# Medicare Monthly Review

Issue No. MMR 2014-10

October 2014

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

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This bulletin should be shared with all health care practitioners and managerial members of the providers/suppliers staff. Bulletins issued during the last two years are available at no cost from our Web site at http://www.NGSMedicare.com.
Centers for Medicare & Medicaid Services
Articles for Part A&B Providers
NEW product from the Medicare Learning Network® (MLN)

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

MLN Matters® Number: MM8506 Revised
Related Change Request (CR) #: CR 8506
Related CR Release Date: September 4, 2014
Effective Date: Upon ICD-10 Implementation
Related CR Transmittal #: R173NCD
Implementation: Upon ICD-10 Implementation

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

Note: This article was revised on September 8, 2014, to reflect the revised CR8506 issued on September 4. The CR release date, effective and implementation dates, transmittal number, and the Web address for accessing the CR are revised. All other information is unchanged.

Provider Types Affected

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

Provider Action Needed

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

The changes were made to comply with:

1. Conversion from ICD-9 to ICD-10;

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2. Conversion from ASC X12 Version 4010 to Version 5010;
3. Conversion of former contractor types to MACs; and,
4. Other miscellaneous editorial and formatting updates provided for better clarity, correctness, and consistency.

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

Background

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

Additional Information


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

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MLN Matters® Number: MM8758 Revised  Related Change Request (CR) #: CR 8758
Related CR Release Date: August 29, 2014  Effective Date: February 18, 2014
Related CR Transmittal #: R171NCD, R3058CP, R539PI, and R193BP  Implementation Date: August 18, 2014

Cardiac Rehabilitation Programs for Chronic Heart Failure

Note: This article was revised on September 4, 2014, to reflect changes to CR8758. In the article, the transmittal numbers, the CR release date, and the Web addresses for accessing the transmittals are revised. All other information remains the same.

Provider Types Affected

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

What You Need to Know

Effective for dates of service on and after February 18, 2014, Medicare covers cardiac rehabilitation services for beneficiaries with stable, chronic heart failure.
CAUTION – What You Need to Know

This article, based on Change Request (CR) 8758, informs you that, effective for dates of service on and after February 18, 2014, Medicare covers cardiac rehabilitation services for beneficiaries with stable, chronic heart failure, defined as patients with left ventricular ejection fraction of 35% or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal heart failure therapy for at least six weeks. Stable patients are defined as patients who have not had recent (≤6 weeks) or planned (≤6 months) major cardiovascular hospitalizations or procedures.

GO – What You Need to Do

Make sure your billing staffs are aware of these changes.

Background

On June 4, 2013, the Centers for Medicare & Medicaid Services (CMS) initiated a National Coverage Analysis (NCA) to expand Medicare coverage of cardiac rehabilitation for beneficiaries diagnosed with chronic heart failure.

Items and services furnished under a Cardiac Rehabilitation (CR) program may be covered under Medicare Part B per Section 1861(s)(2)(CC) and 1861(eee)(1) of the Social Security Act. Among other things, Medicare regulations define key terms, address the components of a Cardiac Rehabilitation program, establish the standards for physician supervision, and limit the maximum number of program sessions that may be furnished. These regulations may be viewed at 42 Code of Federal Regulations (CFR), Section 410.49, available at http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A2.0.1.2.10 on the Internet.

CR services mean a physician-supervised program that furnishes physician prescribed exercise, cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment, outcomes assessment, and other items/services as determined by the Secretary under certain conditions.

The regulations describe the cardiac conditions that would enable a beneficiary to obtain CR services. Specifically, coverage is permitted for beneficiaries who have experienced one or more of the following:

- An acute myocardial infarction within the preceding 12 months;
- A coronary artery bypass surgery;
- Current stable angina pectoris;
- Heart valve repair or replacement;
- Percutaneous Transluminal Coronary Angioplasty (PTCA) or coronary stenting; or
- A heart or heart-lung transplant.

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Effective for dates of service on or after February 18, 2014, this change request adds stable, chronic heart failure to the list of cardiac conditions above that would enable a beneficiary to obtain Cardiac Rehabilitation services.

CMS may add “other cardiac conditions as specified through a national coverage determination” (42 CFR Section 410.49(b)(vii).

Any cardiac indication not specifically identified in 42 CFR 410.49(b)(l)(vii) or identified as covered in any National Coverage Determination (NCD) is considered non-covered.

Also, note that MACs will not search for and adjust claims processed prior to the implementation of CR8758. However, your MAC will adjust such claims that you bring to their attention.

**Additional Information**


You may also want to review MLN Matters® Article MM6850, which is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm6850.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm6850.pdf) for more information on cardiac rehabilitation services.

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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Ventricular Assist Devices for Bridge-to-Transplant and Destination Therapy

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8803 which instructs that, effective for claims with dates of service on and after October 30, 2013, the Centers for Medicare & Medicaid Services (CMS) is modifying the criteria for coverage of ventricular assist devices (VADs) as Bridge-to-Transplant (BTT) and is modifying the facility criteria for coverage as Destination Therapy (DT). Make sure your billing staffs are aware of these changes.

Background

CR 8803 states that Medicare covers VADs for the following three general indications:

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1. Postcardiotomy - Postcardiotomy refers to the placement of VADs following open-heart surgery.
2. Bridge–to-transplantation (BTT) - Coverage for BTT is restricted to patients listed for heart transplantation; and,
3. Destination therapy (DT) - Coverage for DT is restricted to patients who are not candidates for heart transplantation, require mechanical cardiac support, and who meet specific clinical criteria.

Note: VADs implanted as DT are only covered when implanted in a facility that is approved by CMS to provide this procedure.

Effective for claims with dates of service on and after October 30, 2013, CMS has determined that the evidence is adequate to conclude that VAD implantation is reasonable and necessary with the following modifications to current CMS policy at 20.9.1:

- **VADs for BTT**: CMS clearly identifies that the patient must be active on the wait list maintained by the Organ Procurement and Transplantation Network and removes the general time requirement that patients receive a transplant as soon as medically reasonable.

- **VADs for DT**: CMS expands the credentialing requirement to allow credentialing by other organizations approved by Medicare and include requirements for a multidisciplinary team. CMS removes mandatory participation in the INTERMACS registry, but encourages facilities to track patient outcomes.

Note that coverage for items and services under the Social Security Act (the Act) (section 1862(a)(1)(A); see [http://www.ssa.gov/OP_Home/ssact/title18/1862.htm](http://www.ssa.gov/OP_Home/ssact/title18/1862.htm)) in these situations will be made by your MAC within its jurisdiction.

CR 8803 revises the "Medicare National Coverage Determinations (NCD) Manual" (Chapter 1) by revising section 20.9 (Artificial Hearts and Related Devices) and adding a new sub-section (20.9.1) titled ‘Ventricular Assist Devices.’

CR 8803 also revises the "Medicare Claims Processing Manual" (Chapter 32, Section 320 (Artificial Hearts and Related Devices). ICD-10 codes related to these services are included in this manual update. The revised portions of these two manuals are available as attachments to CR 8803.

All other indications for the use of VADs not otherwise listed remain non-covered, except in the context of Category B investigational device exemption clinical trials (42 CFR 405) or as a routine cost in clinical trials defined under section 310.1 of the NCD Manual.

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This policy does not address coverage of VADs for right ventricular support, biventricular support, use in beneficiaries under the age of 18, use in beneficiaries with complex congenital heart disease, or use in beneficiaries with acute heart failure without a history of chronic heart failure. Coverage under section 1862(a)(1)(A) of the Act for VADs in these situations will be made by your MAC.

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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- "Medicare Learning Network® (MLN) Suite of Products & Resources for Billers and Coders,” Educational Tool, ICN 904183, Downloadable only.

MLN Matters® Number: MM8837  
Related Change Request (CR) #: CR 8837

Related CR Release Date: August 29, 2014  
Effective Date: April 1, 2014

Related CR Transmittal #: R3056CP  
Implementation Date: December 1, 2014

Sample Collection Fee Adjustment for Clinical Laboratory Fee Schedule and Laboratory Services

Provider Types Affected

This MLN Matters® Article is intended for independent clinical laboratories, skilled nursing facilities (SNFs) and home health agencies (HHAs) submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 8837 provides instructions to MACs for adjusting payment for a sample collected by a laboratory from an individual in a SNF or on behalf of a HHA. Make sure your billing staffs are aware of these changes.

Background


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When a sample is collected by a laboratory from an individual in a SNF or from an individual on behalf of a HHA, the Healthcare Common Procedure Coding System (HCPCS) code, G0471 “Collection of venous blood by venipuncture or urine sample by catheterization from an individual in a SNF or by a laboratory on behalf of a HHA,” is used. Effective April 1, 2014, the nominal fee is increased by $2, from $3 to $5, in accordance with the Protecting Access to Medicare Act (PAMA).

The “Sample Collection Fee” is raised from $3.00 to $5.00 ONLY when the following statements apply:

- The sample is being collected by a laboratory technician that is employed by the laboratory that is performing the test, and
- The sample is from an individual in either a SNF or a HHA.

