# Medicare Monthly Review

**Issue No. MMR 2014-11**

**November 2014**

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Local Coverage Determinations and Article Revisions and Updates
Effective November 2014

Bevacizumab (Avastin™) - Related to LCD L25820 (A46095)

Article published October 2014: Based on two reconsideration requests a) recurrent respiratory papillomatosis of larynx and b) malignant meningiomas, sources have been added to the “Other Comments” section of the article. No changes were made in coverage. Choroidal retinal neovascularization, secondary to pathologic myopia has been added to the “OPHTHALMOLOGIC INDICATIONS” section. The indication for cervical cancer has been revised to include new FDA approval language. The Group 2: Paragraph section has been revised to remove instructions regarding secondary diagnosis requirements for ICD-9 code 362.07.

Bortezomib (Velcade®) – Related to LCD L25820 (A47582)

Article published October 2014: The “Indications” section has been revised for clarity. ICD-9-CM codes 204.10, 204.12, 204.90 and 204.92 have been deleted and replaced with ICD-9-CM codes 204.80, 204.82 effective for dates of service on or after 10/1/2014. ICD-9-CM code 277.39 has also been added effective for dates of service on or after 10/1/2014.

Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L25820)

The following article has been retired and removed from the LCD: A48211 - Thyrotropin Alfa (Thyrogen®) - Related to LCD L25820. No comment and notice period required and none given.

Galectin-3 (L32977)

Based on a request for reconsideration of the conclusion that “the assay is of an uncertain role in the clinical management of patients”, sources were added to the “Sources of Information and Basis for Decision” section of the LCD. No changes were made in coverage. The “Other Comments” section has been removed. No comment or notice periods required and none given.

Intravenous Immune Globulin (IVIG) - Related to LCD L25820 (A47381)

Article published October 2014: The “Indications” have been corrected to show that “Acute and chronic inflammatory demyelinating polyradiculoneuropathy, Guillain-Barre syndrome, myasthenia gravis, immune thrombocytopenic purpura in pregnancy, multifocal motor neuropathy (MMN), and dermatomyositis” is listed as a separate indication and not part of Indication #9 for “Kawasaki disease.”

Ranibizumab (Lucentis™) and Aflibercept (Eylea™) – Related to LCD L25820 (A46091)

Article published October 2014: Choroidal retinal neovascularization, secondary to pathologic myopia and proliferative diabetic retinopathy, as adjunctive therapy to panretinal photocoagulation in the treatment of high-risk disease have been added to the “Indications” section for ranibizumab. ICD-9-CM codes 362.02, 362.16 and 362.53 have been added to the Group 1: Codes for ranibizumab effective for dates of service on or after 10/1/2014. ICD-9-CM code 362.53 has been added to the Group 2: Codes for aflibercept effective for dates of service on or after 10/1/2014. The ICD-9-CM code groups have been revised to remove instructions regarding secondary diagnosis requirements.

Rituximab (Rituxan®) (effective 2010) - Related to LCD L25820 (A49636)

Article published October 2014: The second bullet under Non-Hodgkin’s Lymphoma (NHL) has been corrected to state: previously untreated follicular, CD20-positive, B-cell NHL in combination with first line chemotherapy and in patients achieving a complete or partial response to Rituxan in combination with chemotherapy, as single-agent maintenance therapy. The indication for pemphigus vulgaris, severe has been expanded to include other autoimmune blistering skin diseases (for example, pemphigus foliaceus, bullous pemphigoid, cicatricial pemphigoid, epidermolysis bullosa acquisita and paraneoplastic pemphigus) when refractory. ICD-9-CM codes 694.0-694.3, 694.5-694.9 and 695.15 have been added to the “Covered ICD-9 Codes” section effective for dates of service on or after 10/1/2014. Outdated information has been removed.

Retired Article

Thyrotropin Alfa (Thyrogen®) - Related to LCD L25820 (A48211) – 09/30/2014
November 2014 Revisions

Bortezomib (Velcade®) – Related to LCD L25820 (A47582)

Article published November 2014: The “Indications” section has been revised to add mantle cell lymphoma effective for dates of service on or after 10/8/2014. The “Sources of Information” section has been revised to add FDA label information for bortezomib effective 10/8/2014. The statement in the “Documentation Requirements” section has been revised:

From:
When a portion of the drug is discarded, the medical record must clearly show the amount administered and the amount wasted.

To:
When modifier –JW is used to report that a portion of the drug is discarded, the medical record must clearly show the amount administered and the amount wasted.

