinct from the appeals process. A reopening will not be granted if an appeal decision is pending or in process.

Decisions to allow reopenings are discretionary actions on the part of your A/MAC. An A/MAC’s decision to reopen a claim determination or refusal to reopen a claim determination, is not an initial determination and is therefore not appealable. Requesting a reopening does not guarantee that request will be accepted and the claim determination will be revised, and does not extend the timeframe to request an appeal. If an A/MAC decides not to reopen an initial determination, the A/MAC will Return To Provider (RTP) the reopening request indicating that the A/MAC is not allowing this discretionary action. In this situation, the original initial determination stands as a binding decision, and appeal rights are retained on the original initial determination. New appeal rights are not triggered by the refusal to reopen, and appeal filing timeframes on the original initial determination are not extended following a contractor’s refusal to reopen. However, when an A/MAC reopens and revises an initial determination, that revised determination is a new determination with new appeal rights.

Providers are reminded that submission of adjustment bills or reopening requests in response to claim denials resulting from review of medical records (including failure to
submit medical records in response to a request for records) is not appropriate. Providers must submit appeal requests for such denials.

Additionally, many A/MACs allow reopenings to be submitted hardcopy (by mail or fax) or through a provider online portal. The creation of this new process does not eliminate or negate those processes. Contact your MAC about other ways reopenings may be submitted.

**Additional Information**


To assist providers with claims coding a request for reopening, the following attachment was prepared with condition codes that may be used and scenarios using Adjustment Reason Codes, R1, R2 and R3.
Attachment

Coding Requirements

(1) Type of Bill xxxQ

(2) An applicable Condition Code R1-R9

- R1=Mathematical or computational mistake
- R2=Inaccurate data entry
- R3=Misapplication of a fee schedule
- R4=Computer Errors
- R5=Incorrectly Identified Duplicate
- R6=Other Clerical Error or Minor Error or Omission (Failure to bill for services is not considered a minor error)
- R7=Correction other than Clerical Error
- R8=New and material evidence is available
- R9=Faulty evidence (Initial determination was based on faulty evidence)

(3) A Condition Code to identify what was changed (if appropriate):

- D0=Changes in service date
- D1=Changes to charges
- D2=Changes in Revenue Code/HCPCS/HIPPS Rate Codes
- D4=Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes
- D9=Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, Provider ID, Modifiers and other changes
- E0=Change in patient status

(4) A Condition Code W2=Attestation that there is no Appeal in Process

(5) For DDE claims only) An Adjustment Reason Code on page

- R1 = < 1 yr Initial Determination
- R2 = 1-4 yr Initial Determination
- R3 = > 4 yr Initial Determination

(6) Reopenings that require “Good Cause” to be documented must have a Remark/Note from the provider. Remarks/notes should be formatted as shown below without the parenthetical explanation (this is not an exhaustive list) and a narrative explanation after the word “because”. If the change or addition affects a line item (shown as bold) instead of a claim item, please indicate which lines are being changed in the remark/note. The first fifteen (15) characters of the remark/note must match exactly as shown below.

GOOD CAUSE: C/A CC (CHANGED OR ADDED CONDITION CODE) BECAUSE…
GOOD CAUSE: C/A OC (CHANGED OR ADDED OCCURRENCE CODE) BECAUSE…
GOOD CAUSE: C/A OSC (CHANGED OR ADDED OCCURRENCE SPAN CODE) BECAUSE…
GOOD CAUSE: C/A VC (CHANGED OR ADDED VALUE CODE) BECAUSE…
GOOD CAUSE: C/A DX (CHANGED OR ADDED DIAGNOSIS CODE) BECAUSE…
GOOD CAUSE: C/A MOD (CHANGED OR ADDED MODIFIER) BECAUSE…
GOOD CAUSE: C/A PX (CHANGED OR ADDED PROCEDURE CODE) BECAUSE…
GOOD CAUSE: C/A LIDOS (CHANGED OR ADDED LINE ITEM DATES OF SERVICE) BECAUSE…
GOOD CAUSE: C/A PSC (CHANGED OR ADDED PATIENT STATUS CODE) BECAUSE…
GOOD CAUSE: C/A HCPCS
GOOD CAUSE: C/A HIPPS
GOOD CAUSE: C/A OTHER BECAUSE…
GOOD CAUSE: NME (NEW AND MATERIAL EVIDENCE) BECAUSE…
GOOD CAUSE: F/E (FAULTY EVIDENCE) BECAUSE…