MACs will not search their files to adjust claims already processed. However, they will adjust such 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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Transitioning Medicare Administrative Contractor (MAC) Workloads to the New Banking Contractor(s)

Provider Types Affected

This MLN Matters® Article is intended to alert all providers that your Medicare Administrative Contractor (MAC) may be transitioning their banking to another bank.

What You Need to Know

This article is informational in nature and is intended to inform you that Medicare has re-competed its banking contracts and has awarded two new five year contracts to US Bank (an incumbent bank) and to Citibank (which replaces the prior contract with JP Morgan Chase). The Centers for Medicare & Medicaid Services (CMS) awarded these new contracts on July 10, 2014. Change Request (CR) 8847 was issued to manage the transition of the MAC workloads from JP Morgan Chase to Citibank.

Background

In 2010, CMS changed its Medicare banking policies by discontinuing the use of time accounts to pay for banking service charges and awarded five year commercial services contracts through full and open competition to two banks (US Bank and JP Morgan Chase);
these two banks disburse MAC authorized payments and Demonstration project payments for CMS. The two current commercial banking contracts are terminating in Fiscal Year 2015. CMS has awarded new five year contracts through full and open competition to US Bank (incumbent bank) and Citibank (new bank). Each selected bank shall provide both MAC payment services and Demonstration payment services and shall be designated Financial Agents of the U.S. Treasury.

CMS is transitioning MAC workloads from JP Morgan Chase to Citibank. The MAC workloads with US Bank will remain with US Bank. The transition began in August 2014 and will end in January 2015.

**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.
Screening for Hepatitis C Virus (HCV) in Adults

Provider Types Affected

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

What You Need to Know

Change Request (CR) 8871 states, effective June 2, 2014, the Centers for Medicare & Medicaid Services (CMS) will cover screening for hepatitis C virus (HCV) consistent with the grade B recommendations by the United States Preventive Services Task Force (USPSTF) for the prevention or early detection of an illness or disability and is appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Part B. Make sure your billing staffs are aware of these changes.

Background

Hepatitis C Virus (HCV) is an infection that attacks the liver and is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring,
called cirrhosis. A cirrhotic liver fails to perform the normal functions of the liver which leads to liver failure. Cirrhotic livers are more prone to become cancerous and liver failure leads to serious complications, even death. HCV is reported to be the leading cause of chronic hepatitis, cirrhosis, and liver cancer, and a primary indication for liver transplant in the Western World.

Prior to June 2, 2014, CMS did not cover screening for HCV in adults. Pursuant to §1861(ddd) of the Social Security Act, CMS may add coverage of "additional preventive services" through the National Coverage Determination (NCD) process.

Effective June 2, 2014, CMS will cover screening for HCV with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests (used consistently with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations) when ordered by the beneficiary’s primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

1. Adults at high risk for HCV infection. “High risk” is defined as persons with a current or past history of illicit injection drug use, and persons who have a history of receiving a blood transfusion prior to 1992. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.

2. Adults who do not meet the high risk definition as defined above, but who were born from 1945 through 1965. A single, once-in-a-lifetime screening test is covered for these individuals.

The determination of “high risk for HCV” is identified by the primary care physician or practitioner who assesses the patient’s history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

**General Claims Processing Requirements for Claims with Dates of Service on and After June 2, 2014:**

1. New G code G0472, short descriptor - Hep screen high risk/other and long descriptor- Hepatitis C antibody screening for individual at high risk and other covered indication(s), will be used.

2. Beneficiary coinsurance and deductibles do not apply to code G0472.

3. For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk, HCV screening is limited to once per lifetime, claims shall be submitted with:
   - HCPCS G0472

4. For those determined to be high-risk initially, claims must be submitted with:
   - HCPCS G0472

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5. Screening may occur on an annual basis if appropriate, as defined in the policy. Claims for adults at high risk who have had continued illicit injection drug use since the prior negative screening shall be submitted with:
   - HCPCS G0472,
   - ICD diagnosis code V69.8/Z72.89, and
   - ICD diagnosis code 304.91, unspecified drug dependence, continuous/F19.20, other psychoactive substance abuse, uncomplicated (once ICD-10 is implemented).

   **NOTE:** Annual is defined as 11 full months must pass following the month of the last negative HCV screening.

**Institutional Billing Requirements**

Effective for claims with dates of service on and after June 2, 2014, institutional providers may use types of bill (TOB) 13X and 85X when submitting claims for HCV screening, HCPCS G0472. Medicare will deny G0472 service line-items on other TOBs using the following messages:

- Claim Adjustment Reason Code (CARC) 170 - Payment denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remarks Code (RARC) N95 - This provider type/provider specialty may not bill this service.

The service is paid on the following basis:

- Outpatient hospitals – TOB 13X - based on Clinical Diagnostic Lab Fee Schedule;
- Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost; and
- CAH Method II – TOB 85X - based on 115 percent of the lesser of the Medicare Physician Fee Schedule (MPFS) amount or actual charge as applicable with revenue codes 096X, 097X, or 098X.

   **Note:** For outpatient hospital settings, as in any other setting, services covered under this NCD must be provided by a primary care provider.
**Professional Billing Requirements**
For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCPCS G0472, only when services are submitted by the following provider specialties found on the provider’s enrollment record:

- 01 - General Practice
- 08 - Family Practice
- 11 - Internal Medicine
- 16 - Obstetrics/Gynecology
- 37 - Pediatric Medicine
- 38 - Geriatric Medicine
- 42 – Certified Nurse Midwife
- 50 - Nurse Practitioner
- 89 - Certified Clinical Nurse Specialist
- 97 - Physician Assistant

Medicare will deny claims submitted for these services by providers other than the specialty types noted above. When denying such claims, Medicare will use the following messages:

- CARC 184 - The prescribing/ordering provider is not eligible to prescribe/order the service. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N574 - Our records indicate the ordering/referring provider is of a type/specialty that cannot order/refer. Please verify that the claim ordering/referring information is accurate or contact the ordering/referring provider.
- Group Code CO (contractual obligation) if claim received without GZ modifier.

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCV screening, G0472, only when submitted with one of the following place of service (POS) codes:

- 11 – Physician’s Office
- 22 – Outpatient Hospital
- 49 – Independent Clinic
- 71 – State or Local Public Health Clinic

Medicare will deny claims submitted without one of the POS codes noted above with the following messages:

- CARC 171 - Payment denied when performed 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.
- RARC N428 - Not covered when performed in this place of service.
Other Billing Information for Both Professional and Institutional Claims

On both institutional and professional claims, Medicare will deny claims line-items for HCPCS G0472 with dates of service on or after June 2, 2014, where it is reported more than once in a lifetime for beneficiaries born from 1945 through 1965 and who are not high risk. Medicare will also line-item deny when more than one HCV screening is billed for the same high-risk beneficiary prior to their annual eligibility criteria being met. In denying these claims, Medicare will use:

- CARC 119 - Benefit maximum for this time period or occurrence has been reached.
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code - CO if claim received without GZ modifier.

When applying the annual frequency limitation, MACs will allow both a claim for a professional service and a claim for a facility fee.

In addition, remember that the initial HCV screening for beneficiaries at high risk must also contain ICD-9 diagnosis code V69.8 (ICD-10 code Z72.89 once ICD-10 is implemented). Then, for the subsequent annual screenings for high risk beneficiaries, you must include ICD-9 code V69.8 and 304.91 (ICD-10 of Z72.89 and F19.20). Failure to include the diagnosis code(s) for high risk beneficiaries will result in denial of the line item. In denying these payments, Medicare will use the following:

- CARC - This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code CO if claim received without GZ modifier.

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.
Provider Types Affected

This MLN Matters® Article is intended for Medicare practitioners providing laboratory services to Medicare beneficiaries and billing Medicare Administrative Contractors (MACs) or Durable Medical Equipment Medicare (DME) MACs for those services.

Provider Action Needed

Change Request (CR) 8883 updates the "Medicare Claims Processing Manual" to clarify that the location where the independent laboratory performed the test determines the appropriate billing jurisdiction for specimen collection fees and travel allowance. The changes are intended to clarify the existing policies and no system or processing changes are anticipated. Make sure your billing staffs are aware of these policies.

Key Points

The manual updates, which are attached to CR8883, are as follows:
• The location where the independent laboratory performed the test determines the appropriate billing jurisdiction. If the sample originates in a different jurisdiction from where the sample is being tested, the claim must be filed in the jurisdiction where the test was performed.

• Claims filing jurisdiction for the specimen collection fee and travel allowance is also determined by the location where the test was performed. When billed by an independent laboratory, the specimen collection fee and travel allowance must be billed in conjunction with a covered laboratory test.

• The specimen collection fee is paid based on the location of the independent laboratory where the test is performed and is billed in conjunction with a covered laboratory test.

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.
"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners," Fact Sheet, ICN 903764, Downloadable only.

MLN Matters® Number: MM8888 Revised Related Change Request (CR) #: CR 8888
Related CR Release Date: September 10, 2014 Effective Date: October 1, 2014
Related CR Transmittal #: R3064CP Implementation Date: October 6, 2014

October Update to the CY 2014 Medicare Physician Fee Schedule Database (MPFSDB)

Note: This article was revised on September 12, 2014, to reflect the revised CR8888 issued on September 10. The CR was revised to correct the Procedure Status for HCPCS code 0275T to "R". In addition, the article now adds HCPCS code G0471, which was not mentioned in the original article. In addition, the CR release date, transmittal number and the Web address for accessing CR8888 are revised. All other information remains the same.