Cataract Extraction (L26853)

Deleted the following language from the Indications and Limitations of Coverage section: “Bilateral cataract extraction should not be performed on both eyes on the same day because of the potential for bilateral visual loss. If the first cataract extraction is performed and a subsequent contralateral cataract extraction is considered, the criteria for coverage of the procedure in the contralateral eye are the same as the criteria for the first cataract extraction.”

Effective for services rendered on or after 11/1/2014, added the following language to the Indications and Limitations of Coverage section:

“Immediate, sequential, bilateral surgery has advantages and disadvantages that must be carefully weighed and discussed by the surgeon and patient. Foremost is the risk of potentially blinding complications in both eyes. For this reason the second eye should be treated like the eye of a different patient using separate povidone iodine prepping, draping, instrumentation, and supplies such as irrigating solutions, OVD, and medications.”

Deleted the “Other Comments” section.

Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L25820)

The fifth bullet under “Documentation Requirements” has been revised:

From:
When a portion of the drug or biological is discarded, from single use vials, the medical record must clearly document the amount administered and the amount wasted or discarded.

To:
When modifier –JW is used to report that a portion of the drug or biological is discarded, from single use vials, the medical record must clearly document the amount administered and the amount wasted or discarded.

The following article has been retired and removed from the LCD: A48420 - Intravenous Iron Therapy - Related to LCD L25820. No comment and notice period required and none given.

Drugs and Biologicals, Coverage of, for Label and Off-Label Uses - Supplemental Instructions Article (A44930)

Article published November 2014: The NOC coding information for the Part A and Part B MACs has been moved under the specific headings for “Claims submitted to the Part A MAC” and for “Claims submitted to the Part B MAC.” The fifth bullet under the guidelines for C9399 has been revised:

From:
Total amount of the drug (in units) the beneficiary received

To:
The quantity of the drug that was administered, expressed in the unit of measure applicable to the drug or biological.
Noninvasive Vascular Studies (L27355)
The LCD is revised to remove CPT code 93990 from Indications section V (Vessel Mapping of Vessels for Hemodialysis Access). Coverage for CPT code 93990 is correctly defined in the Indications section for Hemodialysis Access Examination.

Ranibizumab (Lucentis™) and Aflibercept (Eylea™) – Related to LCD L25820 (A46091)
Article published November 2014: The “Indications” section has been revised to add macular edema following retinal vein occlusion (RVO) as a payable indication for aflibercept effective for dates of service on or after 10/6/2014. The second paragraph in the “Utilization” section has been revised to indicate macular edema following RVO. The “Sources of Information” section has been revised to add FDA label information for aflibercept effective 10/6/2014. ICD-9-CM code 362.36 has been added to the Group 2: Codes for aflibercept effective for dates of service on or after 10/6/2014.

Retired LCDs/Articles
Cardiac Output Measurement Thoracic Electrical Bioimpedance (L25477) and (A44455)
Effective 11/1/2014, LCD and SIA are retired. All local policy rules, requirements, and limitations within this LCD and article will no longer be applied on a prepay basis, but as with any billed service, claims will be subject to postpay review. All CMS national policy rules, requirements and limitations remain in effect.

Intravenous Iron Therapy - Related to LCD L25820 (A48420) - 10/31/2014

Notification of the Change in the Amount in Controversy Required to Sustain Appeal Rights for an Administrative Law Judge Hearing or Federal District Court Review

Effective for Federal District Court requests filed on or after 1/1/2015, the amount in controversy will increase to $1,460. The amount that must remain in controversy for review in Federal District Court requested before 12/31/2014 is $1,430.

The amount that must remain in controversy for ALJ hearing requests filed before 12/31/2014 is $140. This amount will increase to $150 for ALJ hearing requests filed on or after 1/1/2015.
National Government Services Articles for Part B Providers

Clarification for Billing Services on Fingers and Toes Using Modifiers F1-F9, FA, TI-T9 and TA vs. Modifier 50

National Government Services has identified some providers who have been billing for services on the fingers and/or the toes with modifier 50. Modifier 50 indicates a bilateral service. For a service to be bilateral according to the definition, you must have one body part on each side of the body. Since there are 10 fingers/toes, the billing must be specific to which finger/toe the service is for by utilizing the appropriate modifier(s).

Modifiers F1-F9 and FA are to be reported for the appropriate finger. Modifiers T1-T9 and TA are to be reported for the appropriate toe. Please make sure that when you submit a service to Medicare on a specific finger, or toe, that you are using one of these modifiers. Do not use modifier 50 to indicate a service was done on one finger on the left hand and one finger on the right hand as that will cause your claim to reject.

**Example:** patient receives tenotomy on the first finger past the thumb of the left hand. The billing for this procedure would be 26460F1 to indicate the specific finger on which the procedure was performed. Billing 26460LT would not identify which finger and would be inappropriate billing.

