Medicare Monthly Review

Issue No. MMR 2014-12

December 2014

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Contact information can be found on our website at [http://www.NGSMedicare.com](http://www.NGSMedicare.com).

Medicare policies can be accessed from the Medical Policy Center section of our Web site. Providers without access to the Internet can request hard copies from National Government Services.

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This bulletin should be shared with all health care practitioners and managerial members of the providers/suppliers staff. Bulletins issued during the last two years are available at no cost from our Web site at [http://www.NGSMedicare.com](http://www.NGSMedicare.com).
CERT Task Force Scenario: Insufficient Documentation

This educational guide was developed by the CERT A/B MAC Outreach & Education Task Force to explain the CERT program and share information with providers on how to provide accurate and supportive medical record documentation.

The CMS implemented the CERT program to measure improper payments in the Medicare FFS program. Under this program, a random sample of all Medicare FFS claims are reviewed to determine if they were paid properly under Medicare coverage, coding and billing rules. Once the CERT program identifies a claim as part of the sample, it requests the associated medical records and other pertinent documentation from the provider or supplier who submitted the claim via letter. The submitted documentation is then reviewed by medical review professionals to see if the claim was paid or denied appropriately. Providers should submit adequate documentation to ensure that claims are supported as billed.

The collection and review of medical records under the CERT Program is managed by the CERT Documentation Contractor (CERT DC) and the CERT Review Contractor (CERT RC). The CERT DC requests medical records from providers and suppliers who billed Medicare. The CERT RC reviews selected claims and associated medical records for compliance with Medicare coverage, coding and billing rules. Upon request for a review, it is the billing provider’s responsibility to obtain supporting documentation as needed from a referring physician’s office (e.g. physician order, notes to support medical necessity) or from an inpatient facility (e.g. progress note). The Medicare Program Integrity Manual (Publication 100-08) Chapter 3, Section 3.2.3.3, Third-party Additional Documentation Request states:

The treating physician, another clinician, provider, or supplier should submit the requested documentation. However, because the provider selected for review is the one whose payment is at risk, it is this provider who is ultimately responsible for submitting, within the established timelines, the documentation requested by the MAC, CERT, Recovery Auditor and ZPIC.

Claims are determined to have insufficient documentation errors when the medical documentation submitted is inadequate to support payment for the services billed, i.e., the reviewer could not conclude that some of the allowed services were actually provided, were provided at the level billed, and/or were medically necessary. Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required to be completed in its entirety.

Insufficient documentation errors identified by the CERT Review Contractor may include:

- Incomplete progress notes (e.g., unsigned, undated, insufficient detail, etc.)
- Unauthenticated medical records - no provider signature, no supervising signature, illegible signatures without a signature log or attestation to identify the signer, an electronic signature without the electronic record protocol or policy that documents the process for electronic signatures
- No documentation of intent to order services and procedures – incomplete or missing signed order or progress note describing intent for services to be provided

For your reference, the CERT A/B MAC Outreach & Education Task Force summarizes below descriptions of errors, and links to requirements, for some of the more common procedures that have resulted in insufficient documentation errors:

Vertebral Augmentation Procedures:

- Missing signature and date for clinical documentation that supports patient’s symptoms – hardcopy physician signature (with signature log if illegible or protocol as above if electronic).
- No evidentiary radiographs performed to support medical necessity of procedure.
- Insufficient medical record documentation supporting that conservative medical management was tried and failed (e.g. medication administration records, therapy discharge summary) or was contraindicated.
• No signed and dated attestation statement for the operative report if a physician signature was missing or illegible. If the operative report is electronically signed, the protocol should also be submitted.

Vertebral Augmentation Procedures References:
• Centers for Medicare and Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-08, Chapter 3, Section 3.3.2.4 - Signature requirements
• The Medicare Coverage Database (MCD) for LCDs on Vertebral Augmentation Procedures (VAPs) serving your specific MAC.

Physical Therapy Services:
• Documentation did not support certification of the plan of care for physical therapy services. The physician’s/NPP signature and date of certification of the plan of care or progress note indicating the physician/NPP reviewed and approved the plan of care is required.

Physical Therapy References:
• CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.1.1(A) - Outpatient Therapy Must be Under the Care of a Physician/Nonphysician Practitioners (NPP) (Orders/Referrals and Need for Care)
• Section 220.1.3 - Certification and Recertification of Need for Treatment and Therapy Plans of Care
• CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.4 – Functional Reporting

Evaluation and Management Services:
• E&M services for Office Visits Established, Hospital Initial and Hospital Subsequent were identified as the top three CERT errors in E&M services categories. High errors consisted of insufficient documentation, no documentation, and incorrect coding of E&M services to support medical necessity and accurate billing of E&M services.

Evaluation and Management References:
• CMS IOM Publication 100-04, Claims Processing Manual, Chapter 12, Section 30.6 - Evaluation and Management Service Codes - General (Codes 99201 - 99499)
• Evaluation and Management Services 1995 and 1997 Documentation Guidelines
• Program Integrity Manual Publication 100-08, Chapter 3, Section 3.3.2.4 - Signature Requirements

Durable Medical Equipment:
• Effective 07/01/2013, certain DME HCPCS codes (i.e., hospital beds, glucose monitors, and manual wheelchairs) require a valid detailed written order prior to delivery per MLN Matters MM8304.

The physician’s NPI must be on the valid detailed written order. Please see MLN Article - CR 8304 - Detailed Written Orders for Face-to-Face Encounters for additional information and the list of HCPCS codes affected by this rule.

Computed Tomography:
• Documentation of the plan or intent to order computed tomography (CT scan) was insufficient to support medical necessity. If the handwritten signature is illegible, include a signature log, and if electronic, the protocol should also be submitted.

Computed Tomography References:
• CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 80.6.1(A) Requirements for Ordering and Following Orders for Diagnostic Tests
• Program Integrity Manual, Publication 100-08, Chapter 3, Section 3.3.2.4 - Signature Requirements

The CERT A/B MAC Provider Outreach & Education Task Force is focused on education to reduce CERT errors. Visit the CMS CERT web page at https://www.cms.gov/CERT/ to review information on the CERT 101 presentation, Improper Payments Reports, CMS Fact sheets and more helpful tips.

Disclaimer: The CERT A/B MAC Outreach & Education Task Force is independent from the CMS CERT team and CERT contractors, which are responsible for calculation of the Medicare FFS improper payment rate.
Centers for Medicare & Medicaid Services
Articles for Part A&B Providers
(CR 3274) Medicare’s Acceptance of Voluntary Refunds

The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.
Recognizing Lung Cancer Awareness Month and the Great American Smokeout

November is Lung Cancer Awareness Month and November 20 is the Great American Smokeout. Lung cancer is the leading cause of cancer death in the United States for both men and women. Cigarette smoking is the number one cause of lung cancer. Almost 1 in 5 Americans smokes cigarettes, and tens of thousands more smoke pipes or cigars, which also cause lung cancer. Many smokers who want to quit have great difficulty succeeding. As a provider of health care services to people with Medicare, you can provide support to seniors who want to quit tobacco use, and Medicare can help. Read more.

MLN Matters® Article Number: MM8583 Revised Related Change Request (CR) #: CR 8583
Related CR Release Date: November 14, 2014 Effective Date: April 1, 2015
Related CR Transmittal #: R554PI Implementation Date: April 6, 2015

New Timeframe for Response to Additional Documentation Requests

Note: This article was revised on November 18, 2014, to make corrections in the article, especially to clarify ADR requirements related to pre-payment review.