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 December 10, 2013, which is available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html) on the Centers for Medicare & Medicaid Services (CMS) website, as modified by Section 101 of the "Pathway for SGR Reform Act of 2013" to be effective for services furnished between January 1, 2014, and March 31, 2014. On April 1, 2014, the President signed the “Protecting Access to Medicare Act of 2014,” which extends those rates through December 31, 2014.

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 G0471 “Ven blood coll SNF/HHA” is added to the MPFS with a procedure status code of X, effective April 1, 2014.
- HCPCS Code 0275T “Perq lamot/lam lumbar” is revised to the 2014 Physician Fee Schedule with a procedure status code of “R”=”Restricted”, 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.
Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season

Note: This article was revised on September 3, 2014, to reflect a new Change Request (CR). The revised CR corrected the implementation date. In this article the CR release date, transmittal number and link to the CR also changed. All other information remains the same.

Provider Types Affected

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

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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
- “Medicare Learning Network® (MLN) Suite of Products & Resources for Educators and Students,” Educational Tool, ICN 903763, Downloadable only.

MLN Matters® Number: MM8891  Related Change Request (CR) #: CR 8891
Related CR Release Date: August 29, 2014  Effective Date: January 1, 2015
Related CR Transmittal #: R3055CP  Implementation Date: January 5, 2015

Annual Clotting Factor Furnishing Fee Update 2015

Provider Types Affected

This MLN Matters® Article is intended for physicians and other providers billing Medicare Administrative Contractors (MACs) for services related to the administration of clotting factors to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8891 announces that for Calendar Year 2015 the clotting factor furnishing fee of $0.197 per unit is included in the published payment limit for clotting factors. For dates of service of January 1, 2015, through December 31, 2015, the clotting factor furnishing fee of $0.197 per unit is added to the payment when no payment limit for the clotting factor is included in the Average Sales Price (ASP) or Not Otherwise Classified (NOC) drug pricing files. Please be sure your billing staffs are aware of this fee update.

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Background

The Medicare Modernization Act section 303(e)(1) added section 1842(o)(5)(C) of the Social Security Act which requires that a furnishing fee will be paid for items and services associated with clotting factor.

The Centers for Medicare & Medicaid Services (CMS) includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. When the national payment limit for a clotting factor is not included on the Average Sales Price (ASP) Medicare Part B Drug Pricing File or the Not Otherwise Classified (NOC) Pricing File, your MAC must make payment for the clotting factor as well as make payment for the furnishing fee.

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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Ambulance Inflation Factor for CY 2015 and Productivity Adjustment

Provider Types Affected

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

Provider Action Needed

CR8895 furnishes the CY 2015 ambulance inflation factor (AIF) for determining the payment limit for ambulance services. Make sure that your billing staffs are aware of the change.

Background

CR8895 furnishes the CY 2015 ambulance inflation factor (AIF) for determining the payment limit for ambulance services required by section 1834(l)(3)(B) of the Social Security Act (the Act).

Section 1834(l)(3)(B) of the Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to apply a
productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity (MFP) beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

The MFP for calendar year (CY) 2015 is 0.70 percent and the CPI-U for 2015 is 2.10 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for CY 2015 is 1.40 percent.

Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule. The 2015 ambulance fee schedule file will be available to MACs in November 2014. It may be updated with each quarterly Common Working File (CWF) 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.

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NEW product from the Medicare Learning Network® (MLN)

- “Medicaid Compliance and Your Dental Practice” Fact Sheet, ICN 908668, Downloadable only.

MLN Matters® Number: MM8912 Related Change Request (CR) #: CR 8912
Related CR Release Date: September 19, 2014 Effective Date: January 1, 2015
Related CR Transmittal #: R3072CP Implementation Date: January 5, 2015

January 2015 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8912 instructs Medicare Administrative Contractors (MACs) to download and implement the January 2015 and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised October 2014, July 2014, April 2014, and January 2014, average sales price (ASP) drug pricing files for Medicare Part B drugs.

Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 5, 2015, with dates of service January 1, 2015, through March 31, 2015. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.
Background

The Average Sales Price (ASP) methodology is based on quarterly data submitted that manufacturers submit to CMS. CMS will supply MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in Chapter 4, section 50, of the "Medicare Claims Processing Manual" which is available 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.

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

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2015 ASP and ASP NOC</td>
<td>January 1, 2015, through March 31, 2015</td>
</tr>
<tr>
<td>October 2014 ASP and ASP NOC</td>
<td>October 1, 2014, through December 31, 2014</td>
</tr>
<tr>
<td>July 2014 ASP and ASP NOC</td>
<td>July 1, 2014, through September 30, 2014</td>
</tr>
<tr>
<td>April 2014 ASP and ASP NOC</td>
<td>April 1, 2014, through June 30, 2014</td>
</tr>
<tr>
<td>January 2014 ASP and ASP NOC</td>
<td>January 1, 2014, through March 31, 2014</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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News Flash – Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through Electronic Funds Transfer (EFT). Section 1104 of the Affordable Care Act further expands Section 1862(a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of CMS’s revalidation efforts, all suppliers and providers who are not currently receiving EFT payments are required to submit the CMS-588 EFT form with the Provider Enrollment Revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official. For more information about provider enrollment revalidation, review the MLN Matters® Special Edition Article SE1126, “Further Details on the Revalidation of Provider Enrollment Information.”

Examining the Difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN)

Note: This article was revised on September 5, 2014, to add the "Where Can I Find My PTAN?" section on page 3. All other information is the same.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians, providers, and suppliers who are enrolled in Medicare.
What You Need to Know

This article explains the difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN). There are no policy changes in this article.

Background

New Enrollees

All providers and suppliers who provide services and bill Medicare for services provided to Medicare beneficiaries must have an NPI. Upon application to a Medicare Administrative Contractor (MAC), the provider or supplier will also be issued a Provider Transaction Access Number (PTAN). While only the NPI can be submitted on claims, the PTAN is a critical number directly linked to the provider or supplier’s NPI.

Revalidation

Section 6401(a) of the Affordable Care Act established a requirement for all enrolled physicians, providers, and suppliers to revalidate their enrollment information under new enrollment screening criteria.

Providers and suppliers receiving requests to revalidate their enrollment information have asked the Centers for Medicare & Medicaid Services (CMS) to clarify the differences between the NPI and the PTAN.

National Provider Identifier (NPI)

The NPI is a national standard under the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification provisions.

- The NPI is a unique identification number for covered health care providers.
- The NPI is issued by the National Plan and Provider Enumeration System (NPPES).
- Covered health care providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions (for example, insurance claims) adopted under HIPAA.
- The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). The NPI does not carry information about healthcare providers, such as the state in which they live or their medical specialty. This reduces the chances of insurance fraud.
- Covered providers and suppliers must share their NPI with other suppliers and providers, health plans, clearinghouses, and any entity that may need it for billing purposes.
Since May 23, 2008, Medicare has required that the NPI be used in place of all legacy provider identifiers, including the Unique Physician Identification Number (UPIN), as the unique identifier for all providers, and suppliers in HIPAA standard transactions.

You should note that individual health care providers (including physicians who are sole proprietors) may obtain only one NPI for themselves (Entity Type 1 Individual). Incorporated individuals should obtain one NPI for themselves (Entity Type 1 Individual) if they are health care providers and an additional NPI(s) for their corporation(s) (Entity Type 2 Organization). Organizations that render health care or furnish health care supplies may obtain NPIs (Entity Type 2 Organization) for their organizations and their subparts (if applicable).

For more information about the NPI, visit the NPPES website at https://nppes.cms.hhs.gov/NPPES/Welcome.do on the CMS website.

**Provider Transaction Access Number (PTAN)**

A PTAN is a Medicare-only number issued to providers by MACs upon enrollment to Medicare. When a MAC approves enrollment and issues an approval letter, the letter will contain the PTAN assigned to the provider.

- The approval letter will note that the NPI must be used to bill the Medicare program and that the PTAN will be used to authenticate the provider when using MAC self-help tools such as the Interactive Voice Response (IVR) phone system, internet portal, on-line application status, etc.

- The PTAN's use should generally be limited to the provider’s contacts with their MAC.

**Where can I find my PTAN?**

You can find your PTAN by doing any one of the following:

1. View the letter sent by your MAC when your enrollment in Medicare was approved.
2. Log into [Internet-based PECOS](https://nppes.cms.hhs.gov/NPPES/Welcome.do). Click on the “My Enrollments” button and then “View Enrollments”. Locate the applicable enrollment and click on the “View Medicare ID Report” link which will list all of the provider or supplier’s active PTANs in one report.
3. The provider (or, in the case of an organizational provider, an authorized or delegated official) shall send a signed written request on company letterhead to your [MAC](https://nppes.cms.hhs.gov/NPPES/Welcome.do); include your legal name/legal business name, national provider identifier (NPI), telephone and fax numbers.
Relationship of the NPI to the PTAN

The NPI and the PTAN are related to each other for Medicare purposes. A provider must have one NPI and will have one, or more, PTAN(s) related to it in the Medicare system, representing the provider’s enrollment. If the provider has relationships with one or more medical groups or practices or with multiple Medicare contractors, separate PTANS are generally assigned.