Proper finger modifiers for usage with Medicare claim submissions are:
- FA – Left hand, thumb
- F1 – Left hand, second digit
- F2 – Left hand, third digit
- F3 – Left hand, fourth digit
- F4 – Left hand, fifth digit
- F5 – Right hand, thumb
- F6 – Right hand, second digit
- F7 – Right hand, third digit
- F8 – Right hand, fourth digit
- F9 – Right hand, fifth digit

Proper toe modifiers for usage with Medicare claim submissions are:
- TA – Left foot, thumb
- T1 – Left foot, second digit
- T2 – Left foot, third digit
- T3 – Left foot, fourth digit
- T4 – Left foot, fifth digit
- T5 – Right foot, thumb
- T6 – Right foot, second digit
- T7 – Right foot, third digit
- T8 – Right foot, fourth digit
- T9 – Right foot, fifth digit

Compound Drugs Billing Requirements for Implantable Pain Pumps

Compound drugs for implantable pain pumps should be billed on a single claim line as HCPCS code J3490. Providers may bill with the KD modifier, but it is not required. Please supply each drug name, dose, and the **total invoice price for the compounded product** on the 2300 or 2400 NTE segment or SV101-7 segment for electronic claims (or in Item 19 on the CMS-1500 claim form for providers who file paper claims). If using Baclofen as it comes from the manufacturer, you should bill J0475 for each 10 milligrams or J0476 for the 50 microgram intrathecal trial kit. However, if Baclofen is not in its original container and is compounded by a pharmacy, you must submit an invoice for the drug from the compounding pharmacy and bill as J3490 or J3490 KD.

**National Government Services will not request an invoice for compounded drugs used with implanted pain pumps.** Failure to provide this information will result in the rejection of the claim.
**Documentation Errors for Transcatheter Aortic Valve Replacement**

The CMS CERT program produces a national Medicare FFS error rate, as required by the Improper Payments Information Act. CMS strives to eliminate improper payments in the Medicare Program to maintain the Medicare trust funds and protect patients. If a claim is found to be in error, payment will be retracted.

We are providing you with this reminder as a result of several errors identified through the CERT program related to the NCD for transcatheter aortic valve replacement (TAVR) (20.32).

NCD 20.32 establishes comprehensive requirements which must be met in order for the TAVR to be considered reasonable and necessary. In particular, there is a need to ensure the hospital record reflects that, “Two cardiac surgeons have independently examined the patient face-to-face and evaluated the patient's suitability for open aortic valve replacement (AVR) surgery; and both surgeons have documented the rationale for their clinical judgment and the rationale is available to the heart team.”

Please note, there are many other requirements within NCD 20.32 which must also be met. Briefly, these other requirements include:

1. The valve and implantation system that has received FDA approval;
2. The patient (preoperatively and postoperatively) is under the care of a heart team which meets the requirements listed in the NCD regarding volume, availability of related services and personnel, and other qualifications;
3. The heart team's interventional cardiologist(s) and cardiac surgeon(s) must jointly participate in the intra-operative technical aspects of TAVR;
4. The heart team and hospital are participating in a prospective, national, audited registry.

Please review the full text of NCD 20.32 available through the Medicare Coverage Database found on the CMS website.

For this CERT Alert and others, please visit our website and click on CERT within the Medical Policy & Review mega tab.

**Modifier 52 - Claim Submission Billing**

National Government Services has found that on many occasions providers are billing for reduced services with modifier 52 appended to the CPT code; however, they are billing the regular charged amount for the procedure. In some of these cases, this type of billing could lead to an overpayment.

When billing for a reduced service, providers should reduce the billed amount by 50% just as providers are to increase a bilateral billing by 50%. Maintaining the same charge for a reduced service is not proper billing. Please make sure that when you submit any CPT code with modifier 52 that you are also reducing the billed amount by 50% prior to submission to Medicare.
Centers for Medicare & Medicaid Services
Articles for Part A&B Providers
REVISED product from the Medicare Learning Network® (MLN)

- “Contractor Entities At A Glance: Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities”, Educational Tool, ICN 906983, downloadable

MLN Matters® Number: MM8509 Revised       Related Change Request (CR) #: CR 8509
Related CR Release Date: October 2, 2014        Effective Date: January 6, 2014 for CMS-1500; for ICD-10 - upon implementation of ICD-10
Related CR Transmittal #: R3083CP                     Implementation Date: January 6, 2014 for CMS-1500; for ICD-10 - upon implementation of ICD-10

CMS 1500 Claim Form Instructions: Revised for Form Version 02/12

Note: This article was revised on October 6, 2014, to reflect the revised CR8509 issued on October 2. In the article, the effective and implementation dates have changed and the CR release date, transmittal number and the Web address for accessing the CR are changed. All other information is the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians and other providers submitting claims to Medicare contractors (carriers, A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME/MACs)) for services provided to Medicare beneficiaries.
Provider Action Needed

STOP – Impact to You
This change request (CR) 8509 revises the current CMS 1500 claim form instructions to reflect the revised CMS 1500 claim form, version 02/12.