(7) To assist in quickly processing a reopening, any reopening request that contains changes or additions from the original claim should contain a remark/note explaining what has been changed. If the change or addition affects a line item instead of a claim item, please indicate which lines are being changed in the remark/note.
Reopening Request Scenarios (Examples are not all-inclusive)

**Scenario A - Adjustment Reason Code R1**

**Claim 1:** Clerical Error – Minor Error – New Pricer/New Fee-Scheduled, Revised MCE, Revised IOCE, Revised NCD edits, Revised MUE edits

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<td>Adjustment Condition Code</td>
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<tr>
<td>Adjustment Reason Code</td>
<td>R1</td>
</tr>
<tr>
<td>Remarks – (Good Cause)</td>
<td>Not Required</td>
</tr>
</tbody>
</table>

**Claim 2:** Clerical Error – Minor Error – Keying Error

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<td></td>
<td>D2</td>
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<td>D4</td>
</tr>
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<td></td>
<td>D9</td>
</tr>
<tr>
<td></td>
<td>E0</td>
</tr>
<tr>
<td>Adjustment Reason Code</td>
<td>R1</td>
</tr>
<tr>
<td>Remarks – (Good Cause)</td>
<td>Not Required</td>
</tr>
</tbody>
</table>
**Claim 3:** Clerical Error – Minor Error – Wrong Locality or Wrong payment system used to Price the claim (Claim paid using the wrong locality or the locality wasn’t loaded; or claim paid at CLFS and should have been paid cost or OPPS) Provider file not set up correctly.

<table>
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<tr>
<th>TOB</th>
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<th>Misapplication of a fee schedule</th>
</tr>
</thead>
<tbody>
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<td>Misapplication of a fee schedule</td>
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<td>Adjustment Condition Code</td>
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<td>Other</td>
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<tr>
<td>Adjustment Reason Code</td>
<td>R1</td>
<td>&lt; 1 yr Initial Determination</td>
</tr>
<tr>
<td>Remarks – (Good Cause)</td>
<td>Not Required</td>
<td>May be added to provide additional information for claims processing.</td>
</tr>
</tbody>
</table>

**Claim 4:** Clerical Error – Minor Error – (i.e., Provider had wrong code or units hardcoded/loaded in their charge master or billing software)

<table>
<thead>
<tr>
<th>TOB</th>
<th>xxxQ</th>
<th>Computer errors</th>
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<tbody>
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<td>Computer errors</td>
</tr>
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<td>Adjustment Condition Code</td>
<td>D1</td>
<td>Changes to charges</td>
</tr>
<tr>
<td></td>
<td>D2</td>
<td>Changes in Revenue Code/HCPCS/HIPPS Rate Codes</td>
</tr>
<tr>
<td></td>
<td>D4</td>
<td>Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes</td>
</tr>
<tr>
<td></td>
<td>D9</td>
<td>Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers</td>
</tr>
<tr>
<td></td>
<td>E0</td>
<td>Change in patient status</td>
</tr>
<tr>
<td>Adjustment Reason Code</td>
<td>R1</td>
<td>&lt; 1 yr Initial Determination</td>
</tr>
<tr>
<td>Remarks – (Good Cause)</td>
<td>Not Required</td>
<td>May be added to provide additional information for claims processing.</td>
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</tbody>
</table>

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**Claim 5: Clerical Error – Minor Error – Incorrectly Identified Duplicate**

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<th>TOB</th>
<th>xxxQ</th>
<th><strong>Incorrectly Identified Duplicate</strong></th>
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</thead>
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<td>Incorrectly Identified Duplicate</td>
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<td>D9</td>
<td>Other</td>
</tr>
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<td>Adjustment Reason Code</td>
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<td>&lt; 1 yr Initial Determination</td>
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<td>Remarks – (Good Cause)</td>
<td>Not Required</td>
<td>May be added to provide additional information for claims processing.</td>
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</table>

**Claim 6a: Other Clerical Errors – Minor Errors – Coding Error (i.e., Incorrect data items such as discharge status, modifier or date of service.)**