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8583, which instructs MACs and Zone Program Integrity Contractors (ZPICs) to produce pre-payment review Additional Documentation Requests (ADRs) that state that providers and suppliers have 45 days to
respond to an ADR issued by a MAC or a ZPIC. Failure to respond within 45 days of a pre-payment review ADR will result in denial of the claim(s) related to the ADR. Make sure your billing staffs are aware of these changes.

**Background**

In certain circumstances, CMS review contractors (MACs, ZPICs, Recovery Auditors, the Comprehensive Error Rate Testing contractor and the Supplemental Medical Review Contractor) may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments or the billing history found in claims processing system (if applicable) or Medicare's Common Working File (CWF).

In those instances, the CMS review contractor will solicit documentation from the provider or supplier by issuing an ADR. The requirements for additional documentation are as follows:

- The Social Security Act, Section 1833(e) - Medicare contractors are authorized to collect medical documentation. The Act states that no payment shall be made to any provider or other person for services unless they have furnished such information as may be necessary in order to determine the amounts due to such provider or other person for the period with respect to which the amounts are being paid or for any prior period.

- According to the "Medicare Program Integrity Manual," Chapter 3, Section 3.2.3.2, (Verifying Potential Errors and Tracking Corrective Actions), when requesting documentation for pre-payment review, the MAC and ZPIC shall notify providers that the requested documentation is to be submitted within 45 calendar days of the request. Reviewers shall deny claims for which the requested documentation was not received by day 46.

**Additional Information**


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

**Disclaimer**

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.
Quarterly Update to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS)

Provider Types Affected

This MLN Matters® Article is intended for End Stage Renal Disease (ESRD) facilities that submit claims to Medicare Administration Contractors (MACs) for renal dialysis services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8698 which provides the July 2014 Quarterly Update to the ESRD Prospective Payment System (PPS). See the Background and Additional Information Sections of this article for further details regarding this ESRD PPS update, and make sure that your billing staff are aware of these changes.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b); see http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf on the Internet) required the implementation of an ESRD PPS effective January 1, 2011. The ESRD PPS provides a single payment to ESRD facilities that covers all of the resources
used in furnishing an outpatient dialysis treatment, and it includes consolidated billing requirements for limited Part B services included in the ESRD facility’s bundled payment.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of items and services that are subject to Part B consolidated billing and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities. The ESRD PPS provides:

- Payment adjustments for comorbid conditions identified by specific diagnostic codes. The diagnostic codes are updated annually and effective each October 1st; and
- Outlier payments, if applicable, for high cost patients due to unusual variations in the type or amount of medically necessary care.

**ESRD-Related Drugs and Biologicals Subject to the ESRD PPS Consolidated Billing Requirements**

CR8698 provides instructions for the following new code in the table below which is being added to the Healthcare Common Procedure Coding System (HCPCS) file for anemia management treatment effective July 1, 2014:

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<th>Description</th>
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<td>Q9970</td>
<td>Injection, Ferric Carboxymaltose, 1mg</td>
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Ferric carboxymaltose is used for anemia management which is a category of drugs and biologicals that are always considered to be ESRD-related. ESRD facilities will not receive separate payment for Q9970 with or without the AY modifier, and line items with this code will process as covered with no separate payment under the ESRD PPS effective July 1, 2014.

In accordance with 42 CFR 413.237(a)(1), Q9970 Injection, ferric carboxymaltose is considered to be an eligible outlier service, and it will be included in the outlier calculation when CMS provides a fee amount on the Average Sales Price fee schedule. You can review 42 CFR 413.237(a)(1) at [http://www.ecfr.gov/cgi-bin/text-idx?SID=e88efd0cc8ec3b503b30016e5463d95c&node=42:2.0.1.2.13&rgn=div5#42:2.0.1.2.13.8.59.27](http://www.ecfr.gov/cgi-bin/text-idx?SID=e88efd0cc8ec3b503b30016e5463d95c&node=42:2.0.1.2.13&rgn=div5#42:2.0.1.2.13.8.59.27) on the Internet.

The updated list of ESRD-related items and services that are subject to the ESRD PPS consolidated billing requirements is available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html) on the CMS website.

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Diagnosis Coding Updates

Effective July 1, 2014 the following International Classification of Diseases (ICD)-10-CM codes were removed from the comorbidity list:

- D89.2 Hypergammaglobulinemia, unspecified; and
- K52.81 Eosinophilic gastritis or gastroenteritis.

These two codes will not be eligible for the comorbidity payment adjustment with the implementation of the ICD-10-CM coding scheme.

Additional Information


For the latest information regarding the implementation of ICD-10, please go to [http://www.cms.gov/Medicare/Coding/ICD10/index.html](http://www.cms.gov/Medicare/Coding/ICD10/index.html) on the CMS website.

For more information regarding ESRD co-morbidity conditions, please go to [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Comorbidity_Conditions.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Comorbidity_Conditions.html) on the CMS website.

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

MLN Matters® Number: MM8865 Revised Related Change Request (CR) #: CR 8865
Related CR Release Date: November 13, 2014 Effective Date: October 1, 2014
Related CR Transmittal #: R3123CP Implementation Date: October 6, 2014

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

Note: This article was revised on November 17, 2014, to reflect the revised CR8865 issued on November 13. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

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.
Background

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

Key Points of CR8865

**Splints, Casts, and Certain Intraocular Lenses (IOLs)**

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

- A4565
- Q4001
- Q4002
- Q4003
- Q4004
- Q4005
- Q4006
- Q4007
- Q4008
- Q4009
- Q4010
- Q4011
- Q4012
- Q4013
- Q4014
- Q4015
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- Q4047
- Q4048
- Q4049

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


**Off-the-Shelf (OTS) Orthotics**

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

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

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

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

**Specific Coding and Pricing Issues**

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

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

**Additional Information**


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

**Disclaimer**

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Screening for Hepatitis C Virus (HCV) in Adults

Note: This article was revised on November 26, 2014, in order to (1) make editorial changes, (2) add TOBs 71X & 77X and clarify payment methodology, (3) add POS 50, 72 & 81, (4) clarify MAC claims processing prior to January 1, 2015, (5) clarify remittance codes, and (6) revise implementation information. 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 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) and point-of-care tests (such as rapid anti-body tests that are performed in outpatient clinics and physician offices) 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.

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

1. New HCPCS G0472, short descriptor - Hep C screen high risk/other and long descriptor- Hepatitis C antibody screening for individual at high risk and other covered indication(s), will be used. HCPCS G0472 will appear in the January 2015 recurring updates of the Medicare Physician Fee Schedule Data Base (MPFSDB) and the Integrated Outpatient Code Editor (IOCE) with a June 2, 2014 effective date. Contractors shall apply contractor pricing to claims with dates of service June 2, 2014, through December 31, 2014, that contain HCPCS G0472.

2. Beneficiary coinsurance and deductibles do not apply to HCPCS 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; and
   - ICD-9 diagnosis code V69.8, other problems related to life style/ICD-10 diagnosis code Z72.89, other problems related to lifestyle (once ICD-10 is implemented)

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, 71X, 77X, 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.

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• Remittance Advice Remarks Code (RARC) N95 - This provider type/provider specialty may not bill this service.
• Group Code CO (contractual obligation) – If claim received without a GZ modifier.

The service is paid on the following basis:

• Outpatient hospitals – TOB 13X - based on Medicare Physician Fee Schedule (MPFS).
• Rural Health Clinics (RHCs) - TOB 71X - and Federally Qualified Health Centers (FQHCs) - 77X - technical component paid based on the MPFS. For RHCs and FQHCs that are authorized to bill under the reasonable cost system, payment for the professional component is included in the RHC/FQHC all-inclusive rate (AIR). HCV screening is not a stand-alone payable visit for RHCs and FQHCs.
• Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost; and
• CAH Method II – TOB 85X - based on 115% of the lesser of the MPFS amount or actual charge as applicable with revenue codes 096X, 097X, or 098X.