CAUTION – What You Need to Know
Form Version 02/12 will replace the current CMS 1500 claim form, 08/05, effective with claims received on and after April 1, 2014:

- Medicare will begin accepting claims on the revised form, 02/12, on January 6, 2014;
- Medicare will continue to accept claims on the old form, 08/05, through March 31, 2014;
- On April 1, 2014, Medicare will accept paper claims on only the revised CMS 1500 claim form, 02/12; and
- On and after April 1, 2014, Medicare will no longer accept claims on the old CMS 1500 claim form, 08/05.

GO – What You Need to Do
Make sure that your billing staff are aware of these instructions for the revised form version 02/12.

Background
The National Uniform Claim Committee (NUCC) recently revised the CMS 1500 claim form. On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised form, 02/12. The revised form has a number of changes. Those most notable for Medicare are new indicators to differentiate between ICD-9 and ICD-10 codes on a claim, and qualifiers to identify whether certain providers are being identified as having performed an ordering, referring, or supervising role in the furnishing of the service. In addition, the revised form uses letters, instead of numbers, as diagnosis code pointers, and expands the number of possible diagnosis codes on a claim to 12.

The qualifiers that are appropriate for identifying an ordering, referring, or supervising role are as follows:

- DN - Referring Provider
- DK - Ordering Provider

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 2012 American Medical Association.
• DQ - Supervising Provider

Providers should enter the qualifier to the left of the dotted vertical line on item 17.

The Administrative Simplification Compliance Act (ASCA) requires Medicare claims to be sent electronically unless certain exceptions are met. Those providers meeting these exceptions are permitted to submit their claims to Medicare on paper. Medicare requires that the paper format for professional and supplier paper claims be the CMS 1500 claim form. Medicare therefore supports the implementation of the CMS 1500 claim form and its revisions for use by its professional providers and suppliers meeting an ASCA exception. More information about ASCA exceptions can be found in Chapter 24 of the "Medicare Claims Processing Manual" which is available at [http://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/clm104c24.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/clm104c24.pdf) on the Centers for Medicare & Medicaid Services (CMS) website.

Additional Information


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

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

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

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REVISED products from the Medicare Learning Network® (MLN)

- “Medicare Shared Savings Program and Rural Providers”, Fact Sheet, ICN 907408, downloadable

MLN Matters® Number: MM8676  Related Change Request (CR) #: CR 8676
Related CR Release Date: May 23, 2014  Effective Date: October 1, 2014
Related CR Transmittal #: R2968CP  Implementation Date: October 6, 2014

Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2014

Note: This article was revised on September 23, 2014, to reference the correct HCPCS codes in the "What You Need to Know" section. All other information remains the same.

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8676 to provide the DMEPOS Competitive Bidding Program (CBP) October 2014 quarterly update. CR 8676 provides specific instructions to your DME MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

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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.
ZIP Codes (Round 2 Only)

The following ZIP codes have been added to the Round 2 ZIP code files listed below to conform with U.S. Postal Service ZIP code changes within the identified competitive bidding areas:

- 97003 Portland-Vancouver-Beaverton, OR-WA
- 97078 Portland-Vancouver-Beaverton, OR-WA
- 20252 Washington-Arlington-Alexandria, DC-VA-MD-WV
- 56988 Washington-Arlington-Alexandria, DC-VA-MD-WV

The ZIP code files can be used to identify when a specific item furnished to a beneficiary is subject to the Competitive Bidding Program.

HCPCS Codes (Round 1 Recompete Only)

Effective January 1, 2014, the Round 1 Recompete Single Payment Amount file has been updated to replace HCPCS code, E0731NU, with HCPCS code, E0731KG. This change allows Medicare to accurately process and pay HCPCS code E0731 (Form Fitting Conductive Garment for Delivery of TENS or NMES (with Conductive Fibers Separated from the Patient's Skin by Layers of Fabric)) according to competitive bidding payment rules when used in conjunction with a competitive bidding base unit, such as TENS.

Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new CBP for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas. CMS awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, the result being reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 areas in 2007. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008 and made certain limited changes. In accordance with MIPPA, CMS conducted the supplier competition again in nine areas in 2009, referring to it as the Round
One Rebid. The Round One Rebid contracts and prices became effective on January 1, 2011 in the nine areas.