<table>
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<th>TOB</th>
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<th><strong>Incorrect data entry (used wrong code completely)</strong></th>
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</thead>
<tbody>
<tr>
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<td>Incorrect data entry (used wrong code completely)</td>
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<td>Changes in service date</td>
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<tr>
<td></td>
<td>D1</td>
<td>Changes to charges</td>
</tr>
<tr>
<td></td>
<td>D2</td>
<td>Changes in Revenue Code/HCPCS/HIPPS Rate Codes</td>
</tr>
<tr>
<td></td>
<td>D4</td>
<td>Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes</td>
</tr>
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<td></td>
<td>D9</td>
<td>Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers</td>
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<tr>
<td></td>
<td>E0</td>
<td>Change in patient status</td>
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<td>Adjustment Reason Code</td>
<td>R1</td>
<td>&lt; 1 yr Initial Determination</td>
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<td>Remarks – (Good Cause)</td>
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<td>May be added to provide additional information for claims processing.</td>
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</table>
**Claim 6b:** Other Clerical Errors – Omissions (i.e., Incorrect data items such as modifier or clinical information.)

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<th><strong>Incorrect data entry (left off the code from billing)</strong></th>
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<tbody>
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<td>Reopening Condition Code</td>
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<td>Changes in Revenue Code/HCPCS/HIPPS Rate Codes</td>
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<td>D4</td>
<td>Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes</td>
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<td></td>
<td>D9</td>
<td>Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers</td>
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<tr>
<td>Adjustment Reason Code</td>
<td>R1</td>
<td>&lt; 1 yr Initial Determination</td>
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<tr>
<td>Remarks – (Good Cause)</td>
<td>Not Required</td>
<td>May be added to provide additional information for claims processing.</td>
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**Claim 7:** Corrections Other than Clerical Errors – Computer System Omissions (i.e., Off-site provider zip code, condition code, Occurrence Code, Occurrence Span Code, Value Code, Modifier)

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<thead>
<tr>
<th>TOB</th>
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<th><strong>Computer System Omission</strong></th>
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<td>Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, Value Codes or Modifiers</td>
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<td>Remarks – (Good Cause)</td>
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Claim 8: Corrections Other than Clerical Errors – New and Material Evidence (subsequent test results, new documentation has become available since the initial determination)

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Claim 9: Corrections Other than Clerical Errors – Faulty Evidence

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Scenario B - Adjustment Reason Code R2

**Claim 1:** Clerical Error – Minor Error – New Pricer/New Fee-Scheduled, Revised MCE, Revised IOCE, Revised NCD edits, Revised MUE edits

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**Claim 2:** Clerical Error – Minor Error – Keying Error

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<td>E0</td>
</tr>
<tr>
<td>Adjustment Reason Code</td>
<td>R2</td>
</tr>
<tr>
<td>Remarks – (Good Cause)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Claim 3:** Clerical Error – Minor Error – Wrong Locality or Wrong payment system used to Price the claim (Claim paid using the wrong locality or the locality wasn’t loaded; or claim paid at CLFS and should have been paid cost or OPPS) Provider file not set up correctly.

<table>
<thead>
<tr>
<th>TOB</th>
<th>xxxQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reopening Condition Code</td>
<td>R3</td>
</tr>
<tr>
<td>Adjustment Condition Code</td>
<td>D9</td>
</tr>
<tr>
<td>Adjustment Reason Code</td>
<td>R2</td>
</tr>
<tr>
<td>Remarks – (Good Cause)</td>
<td>Yes</td>
</tr>
</tbody>
</table>
**Claim 4:** Clerical Error – Minor Error – (i.e., Provider had wrong code or units hardcoded/loaded in their charge master or billing software)

<table>
<thead>
<tr>
<th>TOB</th>
<th>xxxQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reopening Condition Code</td>
<td>R4</td>
</tr>
<tr>
<td><strong>Computer errors</strong></td>
<td></td>
</tr>
<tr>
<td>Adjustment Condition Code</td>
<td>D1</td>
</tr>
<tr>
<td>Changes to charges</td>
<td></td>
</tr>
<tr>
<td>D2</td>
<td></td>
</tr>
<tr>
<td>Changes in Revenue Code/HCPCS/HIPPS Rate Codes</td>
<td></td>
</tr>
<tr>
<td>D4</td>
<td></td>
</tr>
<tr>
<td>Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes</td>
<td></td>
</tr>
<tr>
<td>D9</td>
<td></td>
</tr>
<tr>
<td>Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers</td>
<td></td>
</tr>
<tr>
<td>E0</td>
<td></td>
</tr>
<tr>
<td>Change in patient status</td>
<td></td>
</tr>
</tbody>
</table>

| Adjustment Reason Code | R2   |
| Remark – (Good Cause)  | Yes  |
| 1 -4 yrs from Initial Determination |      |