Together, the NPI and PTAN identify the provider, or supplier in the Medicare program. CMS maintains both the NPI and PTAN in the Provider Enrollment Chain & Ownership System (PECOS), the master provider and supplier enrollment system.

Protect Your Information in PECOS

All providers and suppliers should carefully review their PECOS records in order to protect themselves and their practices from identity theft. PECOS should only contain active enrollment records that reflect current practice and group affiliations. You can review and update your PECOS records in the following ways:

- Use the Paper CMS 855 enrollment application (i.e., 855A, 855B, 855I, 855O, 855R, or 855S).
- Note: The Medicare contractor may not release provider specific information to anyone other than the individual provider, authorized/delegated official of the provider organization, or the contact person. The request must be submitted in writing on the provider’s letterhead and signed by the individual provider, authorized/delegated official of the organization or the contact person.

The MLN fact sheet titled “How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS),” provides guidelines and steps you can take to protect your identity while using Internet-based PECOS. This fact sheet is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_ProtID_FactSheet_ICN905103.pdf on the CMS website.

Additional Information


“Medicare Provider–Supplier Enrollment National Educational Products,” contains a list of products designed to educate Medicare Fee-For-Service (FFS) providers about important Medicare enrollment information, including how to use Internet-based PECOS to enroll in

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the Medicare Program and maintain their enrollment information. This resource is available at [http://www.cms.gov/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf](http://www.cms.gov/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf) on the CMS website.

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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2014-2015 Influenza (Flu) Resources for Health Care Professionals

Provider Types Affected

All health care professionals who order, refer, or provide flu vaccines and vaccine administration to Medicare beneficiaries.

What You Need to Know

- Keep this Special Edition MLN Matters article and refer to it throughout the 2014 - 2015 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the new year.
- Remember to immunize yourself and your staff.
Introduction

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of Medicare’s coverage of the annual flu shot.

As a reminder, please help prevent the spread of flu by immunizing yourself and your staff!

Know What to Do About the Flu!

Educational Products for Health Care Professionals

The Medicare Learning Network® (MLN) has developed a variety of educational resources to help you understand Medicare guidelines for seasonal flu vaccines and their administration.

1. MLN Influenza Related Products for Health Care Professionals


Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
2. Other CMS Resources

- Prevention General Information - http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html

3. Other Resources

The following non-CMS resources are just a few of the many available in you may find useful information and tools for the 2014 – 2015 flu season:

- Other sites with helpful information include:
  - Centers for Disease Control and Prevention - http://www.cdc.gov/flu;
  - Food and Drug Administration - http://www.fda.gov;
  - Immunization Action Coalition - http://www.immunize.org;
  - Indian Health Services - http://www.ihs.gov;
  - National Alliance for Hispanic Health - http://www.hispanichealth.org;
  - National Foundation For Infectious Diseases - http://www.nfid.org/influenza;

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Beneficiary Information

For information to share with your Medicare patients, please visit http://www.medicare.gov on the Internet.

Medicare provides coverage for one seasonal influenza virus vaccine per influenza season for all Medicare beneficiaries. Medicare generally provides coverage of pneumococcal vaccination and its administration once in a lifetime for all Medicare beneficiaries; however, Medicare may cover additional pneumococcal vaccinations based on risk or uncertainty of beneficiary pneumococcal vaccination status. Medicare provides coverage for these vaccines and their administration with no co-pay or deductible.

Remember to immunize yourself and your staff. Protect yourself from the flu.

Remember – The influenza vaccine plus its administration is a covered Part B benefit. The influenza vaccine is NOT a Part D covered drug. For more information on coverage and billing of the flu vaccine and its administration, please visit the CMS Medicare Learning Network® Preventive Services Educational Products and CMS Immunizations web pages.

While some health care professionals may offer the flu vaccine, others can help their patients locate a vaccine provider within their local community. HealthMap Vaccine Finder is a free, online service where users can search for locations offering flu vaccines.

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Centers for Medicare & Medicaid Services
Articles for Part A Providers
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 Revised Related Change Request (CR) #: CR 8581
Related CR Release Date: September 3, 2014 Effective Date: Claims received on or after April 1, 2015
Related CR Transmittal #: R3060CP Implementation Date: July 6, 2015

Note: This article was revised on September 3, 2014, to reflect a new Change Request (CR). The revised CR corrected the effective date to “Claims received on or after April 1, 2015,” and spread the implementation across four quarterly releases. In this article the CR release date, transmittal number and link to the CR also changed. All other information remains the same.

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 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.

**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 April 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

The official instruction, CR 8581, issued to your MAC regarding this change may be viewed
at http://www.cms.gov/Regulations-and-

For additional information regarding the distinction between adjustment bills, which are
subject to normal claims processing timely filing limits, and reopenings, 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.

For additional information regarding the processing of appeals, review Chapter 29 in the
"Medicare Claims Processing Manual" at http://www.cms.gov/Regulations-and-
Guidance/Guidance/Manuals/Downloads/clm104c29.pdf on the CMS website.

For additional information regarding the processing of requests for reopening, review
Chapter 34 in the "Medicare Claims Processing Manual" at http://www.cms.gov/Regulations-
and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf on the CMS website.

Attachment 1 will assist providers with coding claim’s request for reopening.
**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 -</td>
<td>Mathematical or computational mistakes</td>
</tr>
<tr>
<td></td>
<td>Mathematical or Computational Mistakes</td>
<td></td>
</tr>
<tr>
<td>R2</td>
<td>Request for Reopening Reason Code -</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></td>
<td>Inaccurate Data Entry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Misapplication of a Fee Schedule</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Computer Errors</td>
<td></td>
</tr>
<tr>
<td>R5</td>
<td>Request for Reopening Reason Code -</td>
<td>Claim Claims denied as duplicates which the party believes were incorrectly identified as a duplicate.</td>
</tr>
<tr>
<td></td>
<td>Incorrectly Identified Duplicate</td>
<td></td>
</tr>
<tr>
<td>R6</td>
<td>Request for Reopening Reason Code -</td>
<td>Other clerical errors or minor errors and omissions not specified in R1-R5 above.</td>
</tr>
<tr>
<td></td>
<td>Other Clerical Errors or Minor Errors and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Omissions not Specified in R1-R5 above</td>
<td></td>
</tr>
<tr>
<td>R7</td>
<td>Request for Reopening Reason Code -</td>
<td>Claim corrections other than clerical errors within one year of the date of initial determination.</td>
</tr>
<tr>
<td></td>
<td>Corrections other than Clerical Errors</td>
<td></td>
</tr>
<tr>
<td>R8</td>
<td>Request for Reopening Reason Code -</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></td>
<td>New and Material Evidence</td>
<td></td>
</tr>
<tr>
<td>R9</td>
<td>Request for Reopening Reason Code -</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>
<tr>
<td></td>
<td>Faulty Evidence</td>
<td></td>
</tr>
</tbody>
</table>
Correction to Hospice Notice of Revocation Processing

Provider Types Affected

This MLN Matters® Article is intended for hospices 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) 8795, which instructs MACs to update the Direct Data Entry (DDE) system to allow hospice providers access to all fields necessary to complete a termination or revocation of a hospice election prior to submitting their final claim. Make sure your billing staffs are aware of this change.

Background

When a hospice period is terminated, the hospice provider is required to submit the termination or revocation notice within five (5) calendar days. If the provider is not prepared to submit their final claim, they must submit the 08XB type of bill (TOB) to terminate the hospice period. Currently, there are field providers do not have access to under DDE, which are required to submit this TOB through DDE. Therefore, MACs must facilitate the completion of the submission for the hospice. CR8795 requires updates to the DDE system.
to allow providers to complete all fields required for complete submission of the notice of revocation. CR8795 contains no change in policy.

Additional Information


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

- “Medicare Billing Information for Rural Providers and Suppliers” Booklet (ICN 006762), downloadable

MLN Matters® Number: MM8897 Related Change Request (CR) #: CR 8897
Related CR Release Date: September 12, 2014 Effective Date: April 1, 2003
Related CR Transmittal #: R3065CP Implementation Date: December 15, 2014

Billing for Cost Based Payment for Certified Registered Nurse Anesthetists (CRNAs) Services Furnished by Outpatient Prospective Payment System (OPPS) Hospitals

Provider Types Affected

This MLN Matters® Article is intended for rural hospitals submitting claims to Medicare Administrative Contractors (MACs) for Certified Registered Nurse Anesthetist (CRNA) services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 8897 manualizes instructions previously implemented in CR 2325 (Transmittal A-02-109, dated October 25, 2002) that allows small rural hospitals subject to the Outpatient Prospective Payment System (OPPS) that qualify for cost-based CRNA services to bill and be properly paid for those services. This article is for informational purposes and does not convey any new policy.
Background

Payment of outpatient services of CRNAs furnished by small rural hospitals subject to OPPS (that qualify for cost based payment under 42 CFR 412.113(c)) are made through biweekly interim payments that are calculated based on retrospective adjustments from a settled cost report. See 42 CFR 412.113(c) at [http://www.ecfr.gov/cgi-bin/text-idx?SID=afdd6f10630598719fe65d974fde7b019&node=42:2.0.1.2.12.8.50.3&rgn=div8](http://www.ecfr.gov/cgi-bin/text-idx?SID=afdd6f10630598719fe65d974fde7b019&node=42:2.0.1.2.12.8.50.3&rgn=div8) on the Internet.