MIPPA also delayed the competition for Round Two from 2009 to 2011 and authorized national mail order competitions after 2010. The Affordable Care Act of 2010 expanded the number of Round Two MSAs from 70 to 91 and specified that all areas of the country be subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. The contracts and prices for Round 2 and the national mail-order program for diabetic testing supplies became effective on July 1, 2013.

CMS is required by law to recompete contracts for the DMEPOS Competitive Bidding Program at least once every three years. The Round One Rebid contract period for all product categories except mail-order diabetic supplies expired on December 31, 2013. (The Round One Rebid mail-order diabetic supply contracts expired on December 31, 2012.) On January 1, 2014, new contracts for the Round One Recompete became effective in the same competitive bidding areas as the Round One Rebid.

Additional Information


If you have any questions, please contact your DME MAC at their toll-free number, which is available at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.
**MLN Matters® Articles Index:** Have you ever tried to search MLN Matters® articles for information regarding a certain issue, but you did not know what year it was published? To assist you next time in your search, try the CMS article indexes that are published at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/MLNMattersArticles/ on the CMS website. These indexes resemble the index in the back of a book and contain keywords found in the articles, including HCPCS codes and modifiers. These are published every month. Just search for a keyword(s) and you will find articles that contain those word(s). Then just click on one of the related article numbers and it will open that document. Give it a try.

**MLN Matters® Number:** MM8875  
**Related Change Request (CR) #:** CR 8875  
**Related CR Release Date:** October 10, 2014  
**Effective Date:** January 1, 2015  
**Related CR Transmittal #:** R106MSP  
**Implementation Date:** January 1, 2015

**Medicare Secondary Payer (MSP) Group Health Plan (GHP) Working Aged Policy -- Definition of “Spouse;” Same-Sex Marriages**

**Provider Types Affected**

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

**Provider Action Needed**

**STOP – Impact to You**

Section 3 of the Defense of Marriage Act (DOMA) provided for purposes of federal law, the term “spouse” could not include individuals in a same-sex marriage. Because the MSP Working Aged provisions only apply to subscribers and their spouses, the Working Aged provisions did not apply on the basis of spousal status to individuals in a same-sex marriage.
The United States Supreme Court has invalidated this DOMA provision. Thus, the Centers for Medicare & Medicaid Services (CMS) is no longer prohibited from applying the MSP Working Aged provision to individuals in a same-sex marriage.

CAUTION – What You Need to Know

Effective January 1, 2015, the rules below apply with respect to the term “spouse” under the MSP Working Aged provisions. This is true for both opposite-sex and same-sex marriages.

- If an individual is entitled to Medicare as a spouse based upon the Social Security Administration’s rules, that individual is a “spouse” for purposes of the MSP Working Aged provisions.

- If a marriage is valid in the jurisdiction in which it was performed including one of the 50 states, the District of Columbia, or a U.S. territory, or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction, both parties to the marriage are “spouses” for purposes of the MSP Working Aged provisions.

- Where an employer, insurer, third party administrator, Group Health Plan (GHP), or other plan sponsor has a broader or more inclusive definition of spouse for purposes of its GHP arrangement, it may (but is not required to) assume primary payment responsibility for the “spouse” in question. If such an individual is reported as a “spouse” through the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) Section 111, Medicare will pay accordingly and pursue recovery, as applicable.

GO – What You Need to Do

Make sure your billing staffs are aware of these changes.

Background

Based on Change Request (CR) 8875, effective January 1, 2015, the definition of a spouse for purposes of the working aged provisions means "a person who is entitled to Medicare as a spouse based upon the Social Security Administration’s rules or a person whose marriage is valid in the jurisdiction in which it was performed including one of the 50 states, the District of Columbia, or a U.S. territory or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction."

The expanded rules for the definition of “spouse,” including proper reporting pursuant to MMSEA Section 111, must be implemented with a start date for the coverage in question no later than January 1, 2015.

To the extent an employer, insurer, third party administrator, GHP or other plan sponsor insurer has chosen to or chooses to utilize the new definitions referenced above or a broader

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definition of “spouse” for MSP purposes prior to January 1, 2015, it may do so. However, MACs may not apply the revised definition for Medicare purposes for coverage dates prior to January 1, 2015. Nor may MACs accept a definition of spouse broader than that quoted above. In the event, Medicare does pay for coverage prior to January 1, 2015, it will pursue recovery, as applicable.