Note: Separate guidance shall be issued for FQHCs that are authorized to bill under the prospective payment system.

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 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, HCPCS G0472, only when submitted with one of the following place of service (POS) codes:

11 - Physician’s Office
22 - Outpatient Hospital
49 - Independent Clinic
50 - FQHC
71 - State or Local Public Health Clinic
72 - RHC
81 - Independent Laboratory

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.

• Group Code – CO if claim received without GZ modifier.

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 once ICD-10 is implemented). 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 119 - Benefit maximum for this time period or occurrence has been reached. (for initial high risk screening), or,
- CARC 167 - 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. (for subsequent annual high risk screening)
- 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**


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

MLN Connects™ National Provider Call: National Partnership to Improve Dementia Care in Nursing Homes - Tuesday, December 9; 1:30-3pm ET - During this MLN Connects Call, speakers will discuss innovative efforts from State-based Alzheimer’s Association Chapters related to train-the-trainer programs, as well as the implementation of the Comfort First Approach in nursing homes. CMS subject matter experts will provide National Partnership updates and discuss next steps for the initiative. Register or visit the December 9 call web page for more information.

MLN Matters® Number: MM8881  Related Change Request (CR) #: CR 8881
Related CR Release Date: October 17, 2014  Effective Date: January 27, 2014
Related CR Transmittal #: R3096CP, R176NCD, and R196BP  Implementation Date: November 18, 2014

Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) and Screening Fecal-Occult Blood Tests (FOBT)

Provider Types Affected

This MLN Matters® Article is intended for physicians, physician assistants, nurse practitioners, and clinical nurse specialists submitting claims to Medicare Administrative Contractors (MACs) for ultrasound screening for Abdominal Aortic Aneurysms (AAA) and screening fecal-occult blood tests (FOBT) ordered for Medicare beneficiaries.

Provider Action Needed

Effective for dates of service on and after January 27, 2014, MACs shall pay claims for ultrasound screening for AAA and screening FOBTs, per the modified requirements in 42 CFR 410.19 and 410.37. See the details of the changes in the Background section below. Make sure that your billing staffs are aware of these changes.

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Background

Medicare Part B coverage of screening FOBTs and ultrasound screening for AAA is covered for certain beneficiaries that meet eligibility requirements as described in regulations. As part of the CY 2014 Physician Fee Schedule rule, the Centers for Medicare & Medicaid Services (CMS) revised the Medicare Part B coverage requirements for Ultrasound Screening for AAA (42 CFR 410.19) and Screening FOBT (42 CFR 410.37).

As a result of CR8881, the following policy changes are effective for dates of service on and after January 27, 2014:

- **Ultrasound Screening for AAA:** Coverage of AAA screening is modified by eliminating the one year time limit with respect to the referral for this service. This modification allows coverage of AAA screening for eligible beneficiaries without requiring them to receive a referral as part of the Initial Preventive Physical Examination (IPPE, also commonly known as the “Welcome to Medicare Preventive Visit”). The beneficiary need only obtain a referral from their physician, physician assistant, nurse practitioner, or clinical nurse specialist. All other coverage requirements for this service remain unchanged, per 42 CFR 410.19.

- **Screening FOBTs:** In addition to the beneficiary’s attending physician, the beneficiary’s attending physician assistant, nurse practitioner, or clinical nurse specialist may furnish written orders for screening FOBTs, per section 42 CFR 410.37(b). All other coverage requirements for this service remains unchanged, per 42 CFR 410.37.

Additional Information


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Medicare Coverage of Items and Services in Category A and B Investigational Device Exemption (IDE) Studies

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8921, which announces changes effective on and after January 1, 2015, to Medicare coverage requirements and review procedures related to items and services in Food and Drug Administration (FDA) approved Category A and B IDE studies. CR8921 makes changes to the following Medicare manuals:

- “Medicare Benefit Policy Manual,” Chapter 14;
- “Medicare Benefit Policy Manual,” Chapter 16, Section 10; and
- “Medicare Claims Processing Manual,” Chapter 32, Section 68.

Make sure that your billing staffs are aware of these changes.

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Background

Section 1862(m) of the Social Security Act and regulations at 42 CFR 405 Subpart B allows for payment of routine costs of care furnished to Medicare beneficiaries in Category A IDE studies and authorizes the Secretary to establish criteria to ensure that Category A IDE studies conform to appropriate scientific and ethical standards. Additionally, the regulations allowed Medicare contractors to make coverage decisions for Category B IDE devices and routine care services in their review of claims for payment for these items and services.

Category A (Experimental) device refers to a device for which “absolute risk” of the device type has not been established (that is, initial questions of safety and effectiveness have not been resolved) and the FDA is unsure whether the device type can be safe and effective.

Category B (Non-experimental/investigational) device refers to a device for which the incremental risk is the primary risk in question (that is, initial questions of safety and effectiveness of that device type have been resolved), or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained FDA premarket approval or clearance for that device type.

The FDA notifies the Centers for Medicare & Medicaid Services (CMS) when it notifies the IDE study sponsor (i.e. manufacturer) that the device is categorized as either Category A or Category B.

As part of the Calendar Year (CY) 2014 Physician Fee Schedule rule, CMS modified its regulations at 42 CFR 405 Subpart B, related to Medicare coverage of routine care items and services in Category A and B IDE studies and Medicare coverage of Category B IDE devices, effective January 1, 2015. For purposes of Medicare coverage in Category A and B IDE studies, these regulatory modifications define Medicare coverage requirements, Medicare coverage IDE study criteria, and establish a centralized review process for approval of Category A and B IDE studies.

Effective for Category A and B IDE studies approved by the FDA on or after January 1, 2015, interested parties (i.e. study sponsors) that wish to seek Medicare coverage must submit a request for review and approval to CMS. Revised Chapter 14 of the “Medicare Benefit Policy Manual” contains detailed instructions on seeking CMS approval of Category A and B IDE studies for purposes of Medicare coverage. Additional information regarding submission of Category A and B IDE study review requests, along with the list of CMS-approved studies is available on the CMS Coverage Website at [http://www.cms.gov/Medicare/Coverage/IDE/index.html](http://www.cms.gov/Medicare/Coverage/IDE/index.html).

Medicare claims for routine care items and services related to Category A or B IDE studies and Category B IDE devices should be submitted to MACs that will identify routine costs for which Medicare payment is made for each related claim.

NOTE: IDE studies approved by MACs prior to January 1, 2015, will continue to be administered by the MAC. Study sponsors do not have to submit the protocol to CMS if the participating study investigator sites have already received approval from their MAC. Study
sponsors should continue to follow the process established by the MAC for any site additions or protocol changes.

**Additional Information**


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Raising Awareness of Diabetes in November - During the month of November, the United States draws attention to diabetes and its impact on public health through several national health observances, including National Diabetes Month, Diabetic Eye Disease Month, and World Diabetes Day. Millions of Americans have diabetes and don’t know it. Left undiagnosed or untreated, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney disease, amputation, and even premature death. Read more to learn about the preventive services covered by Medicare that focus on early disease detection and disease management.