**Claim 5:** Clerical Error – Minor Error – Incorrectly Identified Duplicate

<table>
<thead>
<tr>
<th>TOB</th>
<th>xxxQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reopening Condition Code</td>
<td>R5</td>
</tr>
<tr>
<td><strong>Incorrectly Identified Duplicate</strong></td>
<td></td>
</tr>
<tr>
<td>Adjustment Condition Code</td>
<td>D9</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Adjustment Reason Code</td>
<td>R2</td>
</tr>
<tr>
<td>1 -4 yrs from Initial Determination</td>
<td></td>
</tr>
<tr>
<td>Remarks – (Good Cause)</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Claim 6a: Other Clerical Errors – Minor Errors – Coding Error (i.e., Incorrect data items such as discharge status, modifier or date of service.)

<table>
<thead>
<tr>
<th>TOB</th>
<th>xxxQ</th>
<th>Reopening Condition Code</th>
<th>Adjustment Condition Code</th>
<th>Remarks – (Good Cause)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>R6</td>
<td>D0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>D1</td>
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<tr>
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<td></td>
<td>D2</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>D4</td>
<td></td>
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<tr>
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<td></td>
<td></td>
<td>D9</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>E0</td>
<td></td>
</tr>
</tbody>
</table>

- Incorrect data entry (used wrong code completely)
- Changes in service date
- Changes to charges
- Changes in Revenue Code/HCPCS/HIPPS Rate Codes
- Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes
- Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers
- Change in patient status

<table>
<thead>
<tr>
<th>Adjustment Reason Code</th>
<th>Remarks – (Good Cause)</th>
</tr>
</thead>
<tbody>
<tr>
<td>R2</td>
<td>1 -4 yrs from Initial Determination</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Claim 6b: Other Clerical Errors – Omissions (i.e., Incorrect data items such as modifier or clinical information.)

<table>
<thead>
<tr>
<th>TOB</th>
<th>xxxQ</th>
<th>Reopening Condition Code</th>
<th>Adjustment Condition Code</th>
<th>Remarks – (Good Cause)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>R6</td>
<td>D2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>D4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>D9</td>
<td></td>
</tr>
</tbody>
</table>

- Incorrect data entry (left off the code from billing)
- Changes in Revenue Code/HCPCS/HIPPS Rate Codes
- Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes
- Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers

<table>
<thead>
<tr>
<th>Adjustment Reason Code</th>
<th>Remarks – (Good Cause)</th>
</tr>
</thead>
<tbody>
<tr>
<td>R2</td>
<td>1 -4 yrs from Initial Determination</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>
**Claim 7:** Corrections Other than Clerical Errors – Computer System Omissions (i.e., Off-site provider zip code, condition code, Occurrence Code, Occurrence Span Code, Value Code, Modifier)

<table>
<thead>
<tr>
<th>TOB</th>
<th>xxxQ</th>
<th>Reopening Condition Code</th>
<th>Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>R7</td>
<td><strong>Computer System Omission</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Changes in Revenue Code/HCPCS/HIPPS Rate Codes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, Value Codes or Modifiers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D2</td>
<td>Changes in Revenue Code/HCPCS/HIPPS Rate Codes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D4</td>
<td>Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D9</td>
<td>Changes in Revenue Code/HCPCS/HIPPS Rate Codes</td>
</tr>
<tr>
<td></td>
<td>Remarks – (Good Cause)</td>
<td>R2</td>
<td>1 -4 yrs from Initial Determination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
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</table>

**Claim 8:** Corrections Other than Clerical Errors – New and Material Evidence (subsequent test results, new documentation has become available since the initial determination)

<table>
<thead>
<tr>
<th>TOB</th>
<th>xxxQ</th>
<th>Reopening Condition Code</th>
<th>Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>R8</td>
<td><strong>New and Material Evidence</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Remarks – (Good Cause)</td>
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<td>1 -4 yrs from Initial Determination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

**Claim 9:** Corrections Other than Clerical Errors – Faulty Evidence

<table>
<thead>
<tr>
<th>TOB</th>
<th>xxxQ</th>
<th>Reopening Condition Code</th>
<th>Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>R9</td>
<td><strong>Faulty Evidence</strong></td>
</tr>
<tr>
<td></td>
<td>Remarks – (Good Cause)</td>
<td>R2</td>
<td>1 -4 yrs from Initial Determination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

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### Scenario C - Adjustment Reason Code R3