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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REVISED product from the Medicare Learning Network® (MLN)

- “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: October 20, 2014 Effective Date: October 1, 2014
Related CR Transmittal #: R3097CP Implementation Date: October 6, 2014

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

Note: This article was revised on October 24, 2014, to reflect the revised CR8888 issued on October 20. The CR was revised to correct the Type of Service Indicator of HCPCS code G0471 to "5". In this article, 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

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(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 (MPFSDDB) 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.

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REVISED product from the Medicare Learning Network® (MLN)

• “Critical Access Hospital” Fact Sheet, ICN 006400, downloadable

MLN Matters® Number: MM8894  Related Change Request (CR) #: CR 8894
Related CR Release Date: October 3, 2014  Effective Date: May 6, 2014
Related CR Transmittal #: R175NCD and R3084CP  Implementation November 4, 2014

Intensive Cardiac Rehabilitation Program - Benson-Henry Institute Cardiac Wellness Program

Provider Types Affected

This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs) for cardiac rehabilitation services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8894 alerts providers that the Benson-Henry Institute Cardiac Wellness Program meets the program requirements set forth by Congress and is a Medicare covered benefit as of May 6, 2014. Make sure your billing staffs are aware of these changes.

Background

In CR8894, the Centers for Medicare & Medicaid Services (CMS) explains that on September 3, 2013, it initiated a national coverage analysis (NCA) to consider the expansion of Medicare coverage of intensive cardiac rehabilitation (ICR) services to include the Benson-Henry Institute Cardiac Wellness Program. As a result, effective for dates of service
on and after May 6, 2014, CMS determines that the evidence is sufficient to expand the ICR benefit to include the Benson-Henry Institute Cardiac Wellness Program, national coverage determination (NCD) NCD 20.31.3. The program meets the ICR program requirements set forth by Congress in section 1861 (eee)(4)(A) of the Social Security Act and in the regulations at 42 C.F.R. section 410.49(c). This program has been included on the list of approved ICR programs available at [http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html](http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html) on the CMS website.

The current ICR policy and program criteria remain unchanged as follows: ICR refers to a physician-supervised program that furnishes cardiac rehabilitation services more frequently and often in a more rigorous manner. An ICR program must show, in peer-reviewed published research, that it accomplished one or more of the following for its patients:

1. Positively affected the progression of coronary heart disease;
2. Reduced the need for coronary bypass surgery; or
3. Reduced the need for percutaneous coronary interventions.

The ICR program must also demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services:

1. Low density lipoprotein;
2. Triglycerides;
3. Body mass index;
4. Systolic blood pressure;
5. Diastolic blood pressure; and
6. The need for cholesterol, blood pressure, and diabetes medications.

For claims with dates of service on or after May 6, 2014, MACs will adjust claims brought to their attention but will not search their files for claims processed prior to implementation of CR8894.


Remember that MACs will only pay for ICR services when submitted on Types of Bill (TOB) 13X and 85X. When these services are submitted on other TOBs, note that the
services will be denied with a new Claim Adjustment Reason Code 171 - Payment is denied when performed by this type of provider in this type of facility.

**Additional Information**


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


MLN Matters® Number: MM8895 Revised  Related Change Request (CR) #: CR 8895
Related CR Release Date: October 7, 2014  Effective Date: January 1, 2015
Related CR Transmittal #: R3090CP  Implementation Date: January 5, 2015

Ambulance Inflation Factor for CY 2015 and Productivity Adjustment

Note: This article was revised on October 9, 2014, to reflect the revised CR8895 issued on October 7. The CR was revised to update the Multifactor Productivity Adjustment which then adjusts the inflation factor. In addition, 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, 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 0.60 percent and the CPI-U for 2015 is 2.10 percent. Under 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 1.50 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.
NEW product from the Medicare Learning Network® (MLN)


MLN Matters® Number: MM8942 Related Change Request (CR) #: CR 8942
Related CR Release Date: October 3, 2014 Effective Date: January 1, 2015
Related CR Transmittal #: R3087CP Implementation Date: January 5, 2015

2015 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8942 alerts you that the annual HPSA bonus payment file for 2015 will be made available by the Centers for Medicare & Medicaid Services (CMS) to your MAC and will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2015, through December 31, 2015. You should review Physician Bonuses webpage at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses) on the CMS website each year to determine whether you need to add modifier AQ to your claim in order to receive the bonus payment, or to see if the ZIP code in which you rendered services will automatically receive the HPSA bonus payment. Make sure that your billing staffs are aware of these changes.