MLN Matters® Number: MM8970  Related Change Request (CR) #: CR 8970
Related CR Release Date: November 14, 2014  Effective Date: January 1, 2015
Related CR Transmittal #: R3120CP  Implementation Date: January 5, 2015

Therapy Cap Values for Calendar Year (CY) 2015

Provider Types Affected
This MLN Matters® Article is intended for physicians, therapists, and other providers, submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for outpatient rehabilitation services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 8970 informs MACs about changes to outpatient therapy caps for Calendar Year (CY) 2015. For physical therapy and speech-language pathology combined, the therapy cap will be $1,940. For occupational therapy, the cap for 2015 will be $1,940. Make sure that your billing staffs are aware of these changes.
Background

The Balanced Budget Act of 1997, P.L. 105-33, Section 4541(c) applies, per beneficiary, annual financial limitations on expenses considered incurred for outpatient therapy services under Medicare Part B, commonly referred to as “therapy caps.” The therapy caps are updated each year based on the Medicare Economic Index. An exceptions process to the therapy caps for reasonable and medically necessary services was required by section 5107 of the Deficit Reduction Act of 2005. The exceptions process for the therapy caps has been continuously extended several times through subsequent legislation. Most recently, section 103 of the Protecting Access to Medicare Act of 2014 extended the therapy caps exceptions process through March 31, 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 under - How Does It Work.

Seasonal Flu Vaccinations - 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 on coverage and billing of the influenza vaccine and its administration, please visit MLN Matters® Article #MM8890, “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season” and MLN Matters® Article #SE1431, “2014-2015 Influenza (Flu) Resources for Health Care Professionals.”

While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community. The HealthMap Vaccine Finder is a free online service where users can search for locations offering flu and other adult vaccines. If you provide vaccination services and would like to be included in the HealthMap Vaccine Finder database, register for an account to submit your information in the database. Also, visit the CDC Influenza (Flu) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza.

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MLN Matters® Number: MM8982  Related Change Request (CR) #: CR 8982
Related CR Release Date: November 21, 2014  Effective Date: January 1, 2015
Related CR Transmittal #: R89GI  Implementation Date: January 5, 2015

Update to Medicare Deductible, Coinsurance, and Premium Rates for 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8982 informs the MACs about the changes needed to update the claims processing system with the new Calendar Year (CY) 2015 Medicare deductible, coinsurance, and premium rates. Make sure that your billing staff are aware of these changes.

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Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person’s initial enrollment period, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person’s initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll. The 2015 rates are as follows:

**2015 PART A - HOSPITAL INSURANCE (HI)**

- **Deductible:** $1,260.00
- **Coinsurance:**
  - $315.00 a day for 61st-90th day
  - $630.00 a day for 91st-150th day (lifetime reserve days)
  - $157.50 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
- **Base Premium (BP):** $407.00 a month
- **BP with 10% surcharge:** $447.70 a month

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• BP with 45% reduction: $224.00 a month (for those who have 30-39 quarters of coverage)

• BP with 45% reduction and 10% surcharge: $246.40 a month

2015 PART B - SUPPLEMENTARY MEDICAL INSURANCE (SMI)

• Standard Premium: $104.90 a month

• Deductible: $147.00 a year

• Pro Rata Data Amount:
  • $114.99 1st month
  • $32.01 2nd month

• Coinsurance: 20 percent

Additional Information

The official instruction, CR 8982, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R89GI.pdf on the CMS website.

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MLN Connects™ National Provider Call: National Partnership to Improve Dementia Care in Nursing Homes - Tuesday, December 9, 1:30-3pm ET - During this MLN Connects Call, speakers will discuss innovative efforts from State-based Alzheimer’s Association Chapters related to train-the-trainer programs, as well as the implementation of the Comfort First Approach in nursing homes. CMS subject matter experts will provide National Partnership updates and discuss next steps for the initiative. Register or visit the December 9 call web page for more information.

MLN Matters® Number: MM8985 Related Change Request (CR) #: CR 8985
Related CR Release Date: November 14, 2014 Effective Date: January 1, 2015
Related CR Transmittal #: R3121CP Implementation Date: January 5, 2015

2015 Annual Update to the Therapy Code List

Provider Types Affected

This MLN Matters® Article is intended for physicians, therapists, and other providers who submit claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for outpatient rehabilitation therapy services that are provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8985 updates the therapy code list for Calendar Year (CY) 2015 by adding two “Sometimes Therapy” codes, and deleting two current codes. The update to the therapy code list reflects those made in the CY 2015 Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4). Make sure your billing staff are aware of these changes.

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Background

The Social Security Act (Section 1834(k)(5)) (see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm on the Internet) requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system. The Healthcare Common Procedure Coding System/Current Procedural Terminology, 2015 Edition (HCPCS/CPT-4) is the coding system used for the reporting of these services.

CR 8985 updates the list of codes that sometimes, or always, describe therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the CY 2014 and 2015 Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4).

The therapy code listing can be found at http://www.cms.gov/Medicare/Billing/TherapyServices/index.html on the Centers for Medicare & Medicaid Services (CMS) website.

Specifically, CR 8985 updates the code list by adding HCPCS Codes 97607 (Neg press wnd tx) and 97608 (Neg press wound tx >50 cm) to the "sometimes therapy" codes and deleting HCPCS Codes G0456 and G0457 from the 2015 therapy code list. Code 97608 replaces current code G0457 effective January 1, 2015 and 97607 replaces current code G0456 effective January 1, 2015.

Additional Information

The official instruction, CR 8985, issued to your MAC regarding this change, is available on the CMS website.

Seasonal Flu Vaccinations - 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 on coverage and billing of the influenza vaccine and its administration, please visit MLN Matters® Article #MM8890, “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season” and MLN Matters® Article #SE1431, “2014-2015 Influenza (Flu) Resources for Health Care Professionals.”

While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community. The HealthMap Vaccine Finder is a free online service where users can search for locations offering flu and other adult vaccines. If you provide vaccination services and would like to be included in the HealthMap Vaccine Finder database, register for an account to submit your information in the database. Also, visit the CDC Influenza (Flu) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza.
Calendar Year (CY) 2015 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8999 to advise providers of the CY 2015 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your staffs are aware of these updates.

Background

CMS updates the DMEPOS fee schedules on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the “Medicare Claims Processing Manual,” Chapter 23, Section 60, which is available at [link].

Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section 1834(a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts and Intraocular Lenses (IOLs) inserted in a physician’s office.

Key Points

Fee Schedule Files

The DMEPOS fee schedule file will be available for providers and suppliers, as well as State Medicaid Agencies, managed care organizations, and other interested parties at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/ on the CMS website.

Healthcare Common Procedure Coding System (HCPCS) Codes Added/ Deleted

The following new codes are effective January 1, 2015:

- A4602 in the inexpensive/routinely purchased (IN) payment category.
- The following new codes are in the prosthetics and orthotics (PO) payment category: A7048, L3981, L6026, L7259, and L8696. (Fee schedule amounts for these codes will be added to the DMEPOS fee schedule, effective January 1, 2015.)
- Also, code A4459 is added.

The base fee for code A4602 will be submitted to CMS by CMS contractors by April 3, 2015, for inclusion in the July 2015 DMEPOS fee schedule update.

The following codes are deleted from the DMEPOS fee schedule files effective January 1, 2015: A7042, A7043, L6025, L7260, and L7261.

For gap-filling purposes, the 2014 deflation factors by payment category are as follows:

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<thead>
<tr>
<th>Factor</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
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<td>Oxygen</td>
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<tr>
<td>0.462</td>
<td>Capped Rental</td>
</tr>
<tr>
<td>0.464</td>
<td>Prosthetics and Orthotics</td>
</tr>
<tr>
<td>0.588</td>
<td>Surgical Dressings</td>
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<tr>
<td>0.640</td>
<td>Parenteral and Enteral Nutrition</td>
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<tr>
<td>0.963</td>
<td>Intraocular Lenses</td>
</tr>
<tr>
<td>0.980</td>
<td>Splints and Casts</td>
</tr>
</tbody>
</table>

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Specific Coding and Pricing Issues

CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004.