In CR8897, CMS is updating the "Medicare Claims Processing Manual" to include the requirements of CR2325.

As a reminder, in order for interim payments to be made to small rural hospitals subject to OPPS, a number of changes were required in the reporting and acceptance of revenue code 0964 “Anesthetists (CRNA).” Those changes are as follows:

1. Hospitals that qualify for cost based CRNA services must report these services under revenue code 0964;
2. Medicare claims systems are required to accept revenue code 0964 on type of bill 013X for these hospitals; and
3. Reporting and acceptance of revenue code 0964 from other OPPS hospitals (without a CRNA pass-through exemption) may not be allowed.

**Reminder:** Value code 05 “Professional Component Included In Charges and Also Billed Separately to B/MACs,” should not be reported with revenue code 0964.

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: MM8900  Related Change Request (CR) #: CR 8900
Related CR Release Date: September 12, 2014  Effective Date: October 1, 2014
Related CR Transmittal #: R3066CP  Implementation October 6, 2014

**Fiscal Year (FY) 2015 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes**

**Provider Types Affected**

This MLN Matters® Article is intended for hospitals that submit claims to Medicare Administrative Contractors (MACs) for acute care and long-term care hospital services provided to Medicare beneficiaries.

**Provider Action Needed**

Change Request (CR) 8900 provides FY 2015 updates to the Acute Care Hospital IPPS and the LTCH PPS. All items covered in CR8900 are effective for hospital discharges occurring on or after October 1, 2014, unless otherwise noted. Make sure your billing staff are aware of these changes.

**Background**

The policy changes for FY 2015 were published in the Federal Register on August 22, 2014. You can find the home page for the FY 2015 Hospital Inpatient PPS final rule at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Proposed-Rule-Home-Page.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Proposed-Rule-Home-Page.html) on the Centers for Medicare &
Medicaid Services (CMS) website. The IPPS home page centralizes file(s) related to the IPPS final rule, and it contains links to the final rule and all subsequent published correction notices (if applicable); and includes:

- All tables;
- Additional data and analysis files; and
- The impact file.

Files related to the Long Term Care PPS can be found at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html on the CMS website.

**Key Points of CR8900**

**IPPS Updates**

**Medicare Severity Diagnosis Related Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Changes**

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed the new MS-DRG Grouper, Version 32.0, software package effective for discharges on or after October 1, 2014. The MCE selects the proper internal code edit tables based on discharge date. Note that the MCE version continues to match the Grouper.

CMS created the following new MS-DRGs for endovascular cardiac valve replacements:

- MS-DRG 266 (Endovascular Cardiac Valve Replacement w MCC); and
- MS-DRG 267 (Endovascular Cardiac Valve Replacement w/o MCC).

CMS deleted:

- MS-DRG 490 (Back & Neck Procedures except Spinal Fusion with CC/MCC or Disc Device/Neurostimulator); and
- MS-DRG 491 (Back & Neck Procedures except Spinal Fusion without CC/MCC).

CMS created the following three new MS-DRGs to account for a separate CC severity level:

- MS-DRG 518 (Back & Neck Procedure Except Spinal Fusion w MCC or Disc Device/Neurostimulator);
- MS-DRG 519 (Back & Neck Procedure Except Spinal Fusion w CC); and
- MS-DRG 520 (Back & Neck Procedure Except Spinal Fusion w/o CC/MCC).

Lastly, CMS modified MS-DRG 483 (Major Joint/Limb Reattachment Procedure of Upper Extremities with CC/MCC) by deleting MS-DRG 484 (Major Joint/Limb Reattachment Procedure of Upper Extremities without CC/MCC).
Procedure of Upper Extremities without CC/MCC) and revising the title for MS-DRG 483 (Major Joint/Limb Reattachment Procedure of Upper Extremities) to create one base DRG.

**Post-acute Transfer and Special Payment Policy**

As a result of changes to MS-DRGs for FY 2015 the following MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy and special payment policy:

- 266, 267 (Endovascular Cardiac Valve Replacement with and without MCC, respectively); and
- 518, 519, and 520 (Back & Neck Procedure except Spinal Fusion with MCC or Disc Device/Neurostimulator, with CC, and without MCC/CC, respectively).

MS-DRG 483 (Major Joint/Limb Reattachment Procedure of Upper Extremities) will be removed from the list of MS-DRGs subject to the post-acute care transfer policy.

MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy and special payment policy:

- Post-acute Transfer and Special Payment Policy
- 266, 267 (Endovascular Cardiac Valve Replacement with and without MCC, respectively); and
- 518, 519, and 520 (Back & Neck Procedure except Spinal Fusion with MCC or Disc Device/Neurostimulator, with CC, and without MCC/CC, respectively).

**MS-DRG 483 (Major Joint/Limb Reattachment Procedure of Upper Extremities)** will be removed from the list of MS-DRGs subject to the post-acute care transfer policy.

See Table Five of the FY 2015 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs at the end of this article or visit [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html) on the CMS website. At that page, click on the link on the left side of the screen titled, “FY 2015 IPPS Final Rule Home Page” or “Acute Inpatient - Files for Download”.

**New Technology Add-On**

The following items will continue to be eligible for new-technology add-on payments in FY 2015:

- Zenith Fenestrated Graft- Cases involving the Zenith Fenestrated Graft that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 39.78. The maximum add-on payment for a case involving the Zenith Fenestrated Graft is $8,171.50. (For your information the ICD-10-CM procedure codes are: 04U03JZ - Supplement Abdominal Aorta with Synthetic Substitute, Percutaneous Approach; 04U04JZ - Supplement Abdominal Aorta with Synthetic Substitute, Percutaneous Endoscopic Approach; 04V03DZ - Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Approach or 04V04DZ - Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Endoscopic Approach.

- Voraxaze- Cases involving Voraxaze that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 00.95. The maximum add-on payment for a case involving the Voraxaze is $45,000. (For your information the ICD-10-CM procedure codes are: 3E033GQ - Introduction of Glucarpidase into Peripheral Vein, Percutaneous Approach or 3E043GQ - Introduction of Glucarpidase into Central Vein, Percutaneous Approach.)

- Argus- Cases involving the Argus ®II System that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 14.81. The maximum
add-on payment for a case involving the Argus®II System is $72,028.75. (For your information the ICD-10-CM procedure codes are: 08H005Z - Insertion of Epiretinal Visual Prosthesis into Right Eye, Open Approach or 08H105Z - Insertion of Epiretinal Visual Prosthesis into Left Eye, Open Approach.)

- **Kcentra** - Cases involving Kcentra that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 00.96. The maximum add-on payment for a case of Kcentra™ is $1,587.50. DO NOT MAKE THIS NEW TECH PAYMENT IF ANY OF THE FOLLOWING DIAGNOSIS CODES ARE ON THE CLAIM: 286.0, 286.1, 286.2, 286.3, 286.4, 286.5, 286.52, 286.53, or 286.59. (For your information the ICD-10-CM procedure codes are: 30280B1 - Transfusion of Nonautologous 4-Factor Prothrombin Complex Concentrate into Vein, Open Approach or 30283B1 - Transfusion of Nonautologous 4-Factor Prothrombin Complex and the ICD-10-CM diagnosis codes are: D66, D67, D68.1, D68.2, D68.0, D68.311, D68.312, D68.318, D68.32, and D68.4.)

- **Zilver** - Cases involving the Zilver® PTX® that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 00.60. The maximum add-on payment for a case of the Zilver® PTX® is, $1,705.25. (For your information the ICD-10-CM procedure codes are: 047K04Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Open Approach; 047K34Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Approach; 047K44Z - Dilation of Right Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach; 047L04Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Open Approach; 047L34Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Approach or 047L44Z - Dilation of Left Femoral Artery with Drug-eluting Intraluminal Device, Percutaneous Endoscopic Approach.)

The following items will be eligible for new-technology add-on payments in FY2015:

- **CardioMEMS™ HF Monitoring System** – Cases involving the CardioMEMS™ HF Monitoring System that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 38.26. The maximum add-on payment is $8,875. (For your information the ICD-10-CM procedure code is: 02HQ30Z- Insertion of Pressure Sensor Monitoring Device into Right Pulmonary Artery, Percutaneous Approach.)

- **MitraClip® System** - Cases involving the MitraClip® System that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 35.97. The maximum add-on payment is $15,000. (For your information, the ICD-10-CM procedure code is: 02UG3JZ Supplement Mitral Valve with Synthetic Substitute, Percutaneous Approach.)
• RNS® System- Cases involving the RNS® System that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 01.20 in combination with 02.93. The maximum add-on payment is $18,475. (The ICD-10-CM procedure codes are: 0NH00NZ-Insertion of Neurostimulator Generator into Skull, Open Approach in combination with 00H00MZ-Insertion of Neurostimulator Lead into Brain, Open Approach.)