#### Claim 1: Corrections Other than Clerical Errors – New and Material Evidence (subsequent test results, new documentation has become available since the initial determination)

<table>
<thead>
<tr>
<th>TOB</th>
<th>xxxQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reopening Condition Code</td>
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</tr>
<tr>
<td>Adjustment Condition Code</td>
<td>D9</td>
</tr>
<tr>
<td>Adjustment Reason Code</td>
<td>R3</td>
</tr>
<tr>
<td>Remarks – (Good Cause)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

#### Claim 2: Corrections Other than Clerical Errors – Faulty Evidence

<table>
<thead>
<tr>
<th>TOB</th>
<th>xxxQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reopening Condition Code</td>
<td>R9</td>
</tr>
<tr>
<td>Adjustment Condition Code</td>
<td>D9</td>
</tr>
<tr>
<td>Adjustment Reason Code</td>
<td>R3</td>
</tr>
<tr>
<td>Remarks – (Good Cause)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

---

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Centers for Medicare & Medicaid Services
Articles for Part B Providers
REVISED products from the MLN
• “Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services,” Fact Sheet, ICN 904084, Downloadable only.

MLN Matters® Number: MM8781
Related Change Request (CR) #: CR 8781
Related CR Release Date: August 22, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3044CP
Implementation Date: January 5, 2015

Quarterly Update to the Correct Coding Initiative (CCI) Edits, Version 21.0, Effective January 1, 2015

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) 8781, which informs MACs about the release of the latest package of CCI edits, Version 21.0, which will be effective January 1, 2015. Make sure that your billing staffs are aware of these changes.

Background
The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims. The coding policies developed are based on coding conventions defined in the American Medical Association’s Current Procedural Terminology manual, national and local policies and edits, coding
guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

The latest package of NCCI edits, Version 21.0, effective January 1, 2015, will soon be available to MACs via the CMS Data Center (CDC). A test file will be available to them on or about November 2, 2014, and a final file will be available to them on or about November 17, 2014.

Version 21.0 will include all previous versions and updates from January 1, 1996, to the present. In the past, NCCI was organized in two tables: Column 1/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two Correct Coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for OCE. It will only be necessary to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits. CMS no longer publishes a Mutually Exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single Column One/Column Two Correct Coding edit file on each website. The edits previously contained in the Mutually Exclusive edit file are NOT being deleted but are being moved to the Column One/Column Two Correct Coding edit file. Refer to the CMS NCCI webpage for additional information at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html on the CMS website.

**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.
Reporting the Service Location National Provider Identifier (NPI) on Anti-Markup and Reference Laboratory Claims

Provider Types Affected

This MLN Matters® Article is intended for physicians 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) 8806, which provides guidance for physicians and suppliers billing anti-markup and reference laboratory claims. Effective for anti-markup and reference laboratory claims submitted with dates of service on and after January 1, 2015, billing physicians and suppliers are required to report the name, address, ZIP code, and the National Provider Identifier (NPI) of the performing physician or supplier when the performing physician or supplier is enrolled in a different contractor’s jurisdiction. Make sure your billing staffs are aware of this update.
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all covered health care entities follow the same standard for submitting and processing electronic claims transactions. According to the instructions for use of the American National Standards Institute (ANSI) X12 837 professional electronic claim transaction, suppliers must submit the NPI that matches the name and address of the servicing provider/supplier identified on the claim.

On anti-markup and reference laboratory claims, physicians and other suppliers are required to identify the supplier's name, address, and ZIP code in Item 32 of the CMS-1500 claim, or the corresponding loop and segment of the ANSI X12 837 professional electronic claim format. The NPI of the physician or supplier who actually performed the service is required in Item 32a of the CMS-1500 claim form or the corresponding loop and segment of the ANSI X12 837 professional electronic claim transaction.

However, prior to the implementation of the Provider Enrollment, Chain, and Ownership System (PECOS), MACs used systems that were specific to each MAC and did not allow MACs from one State to view provider enrollment information from another State. This systems limitation prevented MACs from being able to share information about existing providers/suppliers, and increased the potential for fraud. As a result, physicians and suppliers that were enrolled in another MAC’s jurisdiction could not validate the NPI in Item 32a of the CMS-1500 claim form or on the ANSI X12 837 professional electronic claim format, because the function was not available in PECOS.