For 2015, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2013.

The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2015.

Diabetic Testing Supplies (DTS)

The fee schedule amounts for non-mail order diabetic testing supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for CY 2014. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the single payment amounts for mail order DTS established in implementing the national mail order Competitive Bidding Program (CBP) under Section 1847 of the Act.

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years as CBP contracts are re-competed. The national competitive bidding program for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016.


Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for Multi-Factor Productivity (MFP), which results in update of 1.5% for CY 2015. The single payment amount public use file for the national mail order competitive bidding program is available at

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2015 Fee Schedule Update Factor of 1.5 Percent

For CY 2015, the update factor of 1.5 percent is applied to the applicable CY 2014 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2015 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2014, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP). The MFP adjustment is 0.6 percent and the CPI-U percentage increase is 2.1 percent. Thus, the 2.1 percentage increase in the CPI-U is reduced by the 0.6 percentage increase in the MFP resulting in a net increase of 1.5 percent for the update factor.

2015 Update to the Labor Payment Rates

The table below contains the CY 2015 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI-U for the 12-month period ending with June 30, 2014, is 2.1 percent this change is applied to the 2014 labor payment amounts to update the rates for CY 2015.

The 2015 labor payment amounts in the following table are effective for claims submitted using HCPCS codes K0739, L4205 and L7520 with dates of service from January 1, 2015, through December 31, 2015.

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### 2015 National Monthly Payment Amounts for Stationary Oxygen Equipment

As part of CR8999, CMS is implementing the 2015 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2015. Included is the updated national 2015 monthly payment amount of $180.92 for stationary oxygen equipment codes in the DMEPOS fee schedule. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for Oxygen Generating Portable Equipment (OGPE). Also, the updated 2015 monthly payment amount of $180.92 includes the 1.5 percent update factor for the 2015 DMEPOS fee schedule. Thus, the 2014 rate changed from $178.24 to the 2015 rate of $180.92.

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</table>
When updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2015 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier’s or manufacturer’s warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the “MS” modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2014 maintenance and servicing fee is adjusted by the 1.5 percent MFP-adjusted covered item update factor to yield a CY 2015 maintenance and servicing fee of $69.76 for oxygen concentrators and transfilling equipment.

Update to Change Request (CR) 8566
Effective April 1, 2014, payment on a purchase basis was established for capped rental wheelchair accessory codes furnished for use with complex rehabilitative power wheelchairs. Such accessories are considered as part of the complex rehabilitative power wheelchair and associated lump sum purchase option set forth at 42 CFR Section 414.229(a)(5). These changes were implemented in Transmittal 1332, CR8566, dated January 2, 2014. Code E2378 is added to the list of codes eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair.

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Additional Information


If you have questions please contact your MAC at their toll-free number. The 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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Seasonal Flu Vaccinations - 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.


While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community. The [HealthMap Vaccine Finder](http://www.healthmap.org/) is a free online service where users can search for locations offering flu and other adult vaccines. If you provide vaccination services and would like to be included in the HealthMap Vaccine Finder database, [register](http://www.healthmap.org/) for an account to submit your information in the database. Also, visit the CDC [Influenza (Flu)](http://www.cdc.gov/flu/) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza.

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Recognizing Lung Cancer Awareness Month and the Great American Smokeout
November is Lung Cancer Awareness Month and November 20 is the Great American Smokeout. Lung cancer is the leading cause of cancer death in the United States for both men and women. Cigarette smoking is the number one cause of lung cancer. Almost 1 in 5 Americans smokes cigarettes, and tens of thousands more smoke pipes or cigars, which also cause lung cancer. Many smokers who want to quit have great difficulty succeeding. As a provider of health care services to people with Medicare, you can provide support to seniors who want to quit tobacco use, and Medicare can help. Read more.

MLN Matters® Number: SE1432 Related Change Request (CR) #: NA
Related CR Release Date: N/A Effective Date: June 1, 2015
Related CR Transmittal #: N/A Implementation Date: May 31, 2015

Revised Centers for Medicare & Medicaid Services (CMS) 855R Application - Reassignment of Medicare Benefits

Provider Types Affected
This MLN Matters® Special Edition (SE) is intended for physicians, non-physician practitioners, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) and who choose to reassign their benefits or accept reassigned benefits of those claims.

Provider Action Needed
Physicians, non-physician practitioners, providers, and suppliers must use the revised CMS 855R (Reassignment of Benefits) application beginning June 1, 2015.
CAUTION – What You Need to Know

The revised CMS 855R application will be available for use on the CMS.gov website as of December 29, 2014. MACs may accept both the current and revised versions of the CMS 855R through May 31, 2015, after which the revised CMS 855R application will be required to be submitted.

After May 31, 2015, MACs will return any newly submitted CMS 855R applications on the previous version (07/11) to the provider/supplier with a letter explaining that the CMS 855R has been updated and the current version of the CMS 855R (11/12) must be submitted.

GO – What You Need to Do

Make sure that your billing staffs are aware of these changes.

Background

Physicians, non-physician practitioners, providers, and suppliers must use the revised CMS 855R application starting June 1, 2015. The revised CMS 855R has been streamlined and some sections have been re-ordered for clarity. The revised form includes an optional section for primary practice location address. This information is shared with other programs such as Physician Compare to help beneficiaries identify where their physicians are primarily practicing. This address must be one that is affiliated with the individual/organization where the benefits are being reassigned.

Additional Information

Visit the Medicare Provider Supplier Enrollment webpage for more information about Medicare enrollment, available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html on the CMS website.
Centers for Medicare & Medicaid Services
Articles for Part A Providers
MLN Connects™ National Provider Call: National Partnership to Improve Dementia Care in Nursing Homes - Tuesday, December 9; 1:30-3pm ET -During this MLN Connects Call, speakers will discuss innovative efforts from State-based Alzheimer’s Association Chapters related to train-the-trainer programs, as well as the implementation of the Comfort First Approach in nursing homes. CMS subject matter experts will provide National Partnership updates and discuss next steps for the initiative. Register or visit the December 9 call web page for more information.

MLN Matters® Number: MM8384 Revised
Related Change Request (CR) #: CR 8384
Related CR Release Date: November 6, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R3107CP
Implementation Date: April 6, 2015

Medicare Shared Systems Modifications Necessary to Capture Various HIPAA Compliant Fields

Note: This article was revised on November 13, 2014, to reflect the correct effective and implementation dates. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for hospitals, other providers, and suppliers submitting institutional claims to Medicare Administrative Contractors (MACs) for services paid under the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed

This article is based on Change Request (CR) 8384 which informs MACs that the Centers for Medicare & Medicaid Services (CMS) needs to expand institutional claim processing fields and to update items on the version 5010 837I flat files. Specifically, CMS is:

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• Updating the Direct Data Entry (DDE) screens to allow entry of three Patient Reason for Visit Codes;
• Updating the DDE screens to allow entry of a nine-digit ZIP code for the service facility;
• Editing to ensure that when a Patient Reason for Visit code is received that the 5010 requirements for claims are enforced (that is to say that the services billed involve unscheduled outpatient visits Type of Bill (TOB) 013x or 085x together with Priority of Visit/Type of Admission codes 1,2 or 5 and Revenue Codes 045X, 0516, or 0762). Claims failing this edit will Return To the Provider (RTP).