Cost of Living Adjustment (COLA) Update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2015, and are the same COLAs established for FY 2014. For reference, a table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2014, is in the FY 2015 IPPS/LTCH PPS final rule and is also displayed in the following table:

<table>
<thead>
<tr>
<th>Area</th>
<th>Cost of Living Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska:</td>
<td></td>
</tr>
<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>
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</tr>
<tr>
<td>Rest of Alaska</td>
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<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>

FY 2015 Wage Index Changes and Issues

Effective October 1, 2014, CMS is revising the labor market areas used for the wage index based on the most recent labor market area delineations issued by the Office of Management and Budget (OMB) using 2010 Census data. MACs will update the Actual Geographic Location Core-Based Statistical Area (CBSA) field in the Provider Specific File (PSF) (data element 35) effective October 1, 2014, to reflect the new CBSA delineations.

CMS is adopting a one-year transition for FY 2015 for hospitals that are experiencing a decrease in their wage index exclusively due to the implementation of the new OMB delineations. This mitigates potential negative payment impacts due to the adoption of the new OMB delineations.
Under the new OMB delineations for the few hospitals that have been located in an urban county prior to October 1, 2014, that are becoming rural effective October 1, 2014, CMS is assigning a hold-harmless urban wage index value of the labor market area in which they are physically located for FY 2014 for 3 years beginning in FY 2015. That is, for FYs 2015, 2016, and 2017, assuming no other form of wage index reclassification or redesignation is granted, these hospitals are assigned the area wage index value of the urban CBSA in which they were geographically located in FY 2014.

For FY 2015, for hospitals that are eligible for the 3-year hold-harmless transition, it is possible that receiving the FY 2015 wage index of the CBSA where the hospital is geographically located for FY 2014 might still be less than the FY 2015 wage index that the hospital would have received in the absence of the adoption of the new OMB delineations. The assignment of the 3-year transitional wage index is included in the calculation of the FY 2015 portion of the blended wage index for that hospital. After FY 2015, such a hospital will revert to the second year of the 3-year transition (assuming no other form of wage index reclassification or redesignation is granted).

Note that for hospitals that are receiving a one-year transition blended wage index or the 3-year hold-harmless wage index, these transitions are only for the purpose of the wage index and do not affect a hospital’s urban or rural status for any other payment purposes.

**Treatment of Certain Providers Redesignated Under Section 1886(d)(8)(B) of the Act**

CFR 412.64(b)(3)(ii) implements Section 1886(d)(8)(B) of the Social Security Act, which redesignates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as “Lugar counties”.) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are redesignated.

A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes.

**Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under 42 CFR 412.103**

An urban hospital that reclassifies as a rural hospital under 412.103 is considered rural for all IPPS purposes. Note that hospitals reclassified as rural under 412.103 are not eligible for the capital Disproportionate Share Hospital (DSH) adjustment since these hospitals are considered rural under the capital PPS (see 412.320(a)(1)). Please reference Table 9C of FY 2015 Final rule available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html) on the CMS website.

**Medicare-Dependent, Small Rural Hospital (MDH) Program Expiration**

The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges.
MDH program is currently effective through March 31, 2015, as provided by section 106 of the Protecting Access to Medicare Act of 2014. Provider Types 14 and 15 continue to be valid through March 31, 2015.

Under current law, beginning in April 1, 2015, all previously qualifying hospitals will no longer have MDH status and will be paid based solely on the Federal rate. (CMS notes that the Sole Community Hospital (SCH) policy at section 412.92(b) allows MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program.) Provider Types 14 and 15 will no longer be valid beginning April 1, 2015.

Hospital Specific (HSP) Rate Update for Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospitals (MDHs)

For FY 2015, Hospital-Specific (HSP) amount in the PSF for SCHs and MDHs will continue to be entered in FY 2012 dollars. PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 - 2014 of 0.9480 and make all updates to the HSP amount for FY 2013 and beyond. (As noted above, under current law, the MDH program expires March 31, 2015.)

Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2015

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Section 105 of the Protecting Access to Medicare Act of 2014 extended the temporary changes to the low-volume hospital payment adjustment through March 31, 2015. The regulations implementing the hospital payment adjustment policy are at 412.101.

Beginning with FY 2015 discharges occurring on or after April 1, 2015, the low-volume hospital qualifying criteria and payment adjustment methodology will revert to that which was in effect prior to the amendments made by the Affordable Care Act and subsequent legislation (that is, the low-volume hospital payment adjustment policy in effect for FYs 2005 through 2010).

Effective October 1, 2014, through March 31, 2015, in order to qualify as a low-volume hospital, a hospital must be located more than 15 road miles from another “subsection (d) hospital” and have less than 1600 Medicare discharges (which includes Medicare Part C discharges) during the fiscal year. For FY 2015 discharges occurring through March 31, 2015, the applicable low-volume percentage increase is determined using a continuous linear sliding scale equation that results in a low-volume hospital payment adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more Medicare discharges.

For FY 2015 discharges occurring before April 1, 2015, qualifying low-volume hospitals and their payment adjustment are determined using Medicare discharge data from the March
2014 update of the FY 2013 MedPAR file. Table 14 of the FY 2015 IPPS/LTCH PPS final rule (which is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html) lists the “subsection (d)” hospitals with fewer than 1,600 Medicare discharges based on the March 2014 update of the FY 2013 MedPAR file and their low-volume payment adjustment for FY 2015 discharges occurring before April 1, 2015 (if eligible). CMS notes that the list of hospitals with fewer than 1,600 Medicare discharges in Table 14 does not reflect whether or not the hospital meets the mileage criterion (that is, the hospital is located more than 15 road miles from any other subsection (d) hospital, which, in general, is an IPPS hospital).

Effective April 1, 2015, in order to qualify as a low-volume hospital, a hospital must be located more than 25 road miles from another “subsection (d) hospital” and have less than 200 total discharges (including both Medicare and non-Medicare discharges) during the fiscal year. For FY 2015 discharges occurring on or after April 1, 2015, the low-volume hospital adjustment for all qualifying hospitals is 25 percent. For FY 2015 discharges occurring on or after April 1, 2015, the MAC will make the discharge determination based on the hospital’s number of total discharges, that is, Medicare and non-Medicare discharges as reported on the hospital’s most recently submitted cost report. To meet the mileage criterion to qualify for the low-volume hospital payment adjustment for FY 2015 discharges occurring on or after April 1, 2015, a hospital must be located more than 25 road miles (as defined at § 412.101(a)) from the nearest “subsection (d) hospital” (that is, in general, an IPPS hospital).

A hospital must notify and provide documentation to its MAC that it meets the discharge and distance requirements under 412.101 under 412.101(b)(2)(i) for FY 2015 discharges occurring before April 1, 2015, and 412.101(b)(2)(i) for FY 2015 discharges occurring on or after April 1, 2015, if also applicable. Specifically, for FY 2015, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2014, in order for the applicable low-volume hospital payment adjustment to be applied to payments for its discharges occurring on or after October 1, 2014, and through March 31, 2015, or through September 30, 2015, for hospitals that also meet the low-volume hospital mileage criterion qualifying criteria for discharges occurring during the second half of FY 2015.
A hospital that qualified for the low-volume payment adjustment in FY 2014 may continue to receive a low-volume payment adjustment for FY 2015 discharges occurring before April 1, 2015, without reapplying if it continues to meet the Medicare discharge criterion established for FY 2015 and the distance criterion. However, the hospital must send written verification that is received by its MAC no later than September 1, 2014, stating that it continues to be more than 15 miles from any other “subsection (d)” hospital. If a hospital’s written request for low-volume hospital status for FY 2015 is received after September 1, 2014, and if the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital’s FY 2015 discharges, effective prospectively within 30 days of the date of its low-volume hospital status determination.

The low-volume hospital payment is based on and in addition to all other IPPS per discharge payments, including capital, DSH (including the uncompensated care payment), indirect medical education (IME) and outliers. For SCHs and MDHs, the low-volume hospital payment is based on and in addition to either payment based on the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

**Hospital Quality Initiative**

The hospitals that will receive the quality initiative bonus are listed at the following Web site: [www.qualitynet.org](http://www.qualitynet.org). Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website.

**Electronic Health Record Incentive Program (EHR)**

Section 1886(b) (3) (B) of the Social Security Act as amended by Section 4102(b) (1) of the Health Information Technology for Economic and Clinical Health (HITECH) Act requires CMS to apply a reduced annual payment update to the IPPS update for subsection(d) hospitals that are not meaningful EHR users or have not been granted a hardship exception. The statute also requires payment adjustments for eligible hospitals in states where hospitals are paid under section 1814(b) (3) of the Act (waiver).

For FY2015, the applicable percentage increase to the IPPS payment rate is adjusted downward for those eligible hospitals that are not meaningful EHR users for the associated EHR reporting period for a payment year. This reduction applies to three-quarters of the percentage increase otherwise applicable. The reduction to three-quarters of the applicable update for an eligible hospital that is not a meaningful EHR user is 33 1/3 percent for FY 2015. In other words, for eligible hospitals that are not meaningful EHR users, the percentage increase is reduced for the entire FY by 25 percent (33 1/3 percent of 75 percent) in 2015.