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Background

Section 413(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 mandated an annual update to the automated HPSA bonus payment file. CMS automated HPSA ZIP code file shall be populated using the latest designations as close as possible to November 1 of each year. The HPSA ZIP code file shall be made available to MACs in early December of each year. MACs shall implement the HPSA ZIP code file and, for claims with dates of service January 1 to December 31 of the following year, shall make automatic HPSA bonus payments to physicians providing eligible services in a ZIP code contained on the file. Only areas designated as HPSAs prior to the end of the calendar will be eligible for a bonus payment in the following year.

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)

- “The CMS Value-Based Payment Modifier: What Medicare Eligible Professionals Need to Know in 2014” Web-Based Training (WBT)

MLN Matters® Number: MM8943  Related Change Request (CR) #: CR 8943
Related CR Release Date: October 3, 2014  Effective Date: January 1, 2015
Related CR Transmittal #: R3088CP  Implementation Date: January 5, 2015

2015 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs and Durable Medical Equipment (DME) MACs, for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.

Provider Action Needed

STOP – Impact to You

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in Change Request (CR) 8943 could impact your payments.

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CAUTION – What You Need to Know
CR 8943 provides the 2015 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and explains how the updates affect edits in Medicare claims processing systems.

By the first week in December 2014, the new code files for B MAC processing, and the new Excel and PDF files for A MAC processing will be available at [http://www.cms.gov/SNFConsolidatedBilling](http://www.cms.gov/SNFConsolidatedBilling) on the Centers for Medicare & Medicaid Services (CMS) website; and become effective on January 1, 2015.

GO – What You Need to Do
It is **important and necessary** to read the "General Explanation of the Major Categories" PDF file located at the bottom of each year’s MAC update in order to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

**Background**

Medicare’s claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay, as well as for beneficiaries in a non-covered stay. These edits allow separate payment for only those services that are excluded from consolidated billing.

Changes to HCPCS codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow MACs to make appropriate payments in accordance with policy for SNF CB, found in the "Medicare Claims Processing Manual," Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Sections 20.6 and 110.4.1. You may view this manual at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf) on the CMS website.

**Additional Information**


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

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Centers for Medicare & Medicaid Services
Articles for Part A Providers
REVISED product from the Medicare Learning Network® (MLN)
• "Swing Bed Services", Fact sheet (ICN 006951)

MLN Matters® Number: MM8873 Revised
Related Change Request (CR) #: CR 8873
Related CR Release Date: September 26, 2014
Effective Date: October 1, 2014
Related CR Transmittal #: R3080CP
Implementation Date: October 6, 2014

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

Note: This article was revised on September 30, 2014, to reflect the revised CR8873 issued on September 26. In the article, the long descriptor for HCPCS code C9135 in Table 2 is revised and the APC code for HCPCS code J9171 in Table 7 has been revised. The CR release date, transmittal number, and the Web address for accessing the CR are also changed. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

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Background

The October 2014 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, Status Indicator (SI), and Revenue Code additions, changes, and deletions identified in CR8873.

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

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

Changes to Device Edits for October 2014

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

New Services

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

Table 1 – New Service Effective October 1, 2014

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

Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

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

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

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

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

c. New HCPCS Codes Effective October 1, 2014 for Certain Drugs and Biologicals
Two new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biological listed in Table 2) in the hospital outpatient setting for October 1, 2014. These codes are listed in Table 3, and are effective for services furnished on or after October 1, 2014.

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

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

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

Table 4 – Drugs and Biologicals with Revised Status Indicators

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9160</td>
<td>Injection, denileukin diftitox, 300 micrograms</td>
<td>N/A</td>
<td>E</td>
<td>10/1/2014</td>
</tr>
<tr>
<td>J9300</td>
<td>Injection, gemtuzumab ozogamicin, 5 mg</td>
<td>N/A</td>
<td>E</td>
<td>10/1/2014</td>
</tr>
</tbody>
</table>

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

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

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

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


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

Table 6 – Updated Payment Rate for HCPCS Code J9171, Effective January 1, 2014, through March 31, 2014

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Corrected Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9171</td>
<td>K</td>
<td>0823</td>
<td>Docetaxel injection</td>
<td>$4.63</td>
<td>$0.93</td>
</tr>
</tbody>
</table>

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

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

Table 7 – Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2014 through June 30, 2014

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Corrected Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7335</td>
<td>K</td>
<td>9268</td>
<td>Capsaicin 8% patch</td>
<td>$25.49</td>
<td>$5.10</td>
</tr>
</tbody>
</table>
h. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2014 through September 30, 2014

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

Table 8 – Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2014, through September 30, 2014

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Corrected Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>J8700</td>
<td>K</td>
<td>1086</td>
<td>Temozolomide</td>
<td>$6.94</td>
<td>$1.39</td>
</tr>
<tr>
<td>J9171</td>
<td>K</td>
<td>0823</td>
<td>Docetaxel injection</td>
<td>$4.35</td>
<td>$0.87</td>
</tr>
</tbody>
</table>

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

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

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

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

**Coverage Determinations**

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment.