Medicare outpatient service providers report the nine-digit ZIP code of the service facility location in the 2310E loop of the 837 Institutional claim transaction. Direct Data Entry submitters also are required to report the nine-digit ZIP code of the service facility location for off-site or multiple satellite office outpatient facilities. DDE submitters should key the 9 digit service facility's ZIP code in the "FAC.ZIP" field found on MAP 1711. Paper Submitters shall report this information in Form Locator (FL) 01 on the paper claim form. Medicare systems use this service facility ZIP code to determine the applicable payment locality whenever it is present.

Make sure that your billing staffs are aware of these changes.

**Background**

Services that are paid subject to the Medicare Physician Fee Schedule (MPFS) are adjusted based on the applicable payment locality. Medicare systems determine which locality applies using ZIP codes. In cases where the provider has only one service location, the payment locality used to calculate the fee amount is determined using the ZIP code of the master address contained in the Medicare contractors’ provider file.

Increasingly, hospitals operate off-site outpatient facilities and other institutional outpatient service providers operate multiple satellite offices. In some cases, these additional locations are in a different payment locality than the parent provider. In order for MPFS payments to be accurate, the nine-digit ZIP code of the satellite facility is used to determine the locality in these cases.

**Additional Information**


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

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Quarterly Update to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS)

Provider Types Affected

This MLN Matters® Article is intended for End-Stage Renal Disease (ESRD) facilities submitting claims to Medicare Administrative Contractors (MACs) for ESRD services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8841 provides the October 2014 Quarterly Update to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and adds a new Healthcare Common Procedure Coding System (HCPCS) code to the drugs subject to the ESRD Consolidated Billing List. Make sure your billing staffs are aware of these changes.

Background

The Medicare Improvements for Patients and Providers Act (MIPPA; Section 153(b); see http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf) required the implementation of an ESRD PPS effective January 1, 2011. The ESRD PPS provides a single payment to ESRD facilities that covers all of the resources used in furnishing an
outpatient dialysis treatment, and it includes consolidated billing requirements for limited Part B services included in the ESRD facility’s bundled payment.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of items and services that are subject to Part B consolidated billing and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities.

**ESRD-Related Drugs and Biologicals Subject to the ESRD PPS Consolidated Billing Requirements**

CR8841 provides instructions for the following new code added to the Healthcare Common Procedure Coding System (HCPCS) file effective October 1, 2014:

<table>
<thead>
<tr>
<th>Added HCPCS Code</th>
<th>Long Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9972</td>
<td>Injection, Epoetin Beta (For ESRD On Dialysis), 1 microgram</td>
</tr>
</tbody>
</table>

This drug is used for anemia management which is a category of drugs and biologicals that are always considered to be ESRD-related. ESRD facilities would not receive separate payment for Q9972 with or without the AY modifier, and the MACs will process the claims' line item as covered with no separate payment under the ESRD PPS, effective October 1, 2014.

In accordance with 42 CFR 413.237(a)(1) (See [http://www.ecfr.gov/cgi-bin/text-idx?SID=9a236dd4ead112b7a8a24bf752c36b60&node=42:2.0.1.2.13&rgn=div5#42:2.0.1.2.13.8.59.27](http://www.ecfr.gov/cgi-bin/text-idx?SID=9a236dd4ead112b7a8a24bf752c36b60&node=42:2.0.1.2.13&rgn=div5#42:2.0.1.2.13.8.59.27)), Q9972 is considered to be an eligible outlier service and will be included in the outlier calculation when CMS provides a fee amount on the Average Sales Price (ASP) fee schedule.

The updated list of ESRD-related items and services subject to the ESRD PPS consolidated billing requirements is available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html) on the CMS website.

**Note:** There is also a new HCPCS Code Q9973 for the same drug for non-ESRD use. This code will not be permitted on the ESRD type of bill 072x.

**Additional Information**


You can find additional ESRD resources at the End-Stage Renal Disease (ESRD) Center at [http://www.cms.gov/Center/Special-Topic/End-Stage-Renal-Disease-ESRD-Center.html](http://www.cms.gov/Center/Special-Topic/End-Stage-Renal-Disease-ESRD-Center.html) on the CMS website.

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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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Clarification of the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) Low Volume Adjustment

Provider Types Affected

This MLN Matters® Article is intended for End Stage Renal Disease (ESRD) facilities that submit claims to Medicare Administrative Contractors (MACs) for renal dialysis services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 8898 provides clarification for two criteria required for the validation of the ESRD PPS low volume payment adjustment (LVPA).

Specifically, CR 8898 clarifies the criteria required for the validation of the ESRD PPS LVPA related to:
1. The treatment count requirements for hospital-based ESRD facilities using cost report data and other supporting documents, and

2. When a change of ownership for any ESRD facility does not result in a new provider access transaction number (PTAN) but does result in a new cost reporting period.

CR 8898 also revises the "Medicare Benefit Policy Manual," Chapter 11 (End Stage Renal Disease (ESRD), Section 60 (ESRD PPS Case-Mix Adjustments)) to reflect these clarifications. Make sure that your billing staff are aware of the clarifications and revisions.

Background

For an ESRD facility to qualify for the LVPA, certain criteria must be attested to by the ESRD facility and validated by its MAC. The qualifying criteria include:

- Furnishing less than 4,000 dialysis treatments in each of the 3 cost reporting years preceding its payment year;

- The facility must not have opened, closed, or received a new provider number due to change in ownership in the 3 years preceding the payment year; and

- The facility must not be located within 25 road miles of another ESRD facility under common ownership.

The geographic proximity criterion is only applicable to ESRD facilities that are Medicare certified on or after January 1, 2011, to furnish outpatient maintenance dialysis treatments.

CR 8898 clarifies two criteria required for the validation of the LVPA. The two criteria needing clarification are:

1. The treatment count requirements for hospital-based ESRD facilities using cost report data and other supporting documents, and

2. When a change of ownership for any ESRD facility does not result in a new PTAN but does result in a new cost reporting period.

The first criteria needing clarification relates to hospital-based ESRD facilities meeting the requirement of furnishing less than 4,000 dialysis treatments in each of the 3 cost reporting years preceding the payment year. In the situation where a hospital has multiple locations of a hospital-based ESRD facility under its governing body, the aggregate cost and treatment data of all of the locations (not just the treatment count of one of the sub-units or satellite entities) are reported on the hospital’s cost report. In the case where a hospital has multiple locations reported on its cost report, the MAC may consider other supporting data in addition to the total treatments reported in each of the 12-consecutive month cost reports, including other supporting documentation which may include individual facility treatment counts, rather than the hospital’s cost report alone. The hospital must provide the documentation to support the total treatment count for all the facilities that make up the total

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treatment count on the cost report for the MAC to review, even if not all the facilities are applying for the low volume adjustment.

The second criteria needing clarification is related to any ESRD facility that has a change of ownership (CHOW), but does not obtain a new provider transaction access number (PTAN). If there is a change in ownership that does not result in a change in provider number but does cause a change in the original fiscal year to that of the new provider, resulting in two non-standard cost reporting periods, then the MAC should either:

- Combine the two non-standard cost reports that equals 12 consecutive months, or
- Where the two non-standard cost reporting periods in combination exceed 12 consecutive months, prorate the data to equal a full 12 consecutive month period.

For example, prior to a CHOW, Facility A had a cost reporting period that spanned January 1 through December 31. Facility A had a CHOW mid-year that did not result in a new PTAN but caused a break in the cost reporting period. The MAC would add Facility A’s cost report that spanned January 1 through May 31 to its cost report that spanned June 1 through December 31 to verify the total treatment count. The other situation that could occur is when a CHOW results in a change of the original fiscal period. For example, prior to a CHOW, Facility B had a cost reporting period that spanned January 1 through December 31 and, based on its cost reports for 2012 and 2013, it met the LVPA eligibility criteria. Then, Facility B had a CHOW in the beginning of 2014 that did not result in a new PTAN, but changed its cost reporting period to that of its new owner, October 1, 2014, through September 30, 2015. This scenario would create a short and a long cost report that would not total 12 months that the MAC would need to review for verification. That is, Facility B would have a cost report that spanned January 1, 2014, through July 31, 2014 (7 months) and a cost report that spanned August 1, 2014, through September 30, 2015 (14 months). In this situation, the MAC should combine the two non-standard cost reporting periods that in combination may exceed 12-consecutive months and prorate the data to equal a full 12-consecutive month period.