Since the NPI of the physician/supplier that actually performed the test may not be available to the billing physician or supplier, the "Medicare Claims Processing Manual" currently instructs physicians and suppliers to submit their own NPI with the name and address of the actual performing physician or supplier in Item 32a (and its electronic equivalent) when billing for reference laboratory services, or services subject anti-markup, when the performing physician or supplier is enrolled in another contractor’s jurisdiction.

Effective January 1, 2015, changes to PECOS will allow MACs the ability to verify all physician and supplier NPIs, regardless of the jurisdiction in which they are enrolled. Therefore, beginning January 1, 2015, physicians and suppliers billing anti-markup and reference laboratory claims must report the NPI of the physician or supplier who actually performed the service in Item 32a of the CMS-1500 claim form or the corresponding loop and segment of the American National Standards Institute (ANSI) X12 837 professional electronic claim format. This new requirement applies to all claims, including claims for services where the performing physician/supplier is out of the processing MAC’s jurisdiction.
Anti-mark up claims will be identified by the presence of the “Yes” indicator in Item 20 of the CMS-1500 or its electronic equivalent. Reference laboratory claims will be identified by the presence of 90 on any service line.

MACs will return as unprocessable a claim:

- Where the NPI in Item 32a (or its electronic equivalent) does not belong to the entity whose name and address are identified in Item 32 (or its electronic equivalent)
- For a reference laboratory or anti-markup service that is performed outside the MAC’s billing jurisdiction when submitted without the name, address, and ZIP code of the performing physician/supplier in Item 32, and the NPI of the performing physician/supplier in Item 32a of the CMS-1500 claim form, or on the ANSI X12 837 professional electronic claim format, in the appropriate loops/segments
- For a reference laboratory or anti-markup service performed outside the contractor’s billing jurisdiction when the NPI in Item 32A (or its electronic equivalent) does not match the name and address of a valid servicing physician/supplier identified on the existing table in PECOS.

MACs use the following codes for claims returned as unprocessable:

- Claim Adjustment Reason Code (CARC) 16 - Claim/service lacks information which is needed for adjudication.
- For reference lab claims, Remittance Advice Remarks Code (RARC) N270 - Missing/incomplete/invalid other provider primary identifier.
- For anti-markup claims, RARC N283 - Missing/incomplete/invalid purchased service provider identifier.
- Group Code: Contractual Obligation (CO)

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.
NEW products from the Medicare Learning Network® (MLN)

- “Medicaid Compliance and Your Dental Practice” Fact Sheet, ICN 908668, downloadable

MLN Matters® Number: MM8812  Related Change Request (CR) #: CR 8812
Related CR Release Date: August 22, 2014  Effective Date: January 1, 2015
Related CR Transmittal #: R3048CP, R238FM  Implementation Date: January 5, 2015

New Physician Specialty Code for Interventional Cardiology

Provider Types Affected

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

What You Need to Know

CR 8812, from which this article is taken, provides notice that the Centers for Medicare & Medicaid Services (CMS) is establishing a new physician specialty code for Interventional Cardiology. The CR is also changing the description of specialty code 62, and updating the names associated to specialty codes 88 and 95. Make sure your billing staffs are aware of these changes.

Background

Physicians who enroll in the Medicare program self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855B) or via the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS). Non-physician practitioners who enroll with Medicare are assigned a Medicare specialty code. These Medicare physician/non-physician practitioner specialty codes describe the specific/unique types of
medicine that physicians and non-physician practitioners (and certain other suppliers) practice. They become associated with the claims that physician or non-physician practitioners submit; and are used by CMS for programmatic and claims processing purposes.

CR 8812 establishes a new physician specialty code for Interventional Cardiology (C3). CR8812 is also removing the word “Clinical” from the description of specialty code 62 (Psychologist (Billing Independently)), and is changing the description of specialty code 88 to “Unknown Provider,” and of specialty code 95 to “Unknown Supplier”. The changes to the descriptions for codes 88 and 95 align their names with their intended usages.

**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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Two New “K” Codes for Prefabricated Single and Double Upright Knee Orthoses That Are Furnished Off-The-Shelf (OTS)

Note: This article was revised on August 28, 2014, to reflect the revised CR8839 issued on August 26, 2014. 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 suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8839 announces that, effective October 1, 2014, two new “K” codes (K0901 and K0902) will be established for Prefabricated Single and Double Upright Knee Orthoses That Are Furnished Off-The-Shelf (OTS). The addition of these codes will allow the DME MACs to correctly adjudicate claims. Make sure your billing staffs are aware of these changes.
Background

Definitions

- The orthotics currently paid under Section 1834(h) (Payment for Prosthetic Devices and Orthotics and Prosthetics) of the Social Security Act (the Act), and that are described in its Section 1861(s)(9) (Part E—Miscellaneous Provisions, Definitions of Services, Institutions, etc.) are leg, arm, back, and neck braces. (You can find these sections of the Act at [http://www.ssa.gov/OP_Home/ssact/title18/1834.htm](http://www.ssa.gov/OP_Home/ssact/title18/1834.htm) and [http://www.ssa.gov/OP_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm), respectively).