**Additional Information**


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

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

MLN Matters® Number: MM8889 Revised Related Change Request (CR) #: CR 8889
Related CR Release Date: September 30, 2014 Effective Date: October 1, 2014
Related CR Transmittal #: R3082CP Implementation October 6, 2014

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

Note: This article was revised on October 2, 2014, to reflect the revised CR8889 issued on September 30. 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 providers who submit claims to Medicare Administrative Contractors (MACs) for services provided to inpatient Medicare beneficiaries and are paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS).

Provider Action Needed

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

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Background

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

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

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

Inpatient Psychiatric Facilities Quality Reporting Program (IPFQR)

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

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

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

Market Basket Update

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

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

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

**Pricer Updates for FY 2015**

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

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

CMS is applying the national CCRs to the following situations:

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

**MS-DRG Update**

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

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

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

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

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

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

### Hawaii

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

### Additional Information


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

MLN Matters® Number: MM8806 Revised
Related Change Request (CR) #: CR 8806
Related CR Release Date: October 21, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R3098CP
Implementation Date: Claims received on or after April 1, 2015

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

Note: This article was revised on October 24, 2014, to reflect the revised CR8806 issued on October 21. The CR was revised to change the effective and implementation dates. Also, in the article, the CR release date, transmittal number, and the Web address for accessing the article are revised. All other information remains the same.

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

Provider Action Needed
This article is based on Change Request (CR) 8806, which provides guidance for physicians and suppliers billing anti-markup and reference laboratory claims. Effective for anti-markup and reference laboratory claims submitted with a receipt date on and after April 1, 2015, billing physicians and suppliers are required to report the name, address, ZIP code, and the National Provider Identifier (NPI) of the performing physician or supplier when the

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performing physician or supplier is enrolled in a different contractor’s jurisdiction. Make sure your billing staffs are aware of this update.

**Background**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all covered health care entities follow the same standard for submitting and processing electronic claims transactions. According to the instructions for use of the American National Standards Institute (ANSI) X12 837 professional electronic claim transaction, suppliers must submit the NPI that matches the name and address of the servicing provider/supplier identified on the claim.

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

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

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

Effective April 1, 2015, changes to PECOS will allow MACs the ability to verify all physician and supplier NPIs, regardless of the jurisdiction in which they are enrolled. **Therefore, beginning with claims received on or after April 1, 2015, physicians and suppliers billing anti-markup and reference laboratory claims must report the NPI of the physician or supplier who actually performed the service in Item 32a of the CMS-1500 claim form or the corresponding loop and segment of the American National Standards Institute (ANSI) X12 837 professional electronic claim format.** This new
requirement applies to all claims, including claims for services where the performing physician/supplier is out of the processing MAC’s jurisdiction.

Anti-markup claims will be identified by the presence of the “Yes” indicator in Item 20 of the CMS-1500 or its electronic equivalent. Reference laboratory claims will be identified by the presence of 90 on any service line.

MACs will return as unprocessable a claim:

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

MACs use the following codes for claims returned as unprocessable:

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

Additional Information


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

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

Note: CMS revised this article on September 30, 2014, to reflect the revised CR8880 issued on September 26. In the article, the descriptor for HCPCS code C9135 has been revised in the table on page 2 to end with per i.u., instead of per 10 i.u. In addition, the CR release date, transmittal number and the Web address for accessing the CR are revised. all other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

**New Services**

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

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

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

Payments for separately payable drugs and biologicals based on ASPs are updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the October 2014 release of the ASC Drug File. The updated payment rates, effective October 1, 2014, will be included in the October 2014 update of the ASC Addendum BB, which will be posted at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html) on the Center for Medicare & Medicaid Services (CMS) website.

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

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

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

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

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

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

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.

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

d. Updated Payment Rate for HCPCS Code J9171, Effective January 1, 2014 through March 31, 2014

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

**Updated Payment Rate for HCPCS Code J9171**

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

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

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

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

**Updated Payment Rates for Certain HCPCS Codes**

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

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

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

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Corrected Payment Rate</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9047</td>
<td>Injection, carfilzomib, 1 mg</td>
<td>29.67</td>
<td>K2</td>
</tr>
<tr>
<td>J9171</td>
<td>Docetaxel injection</td>
<td>4.35</td>
<td>K2</td>
</tr>
<tr>
<td>J9315</td>
<td>Romidepsin injection</td>
<td>270.24</td>
<td>K2</td>
</tr>
</tbody>
</table>