A list of hospitals that will receive the EHR Incentive Payment reduction for FY 2015 is listed in the Official Instruction to CR8900 titled: Hospitals Subject to EHR Payment Incentive Reduction for FY 2015.
Hospital Acquired Conditions (HAC)

Section 3008 of the Affordable Care Act establishes a program, beginning in FY 2015, for IPPS hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain HACs. HACs are conditions that patients did not have when they were admitted to the hospital, but which developed during the hospital stay. Under the HAC Reduction Program, hospitals that rank in the worst-performing quartile of selected HAC measures will be subject to a reduction of what they would otherwise be paid under the IPPS. The HAC Reduction Program adjustment amount is calculated after all other IPPS per discharge payments, which includes adjustments for DSH (including the uncompensated care payment), IME, outliers, readmissions, Value-Based Purchasing (VBP), low-volume hospitals, and capital payments. For SCHs and MDHs, the HAC Reduction Program adjustment amount applies to either the Federal rate payment amount or the hospital-specific rate payment amount, whichever results in a greater operating IPPS payment.

CMS did not make the list of providers subject to the HAC Reduction Program public in the final rule because they had not completed the Review and Correction period.

Hospital Value Based Purchasing

Section 3001 of the Affordable Care Act added section 1886(o) to the Social Security Act, establishing the Hospital Value-Based Purchasing (VBP) Program. This program began adjusting base operating DRG payment amounts for discharges from subsection (d) hospitals, beginning in FY 2013. CMS has continued to exclude Maryland hospitals from the Hospital VBP Program for the FY 2015 program year. The regulations that implement this provision are in subpart I of 42 CFR part 412 (sections 412.160 through 412.162).

Under the Hospital VBP Program, CMS reduces base operating DRG payment amounts for subsection (d) hospitals by the applicable percent defined in statute. The applicable percent for payment reductions for FY 2015 is 1.50 percent, and it gradually increases each fiscal year to 2.0 percent in FY 2017. These payment reductions fund value-based incentive payment to hospitals that meet or exceed performance standards on the measures selected for the program. By law, CMS must base value-based incentive payments on hospitals’ performance under the Hospital VBP Program, and the total amount available for value-based incentive payments must be equal to the amount of payment reductions, as estimated by the Secretary.

CMS calculates a Total Performance Score (TPS) for each hospital eligible for the Hospital VBP Program. CMS then uses a linear exchange function to convert each hospital’s TPS into a value-based incentive payment. Based on that linear exchange function’s slope, as well as an individual hospital’s TPS, the hospitals’ own annual base operating DRG payment amount, and the applicable percent reduction to base operating DRG payment amounts, CMS calculates a value-based incentive payment adjustment factor that is applied to each discharge at a hospital, for a given fiscal year.
In the FY 2013 IPPS/LTCH PPS final rule, CMS established the methodology to calculate the hospital value-based incentive payment adjustment factor, the portion of the IPPS payment that will be used to calculate the value-based incentive payment amount, and review and corrections and appeal processes wherein hospitals can review information used to calculate their TPSs and submit requests for corrections to the information before it is made public.

For FY 2015, CMS will implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2015.

Note that the values listed in Table 16A of the FY2015 IPPS Final Rule are “proxy” values. The proxy values are not used to adjust payments. CMS will add Table 16B to display the actual value-based incentive payment adjustment factors, which is expected to be available in October 2014 at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html on the CMS website.

**Hospital Readmissions Reduction Program**

For FY 2015, the readmissions adjustment factor is the higher of a ratio or 0.97 (-3 percent). The readmissions adjustment factor is applied to a hospital’s “base operating DRG payment amount”, or the wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable), to determine the amount reduced from a hospital’s IPPS payment due to excess readmissions. Add-on payments for IME, DSH (including the uncompensated care payment), outliers and low-volume hospitals are not adjusted by the readmissions adjustment factor. In addition, for SCHs, the difference between the SCH’s operating IPPS payment under the hospital-specific rate and the Federal rate is not adjusted by the readmissions adjustment factor. However, the portion of a MDH’s payment reduction due to excess readmissions that is based on 75 percent difference between payment under the hospital-specific rate and payment under the Federal rate will be determined at cost report settlement. In determining the claim payment, the PRICER will only apply the readmissions adjustment factor to a MDH’s wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable) to determine the payment reduction due to excess readmissions.

Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2015 (such as Maryland hospitals), have a readmission adjustment factor of 1.0000. (Hospitals located in Puerto Rico are not subject to the Hospital Readmissions Reduction Program). For FY 2015, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.

The Hospital Readmissions Reduction Program (HRRP) adjustment factors for FY 2015 are proxy values and are available in Table 15 of the FY 2015 IPPS final rule, which is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page-Items/FY2015-Final-Rule-Tables.html on the CMS website. Claims will be reprocessed if a hospital’s
HRR Adjustment factor changes when the actual factors are available in the near future. CMS will display the final HRRP adjustment factors for FY 2015 on the CMS website.

**Medicare Disproportionate Share Hospitals (DSH) Program**

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Starting in FY 2014, hospitals received 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of this uncompensated care pool based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital’s share of uncompensated care is based on its share of insured low income days, defined as the sum of Medicare SSI days and Medicaid days, relative to all Medicare DSH hospitals’ insured low income days.

The Medicare DSH payment will be reduced to 25 percent of the amount they previously would have received under the current statutory formula in PRICER. The calculation of the Medicare DSH payment adjustment will remain unchanged and the 75 percent reduction to the DSH payment will be applied in PRICER.

For FY 2015, the total uncompensated care payment amount to be paid to Medicare DSH hospitals is $7,647,644,885.18, as calculated as the product of 75 percent of Medicare DSH (estimated CMS Office of the Actuary) and the change in percent of uninsured individuals and an additional statutory adjustment at 76.19 percent. The total uncompensated care payment amount to be paid to the Medicare DSH hospitals was finalized in the FY 2015 IPPS Final Rule. The uncompensated care payment will be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2015. The estimated per claim amount is determined by dividing the total uncompensated care payment by the average number of claims from the most recent three years of claims data (FYs 2011-2013).

The hospitals that were located in urban counties that are becoming rural under our adoption of the new OMB delineations, are subject to a transition for their Medicare DSH payment. For a hospital with more than 99 beds and less than 500 beds that was redesignated from urban to rural, it would be subject to a DSH payment adjustment cap of 12 percent. Under the transition, per the regulations at 412.102, for the first year after a hospital loses urban status, the hospital will receive an additional payment that equals two-thirds of the difference between DSH payment before its redesignation from urban to rural and the DSH payment otherwise applicable to the hospital subsequent to its redesignation from urban to rural.

In the second year after a hospital loses urban status, the hospital will receive an additional payment that equals one third of the difference between the DSH payments applicable to the hospital before its redesignation from urban to rural and the DSH payments otherwise applicable to the hospital subsequent to its redesignation from urban to rural.
adjustment will be determined at cost report settlement and will apply the DSH payment adjustment based on its urban/rural status according to the redesignation.

**Recalled Devices**

As a reminder, section 2202.4 of the Provider Reimbursement Manual, Part I states, “charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient.” Accordingly, hospital charges with respect to medical devices must be reasonably related to the cost of the medical device. If a hospital receives a replacement medical device for free, the hospital should not be charging the patient or Medicare for that device. The hospital should not be including costs on the cost report or charges on the Medicare claim. If that medical device was received at a discount, the charges should also be appropriately reduced.


**LTCH PPS FY 2015 Update**

FY 2015 LTCH PPS Rates and Factors are located in the official instruction to CR 8900. The LTCH PPS Pricer has been updated with the Version 31.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2014, and on or before September 30, 2015.

**LTCH Quality Reporting (LTCHQR) Program**

Section 3004(a) of the Affordable Care Act requires the establishment of the Long-Term Care Hospital Quality Reporting (LTCHQR) Program. Beginning in FY 2015, the annual update to a standard Federal rate will be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance with the LTCHQR Program for that year.

**Cost of Living Adjustment (COLA) Update for LTCH PPS**

There are no changes to the COLAs for FY 2015, and are the same COLAs. For reference, a table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2014, can be found in the FY 2015 IPPS/LTCH PPS final rule and is also shown in Table 2 in the Attachment to CR8900 titled, “FY 2015 Tables”.

**Core-Based Statistical Area (CBSA)-based Labor Market Area Updates**

CMS is updating the CBSA based labor market area definitions (and associated CBSA codes) used under the LTCH PPS for FY 2015. These revisions to the LTCH PPS geographic classifications are based on the most recent metropolitan statistical area (MSA) delineations issued by OMB using 2010 Census data.

In order to mitigate potential negative payment impacts due to the adoption of the new OMB delineations, CMS adopted a one-year transition for LTCHs that would experience a decrease in their wage index exclusively due to the implementation of the new OMB delineations. Under this transition policy, for discharges occurring in FY 2015, affected
LTCHs will get a “50/50 blended area wage index” value that is calculated as the sum of 50 percent of the wage index computed under the FY 2014 CBSA designations (from Tables 12C and 12D, as applicable, of the FY 2015 IPPS/LTCH PPS final rule) and 50 percent of the wage index computed under the new OMB delineations for FY 2015 (from Tables 12A and 12B, as applicable, of the FY 2015 IPPS/LTCH PPS final rule).