- The "Medicare Benefit Policy Manual," Chapter 15 (Covered Medical and Other Health Services), Section 130 (Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes) provides the longstanding Medicare definition of “braces” as “rigid or semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.” (You can find this manual section at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf) on the CMS website).

- Further, Section 1847(a)(2) of the Act defines OTS orthotics as those for which payment would otherwise be made under Section 1834(h), above; which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual. You can find this section of the act at [http://www.ssa.gov/OP_Home/ssact/title18/1847.htm](http://www.ssa.gov/OP_Home/ssact/title18/1847.htm).

- Lastly, the Center for Medicare & Medicaid Services (CMS) regulations at 42 CFR 414.402, which you can find at [http://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol3/html/CFR-2007-title42-vol3-sec414-402.htm](http://www.gpo.gov/fdsys/pkg/CFR-2007-title42-vol3/html/CFR-2007-title42-vol3-sec414-402.htm), define the term “minimal self-adjustment” as “an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform; and that does not require the services of a certified orthotist (that is, an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification) or an individual who has specialized training.”

New OTS Orthotics Healthcare Common Procedure Coding System (HCPCS) Codes

In February 2012, CMS issued guidance that initially identified specific HCPCS codes that were considered OTS orthoses. The list of HCPCS codes that were finalized as part of this review as OTS orthotics, effective January 1, 2014, are available for download at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html) on the CMS website.

CR8839 announces that in order to identify prefabricated single and double upright knee orthoses that are furnished in a variety of standard sizes and do not require the skills of an expert to measure and fit to the individual; the following OTS codes will be added to the HCPCS code set, effective October 1, 2014:
1. K0901- Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf; and

2. K0902 -Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf;

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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MLN Matters® Number: MM8856

Related Change Request (CR) #: CR 8856

Related CR Release Date: August 1, 2014

Effective Date: January 1, 2015

Related CR Transmittal #: R1413OTN

Implementation Date: January 5, 2015

**Medicare Remit Easy Print (MREP) Enhancement**

**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.

**Provider Action Needed**

This article is based on Change Request (CR) 8856. Medicare Remit Easy Print (MREP) software was developed by the Centers for Medicare and Medicaid Services (CMS) to help providers to transition to Electronic Remittance Advice (ERA) by offering to translate the ERA into a humanly readable format. CMS introduced the software in October 2005, and has continuously enhanced the software based on feedback from the end users.

CR8856 instructs the developer of the MREP software to update it based on enhancement requests received through the MACs and the CMS website. This software is available free of charge from the CMS website and now offers a number of special reports that users can
view and download in addition to the remittance advice. Make sure that your billing staffs are aware of these changes.

Background

CMS offers free software - Medicare Remit Easy Print (MREP) - to view and print HIPAA compliant ERA, transaction 835 - Health Care Claim Payment/Advice. The software gets enhanced on a regular basis to meet the changing needs of providers and suppliers to help them transition to ERA. The MACs will notify MREP users of the MREP enhancements once implementation is complete. A key change in this latest version of the software is an enhancement to correct paging issues when a long claim runs to another page and that subsequent page was missing headers.

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.
NEW products from the Medicare Learning Network® (MLN)


MLN Matters® Number: MM8880  Related Change Request (CR) #: CR 8880
Related CR Release Date: August 15, 2014  Effective Date: October 1, 2014
Related CR Transmittal #: R3025  Implementation Date: October 6, 2014

October 2014 Update of the Ambulatory Surgical Center (ASC) Payment System

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8880 describes changes to and billing instructions for various payment policies implemented in the October 2014 ASC payment system update. CR8880 also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure that your billing staffs are aware of these changes.