CMS realizes that these two clarifications may change the outcome for some ESRD facilities requesting the LVPA. As a result, ESRD facilities that wish to attest for the LVPA may submit attestations for each year applicable between 2011 and 2015. The timeframe for submission of these attestations will be extended until December 31, 2014. MACs will review the attestations and determine applicability for each previous year submitted by the facility. If the MAC validation results in applying the LVPA to a facility (facilities) that has (have) had claims paid without the adjustment, the MAC will adjust all claims during the applicable payment year(s) within 6 months of approving the attestation. CMS believes these clarifications will impact less than 1 percent of ESRD facilities that have less than 4000 treatments in any given year.

In addition, CMS reiterates the long-standing policy that allows for a maximum of 13 treatment payments per 30-day month, 14 treatment payments per 31-day month for all
ESRD claims. MACs may consider additional documentation to support the medical justification for payment of additional treatments.

**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)

- “Reading the Institutional Remittance Advice” Booklet, ICN 908326, downloadable

MLN Matters® Number: MM8923 Related Change Request (CR) #: CR 8923
Related CR Release Date: November 6, 2014 Effective Date: October 1, 2014
Related CR Transmittal #: R3118CP Implementation Date: April 6, 2015

Correction to Remittance Messages When Hospice Claims are Reduced Due to Late Filing of the Notice of Election

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8923 informs MACs about the changes to remittance advice messages applied to hospice claims when days are non-covered due to late filing of a Notice of Election. The messages will indicate that these days are appealable. Make sure that your billing staffs are aware of these changes.

Background

Change Request (CR) 8877 established a policy for the timely filing of hospice Notices of Election (NOEs). It required that NOEs shall be submitted to, and accepted by, the MAC within five calendar days after the hospice admission date. In instances where a NOE is not timely-filed, Medicare will not cover and pay for the days of hospice care from the hospice admission date to the date the NOE is submitted to, and accepted by, the MAC.
CR8877 established an exception process where, in certain exceptional circumstances, a hospice can request the MAC to waive the consequences of filing the NOE late. The hospice files the associated claim with occurrence span code 77 used to identify the non-covered, provider liable days. The hospice also reports a KX modifier with the Q HCPCS code reported on the earliest dated level of care line on the claim. The KX modifier prompts the MAC to request the documentation supporting the request for an exception. Based on that documentation, the MAC shall determine if a circumstance encountered by a hospice qualifies for an exception.

If the MAC approves the request for an exception, the MAC processes the claim and removes the submitted provider liable days, which will allow payment for the days associated with the late-filed NOE. If the MAC finds that the documentation does not support allowing an exceptional circumstance, the MAC shall process the claim as submitted. Due to a system limitation, the provider liable days on these claims currently receive remittance advice remark code N211 (Alert: You may not appeal this decision) in error. The exception requests decisions are appealable. The purpose of CR8923 is to correct this error.

The provider liable days on these claims will receive the following remittance advice codes:

- Group Code CO;
- Remittance Advice Remarks Code 96; and
- Claim Adjustment Reason Code MA54.

**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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Payment for G0101 and Q0091 in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) that Bill Under the All-Inclusive Rate (AIR) System.

Provider Types Affected

This MLN Matters® Article is intended for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) who are authorized to bill under the All Inclusive Rate (AIR) system and submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8927 adds Healthcare Common Procedure Coding System (HCPCS) code G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) and code Q0091 (screening Papanicolaou smear) to the list of preventive services paid based on the All-Inclusive Rate (AIR) for RHCs and FQHCs. Make sure your billing staffs are aware of this change.
Background

The Centers for Medicare & Medicaid Services (CMS) has determined that HCPCS codes G0101 and Q0091 are billable visits when furnished by a RHC or FQHC practitioner to a RHC or FQHC patient.

CR8927 instructs MACs to allow HCPCS codes G0101 and Q0091 to be billed as a stand-alone encounter/visit. These services will be paid the AIR on RHC and FQHC claims for 71X and 77X Types of Bills (TOBs), effective for dates of service on or after January 1, 2014. Please note that deductible and coinsurance are NOT to be applied to G0101 or Q0091. If other billable visits are furnished on the same day as G0101 or Q0091, only one visit will be paid.

G0101 or Q0091 are payable annually for women at high risk for developing cervical or vaginal cancer, and women of childbearing age who have had an abnormal Pap test within the past 3 years. It is payable every 2 years for women at normal risk. For FQHCs billing under the PPS, G0101 and Q0091 are qualifying visits when billed with FQHC payment HCPCS codes G0466 or G0467.

Your MAC will not search for claims that have been denied with HCPCS code G0101 or Q0091 prior to the implementation of CR8927, but will adjust any 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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MLN Matters® Number: MM8950
Related Change Request (CR) #: CR 8950
Related CR Release Date: November 6, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R3104CP
Implementation Date: April 6, 2015

Correction to Remittance Information When Health Insurance Prospective Payment System (HIPPS) Codes are Re-Coded by Medicare Systems

Provider Types Affected

This MLN Matters® Article is intended for Inpatient Rehabilitation Facilities (IRFs), Home Health Agencies (HHAs), and Skilled Nursing Facilities (SNFs) submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8950 contains no new payment policy. CR 8950 improves the implementation of existing policies.

CR 8950:
1. Provides approved remittance advice code pairs to apply to claims in which only a Remittance Advice Remark Code (RARC) is currently used. This correction is required

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for compliance with operating rules of the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules, for Information Exchange (CORE).

2. Reflects changes to the Home Health (HH) Pricer logic that were implemented as part of the 2015 Home Health Prospective Payment System (HH PPS) payment update.

Make sure that your billing personnel are aware of these changes.

**Background**

The Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules, for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set was implemented by January 1, 2014, as the Affordable Care Act required. In order to be compliant with these Operating Rules, the processing of Original Medicare claims must use remittance advice code combinations that are included in this list that CAQH CORE developed.

Recently, MACs informed the Centers for Medicare & Medicaid Services (CMS) of two situations in which past instructions specified only a single code for a payment adjustment, rather than a compliant pair.

1. Since 2000, Medicare systems have re-coded the Health Insurance Prospective Payment System (HIPPS) code submitted on home HH PPS claims in various circumstances. Under prior instructions, Medicare systems applied only RARC N69 (PPS code changed by claims processing system) without a corresponding claim adjustment reason code (CARC).

2. In 2012, Change Request (CR) 7760 began the implementation of a process to validate HIPPS codes against the assessment records submitted to the Quality Improvement Evaluation System (QIES). This process currently applies to inpatient rehabilitation facility claims and will be expanded to HH and skilled nursing facility claims in the future. CR7760 only required Medicare systems to apply RARC N69 to claims recoded based on QIES data, also without a corresponding Claim Adjustment Reason Code (CARC). You can find the associated MLN Matters® Article at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7760.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7760.pdf) on the CMS website.

CR8950 seeks to correct these oversights. However, CAQH CORE has not yet assigned approved code pairs for RARC N69. Medicare will request the approval of RARC N69 to be paired with CARC 169 (Alternate benefit has been provided); and in the interim, Medicare systems will apply CARC 169 with RARC N69 in both situations described above.