**Additional LTCH PPS Policy Changes for FY 2015**

The statutory moratoria on the full implementation of the “25 percent threshold” payment adjustment originally put in place by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) is extended until the start of LTCH cost reporting periods beginning on either July or October, 2014, as applicable as provided by the Pathway for the Sustainable Growth Rate (SGR) Reform Act. The new extension generally maintained the same policies that have been in place, except that “grandfathered” LTCH hospitals-within-hospitals (HwH) are totally exempt from the application of the 25 percent threshold. For additional details, refer to the discussion in the FY 2015 IPPS/LTCH PPS final rule.

The FY 2015 IPPS/LTCH final rule also included the removal of the “5 percent” policy adjustment. Therefore, the policy specified at 42 CFR 412.532, Special Payment Provisions for Patients Who are Transferred to Onsite Providers and Readmitted to an LTCH, is no longer in effect beginning October 1, 2014.

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](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 Internet-based PECOS for DMEPOS Suppliers” Fact Sheet, ICN 904283, Downloadable

MLN Matters® Number: SE1426  Related Change Request (CR) #: CR 8581
Related CR Release Date: August 8, 2014  Effective Date: Claims received on or after April 1, 2015
Related CR Transmittal #: R3060CP  Implementation Date: July 6, 2015

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”

Note: This article was revised on September 3, 2014, to reflect a new Change Request (CR). The revised CR corrected the effective date to “Claims received on or after April 1, 2015,” and spread the implementation across four quarterly releases. In this article the CR release date, transmittal number and link to the CR also changed. All other information remains the same.

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) on the

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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 April 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…

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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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<tr>
<td>Adjustment Condition Code</td>
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<td>Adjustment Reason Code</td>
<td>R1</td>
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<tr>
<td>Remarks – (Good Cause)</td>
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**Claim 2:** Clerical Error – Minor Error – Keying Error

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<td>R1</td>
</tr>
<tr>
<td>Remarks – (Good Cause)</td>
<td>Not Required</td>
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</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.

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

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<td>Remarks – (Good Cause)</td>
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### Claim 5: Clerical Error – Minor Error – Incorrectly Identified Duplicate

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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.)

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

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<td><strong>Incorrect data entry (left off the code from billing)</strong></td>
<td>Changes in Revenue Code/HCPCS/HIPPS Rate Codes</td>
<td>May be added to provide additional information for claims processing.</td>
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<td>Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes</td>
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<td></td>
<td>Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers</td>
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</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)

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<td>R7</td>
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<td><strong>Computer System Omission</strong></td>
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<td>May be added to provide additional information for claims processing.</td>
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</tbody>
</table>

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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)

<table>
<thead>
<tr>
<th>TOB</th>
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<td>&lt; 1 yr Initial Determination</td>
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<td>Remarks – (Good Cause)</td>
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### Claim 9: Corrections Other than Clerical Errors – Faulty Evidence

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<td>&lt; 1 yr Initial Determination</td>
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<td>May be added to provide additional information for claims processing.</td>
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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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<td>D9</td>
<td>R2</td>
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</table>

- Mathematical or computational mistakes

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

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<th>TOB</th>
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<td>D1</td>
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<td>E0</td>
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</tr>
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</table>

- Inaccurate data entry (inverted code)
- 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

#### 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>
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<th>Adjustment Condition Code</th>
<th>Adjustment Reason Code</th>
<th>Remarks – (Good Cause)</th>
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<td>R3</td>
<td>D9</td>
<td>R2</td>
<td>Yes</td>
</tr>
</tbody>
</table>

- Misapplication of a fee schedule
- Other

Remarks – (Good Cause) Yes

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

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<tr>
<th>TOB</th>
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<td>Changes to charges</td>
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<td>D2</td>
<td></td>
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<tr>
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<tr>
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<td>Change in patient status</td>
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### Claim 5: Clerical Error – Minor Error – Incorrectly Identified Duplicate

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

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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>Change in patient status</td>
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| Adjustment Reason Code | R2   | 1-4 yrs from Initial Determination                     |

| Remarks – (Good Cause) | Yes  |

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

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<td>D9</td>
<td>Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers</td>
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</tbody>
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| Adjustment Reason Code | R2   | 1-4 yrs from Initial Determination                     |

| Remarks – (Good Cause) | Yes  |

---

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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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### 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 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)

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

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<tbody>
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Centers for Medicare & Medicaid Services
Articles for Part B Providers
“Medicare Enrollment Guidelines for Ordering/Referring Providers” Fact Sheet (ICN 906223), downloadable

MLN Matters® Number: MM8805 Revised Related Change Request (CR) #: CR 8805
Related CR Release Date: September 17, 2014 Effective Date: October 1, 2014
Related CR Transmittal #: R3070CP Implementation Date: October 6, 2014

New Waived Tests

Note: This article was revised on September 19, 2014, to reflect the revised CR8805 issued on September 17. The article was revised to correct the description in bullet point 7 on page 2. Also 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 clinical diagnostic laboratory providers submitting clinical diagnostic laboratory claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

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The Current Procedural Terminology (CPT) codes that the Centers for Medicare & Medicaid Services (CMS) consider to be laboratory tests under CLIA (and thus requiring certification) change each year. Change Request (CR) 8805 informs the MACs about the latest new CPT codes that are subject to CLIA edits. Make sure your billing staffs are aware of these latest CLIA-related changes, and that you remain current with certification requirements.

**Background**

Listed below are the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The CPT codes for the following new tests must have the modifier QW (CLIA-waived test) to be recognized as a waived test. However, the tests mentioned on the first page of the list attached to CR8805 (i.e., CPT codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

The CPT code, effective date and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

- **G0434QW, September 6, 2013,** BTNX Inc. Rapid Response Multi-Drug Urine Test Cup;
- **G0434QW, September 6, 2013,** BTNX Inc. Rapid Response Multi-Drug Urine Test Panel;
- **G0434QW, October 4, 2013,** uVera Diagnostics, Inc. CR2 Multi-Drug Urine Test Cup;
- **G0434QW, October 4, 2013,** uVera Diagnostics, Inc. CR3 Multi-Drug Urine Test Cup;
- **G0434QW, October 4, 2013,** uVera Diagnostics, Inc. SMARTOX U3 Multi-Drug Urine Test Cup;
- **G0434QW, October 24, 2013,** American Institute of Toxicology, Inc., AIT Laboratories Drug of Abuse Cup;
- **80061QW, 82962, 82465QW, 83718QW, 84478QW, November 12, 2013, Jant Pharmacal Corp, LipidPlus Professional Lipid Profile and Glucose Measuring System (LipidPlus Lipid Profile test strips);
- **G0434QW, December 4, 2013,** Nobel Medical Inc. INSTA-SCREEN Multi-Drug Urine Test Cup;
- **G0434QW, December 5, 2013,** Micro Distributing II, LTD One Step Multi-Drug Urine Test Panel;
- **G0434QW, February 11, 2014,** Alfa Scientific Designs, Inc. Confidential Drug Test – Multi Drugs of Abuse Urine Test (OTC);
• 87880QW, February 18, 2014, BD Veritor System for Rapid Detection of Group A Strep (direct from throat swab);
• 85018QW, February 18, 2014, Clarity HbCheck Hemoglobin Testing System;
• 87077QW, February 18, 2014, Jant Accutest Rapid Urease test (H. pylori detection);
• G0434QW, March 13, 2014, UCP Biosciences, Inc. UCP Multi-Drug Test Key Cups;
• 83986QW, March 18, 2014, RightBio Metrics, RightSpot Infant pH Indicator;
• 83986QW, March 18, 2014, RightBio Metrics, RightSpot pH Detector;
• 83986QW, March 18, 2014, RightBio Metrics, RightSpot pH Indicator;
• 85018QW, March 21, 2014, AimStrip Hb Hemoglobin (Hb) Testing System;
• G0434QW, April 11, 2014, PTox Drug Screen Cup {Cassette Dip Card format};
• 86308QW, April 22, 2014, Polymedco Polystat Mono {whole blood};
• 82274QW, G0328QW, April 22, 2014, Rapid Response(TM) FIT-Fecal Immunochemical Test;
• 84443QW, May 16, 2014, Germaine Laboratories, Inc. AimStep Thyroid Screen {whole blood};
• 82055QW, May 21, 2014, Express Diagnostics International, Incorporated Saliva Alcohol Test;
• 83037QW, May 22, 2014, BIO-RAD in2it (II) System Analyzer Prescription Home Use; and
• 87880QW, May 23, 2014, Accustrip Strep A {Specimen type (Throat Swab)}.

You should be aware that your MAC will not search their files, to either retract payment or retroactively pay claims; however, they should adjust such 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 under - How Does It Work.

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New Physician Specialty Code for Interventional Cardiology

Note: This article was revised on September 26, 2014, to reflect the revised CR8812 that was issued on September 23. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, 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.