Key Points of CR8880

New Services

There are no new services assigned for separate payment under the Ambulatory Surgical Center (ASC) Payment System, effective October 1, 2014.
Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

Payments for separately payable drugs and biologicals based on ASPs are 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 October 2014 release of the ASC Drug File. The updated payment rates, effective October 1, 2014, will be included in the October 2014 update of the ASC Addendum BB, which will be posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html on the Center for Medicare & Medicaid Services (CMS) website.

b. New HCPCS Codes for Drugs and Biologicals Separately Payable under the ASC Payment System Effective October 1, 2014

Four drugs and biologicals have been granted ASC payment status effective October 01, 2014. These items, along with their descriptors and ASC payment indicators (PIs) are as follows:

New HCPCS Codes for Drugs and Biologicals Separately Payable under the ASC Payment System, Effective October 1, 2014

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9023</td>
<td>Inj testosterone undecanoate</td>
<td>Injection, testosterone undecanoate, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9025</td>
<td>Injection, ramucirumab</td>
<td>Injection, ramucirumab, 5 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9026</td>
<td>Injection, vedolizumab</td>
<td>Injection, vedolizumab, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9135</td>
<td>Factor ix (Alprolix)</td>
<td>Factor ix (antihemophilic factor, recombinant), Alprolix, per 10 i.u.</td>
<td>K2</td>
</tr>
</tbody>
</table>

Note: These HCPCS codes are new codes effective October 1, 2014.

c. Revised ASC Payment Indicator for HCPCS Codes J9160 and J9300

Effective October 1, 2014, the payment indicator for HCPCS codes J9160 (Injection, denileukin diftitox, 300 micrograms) and J9300 (Injection, gemtuzumab ozogamicin, 5 mg) will change from K2 to Y5 because the product associated with HCPCS code J9160 is no longer marketed. Effective October 1, 2014, the payment indicator for HCPCS code J9300 (Injection, gemtuzumab ozogamicin, 5 mg) will change from K2 to Y5 because the product associated with HCPCS code J9300 is no longer marketed.
d. Updated Payment Rate for HCPCS Code J9171, Effective January 1, 2014 through March 31, 2014

The payment rate for one HCPCS code was incorrect in the January 2014 ASC Drug File. The corrected payment rate is listed in the following table, and has been installed in the revised January 2014 ASC Drug File, effective for services furnished on January 1, 2014, through March 31, 2014. Suppliers who think they may have received an incorrect payment for dates of service January 1, 2014, through March 31, 2014, may request their MAC to adjust the previously processed claims.

**Updated Payment Rate for HCPCS Code J9171**

**Effective January 1, 2014, through March 31, 2014**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Corrected Payment Rate</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9171</td>
<td>Docetaxel injection</td>
<td>4.63</td>
<td>K2</td>
</tr>
</tbody>
</table>

---

e. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2014, through June 30, 2014

The payment rate for three HCPCS codes were incorrect in the April 2014 ASC Drug File. The corrected payment rate is listed in the following table, and has been installed in the revised April 2014 ASC Drug File, effective for services furnished on April 1, 2014, through June 30, 2014. Suppliers who think they may have received an incorrect payment for dates of service April 1, 2014, through June 30, 2014, may request their MAC to adjust the previously processed claims.

**Updated Payment Rates for Certain HCPCS Codes**

**Effective April 1, 2014, through June 30, 2014**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Corrected Payment Rate</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7335</td>
<td>Capsaicin 8% patch</td>
<td>25.49</td>
<td>K2</td>
</tr>
<tr>
<td>J8700</td>
<td>Temozolomide</td>
<td>6.94</td>
<td>K2</td>
</tr>
<tr>
<td>J9171</td>
<td>Docetaxel injection</td>
<td>4.35</td>
<td>K2</td>
</tr>
</tbody>
</table>
f. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2014, through September 30, 2014

The payment rate for two HCPCS codes were incorrect in the July 2014 ASC Drug File. The corrected payment rates are listed in the following table, and have been installed in the revised July 2014 ASC Drug File, effective for services furnished on July 1, 2014, through September 30, 2014. Suppliers who think they may have received an incorrect payment for dates of service July 1, 2014, through September 30, 2014, may request their MAC to adjust the previously processed claims.

Updated Payment Rates for Certain HCPCS Codes
Effective July 1, 2014, through September 30, 2014

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Corrected Payment Rate</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9047</td>
<td>Injection, carfilzomib, 1 mg</td>
<td>29.67</td>
<td>K2</td>
</tr>
<tr>
<td>J9315</td>
<td>Romidepsin injection</td>
<td>270.24</td>
<td>K2</td>
</tr>
</tbody>
</table>

Additional Information


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