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Your MAC will:

1. Apply the following remittance advice codes on claims with Type of Bill (TOB) 032x (Home Health Services under a Plan of Treatment) when the output HIPPS code returned by the HH Pricer is different from the input HIPPS code:
   - Group code: CO
   - CARC: 169
   - RARC: N69

2. Apply the following remittance advice codes on claims with TOBs 011x (Hospital Inpatient (Part A)) with CMS Certification Numbers (CCNs) XX3025 - XX3099, XXTXXX, or XXRXXX, or TOBs 018x (Hospital Swing Bed), 021x (SNF Inpatient) or 032x (Home Health) when a HIPPS code is changed due to response file information received from QIES:
   - Group code: CO
   - CARC: 169
   - RARC: N69

HIPPS codes changed on the basis of validation with QIES data are not currently displayed to providers on Direct Data Entry (DDE) screens and are not being sent to the remittance advice.

CR8950 also reflects changes to the HH Pricer logic that were implemented as part of the 2015 HHPPS payment update. You can find these changes in the updated “Medicare Claims Processing Manual,” Chapter 10 (Home Health Agency Billing), Section 70.4 (Decision Logic Used by the Pricer on Claims), which is attached to CR8950.

**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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Elimination of the 50/50 Payment Rule for Laboratory Services on End Stage Renal Disease (ESRD) Claims

Provider Types Affected

This MLN Matters® Article is intended for laboratories and End Stage Renal Disease (ESRD) facilities that submit claims to Medicare Administrative Contractors (MACs) for ESRD-related tests provided to Medicare beneficiaries.

Provider Action Needed

With the implementation of the ESRD Prospective Payment System (PPS), ESRD laboratory services are no longer paid in accordance with the 50/50 rule. Change Request (CR) 8957 instructs that for ESRD claims with dates of service on or after April 1, 2015, ESRD facilities will no longer be required to submit the 50/50 rule modifiers CD, CE, and CF. The ESRD PPS requires that all renal dialysis laboratory services be paid in the ESRD facility bundled payment and therefore may only be billed by the ESRD facility.

Background

The Medicare End Stage Renal Disease (ESRD) benefit previously provided payment for dialysis and some dialysis related services under a per treatment composite rate. Separate
payment for Automated Multi-Channel Chemistry (AMCC) laboratory tests was determined according to the 50/50 rule where separate payment for the laboratory services was subject to whether 50 percent or more of the tests performed were in excess of the composite rate. ESRD facilities were required to report the following modifiers:

- CD to indicate if the laboratory test was included in the composite rate;
- CE to indicate the laboratory tests exceeded the frequency of the composite rate; or
- CF to indicate the laboratory test was not included in the composite rate.

In addition, ESRD facilities were required to itemize on the claim the individual laboratory Current Procedural Terminology (CPT) codes rather than reporting disease panel codes.

CR 8957 instructs that ESRD laboratory services are no longer paid in accordance with the 50/50 rule. The ESRD PPS requires that all renal dialysis laboratory services be paid in the ESRD facility bundled payment and therefore may only be billed by the ESRD facility.

For ESRD claims with dates of service on or after April 1, 2015, ESRD facilities will no longer be required to submit the 50/50 rule modifiers CD, CE, and CF. In addition, ESRD facilities should report organ or disease-oriented panel codes on Type of Bill 072X for codes listed in the following table when performed for an ESRD beneficiary if:

- These codes best describe the laboratory services provided to the beneficiary, which are paid under the ESRD PPS; or
- The test is not related to the treatment of ESRD, in which case the ESRD facility would append modifier “AY” and the service may be paid separately from the ESRD PPS.

<table>
<thead>
<tr>
<th>HCPCS/CPT Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>80047</td>
<td>METABOLIC PANEL IONIZED CA</td>
</tr>
<tr>
<td>80048</td>
<td>METABOLIC PANEL TOTAL CA</td>
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<tr>
<td>80051</td>
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<td>80053</td>
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<td>80061</td>
<td>LIPID PANEL</td>
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<tr>
<td>80069</td>
<td>RENAL FUNCTION PANEL</td>
</tr>
<tr>
<td>80076</td>
<td>HEPATIC FUNCTION PANEL</td>
</tr>
</tbody>
</table>

Additional Information

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Implementing the Payment Policies Related to Patient Status from the CMS-1599-F

Provider Types Affected

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

What You Need to Know

Change Request (CR) 8959 incorporates changes to the "Medicare Claims Processing Manual" related to the payment policies regarding Patient Status from final rule CMS-1599-F. This includes payment of Medicare Part B inpatient services, and admission and medical review criteria for payment of hospital inpatient services under Medicare Part A. Make sure that your billing staffs are aware of these changes.

Background

When an inpatient admission is found to be not reasonable and necessary, Medicare will allow payment of all hospital services that were furnished and would have been reasonable.
and necessary if the beneficiary had been treated as an outpatient, rather than admitted to the hospital as an inpatient, provided the allowed timeframe for submitting claims is not expired. Medicare will not allow payment for services that specifically require an outpatient status, such as outpatient visits, emergency department visits, and observation services that are, by definition, provided to hospital outpatients and not inpatients.

Specific changes to the "Medicare Claims Processing Manual" as a result of CR8959 involve Chapter 240 of that manual. Specifically, inpatient routine services in a hospital generally are those services included by the provider in a daily service charge—sometimes referred to as the "Room and Board" charge. They include the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made to Medicare Part A. Many nursing services provided by the floor nurse (such as IV infusions and injections, blood administration, and nebulizer treatments, etc.) may or may not have a separate charge established depending upon the classification of an item or service as routine or ancillary among providers of the same class in the same State. Some providers established customary charging practice resulting in separate charges for these services following the "Provider Reimbursement Manual" (PRM–1) instructions. However, in order for a provider’s customary charging practice to be recognized it must consistently follow those instructions for all patients and this must not result in an inequitable apportionment of cost to the program. If the PRM–1 instructions have not been followed, a provider cannot bill these services as separate charges. Additionally, it is important that the charges for services rendered and documentation meet the definition of the Healthcare Common Procedure Coding System (HCPCS) in order to separately bill.

All hospitals billing Part A services are eligible to bill the Part B inpatient services, including short term acute care hospitals paid under the Inpatient Prospective Payment System (IPPS), hospitals paid under the Outpatient Prospective Payment System (OPPS), long term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs) and IPF hospital units, inpatient rehabilitation facilities (IRFs) and IRF hospital units, Critical Access Hospitals (CAHs), children's hospitals, cancer hospitals, and Maryland waiver hospitals. Hospitals paid under the OPPS would continue billing the OPPS for Part B inpatient services. Hospitals that are excluded from payment under the OPPS in 42 Code of Federal Regulations (CFR) 419.20(b) would be eligible to bill Part B inpatient services under their non-OPPS Part B payment methodologies.

Beneficiaries are liable for their usual Part B financial liability. Beneficiaries would be liable for Part B copayments for each hospital Part B inpatient service and for the full cost of drugs that are usually self-administered. If the beneficiary's liability under Part A for the initial claim submitted for inpatient services is greater than the beneficiary's liability under Part B for the inpatient services they received, the hospital must refund the beneficiary the difference between the applicable Part A and Part B amounts. Conversely, if the beneficiary's liability under Part A is less than the beneficiary's liability under Part B for the inpatient services they received, the beneficiary may face greater cost sharing.
Timely filing restrictions will apply for Part B inpatient services. Claims that are filed beyond one (1) calendar year from the date of service will be rejected as untimely and will not be paid.

Remember that when beneficiaries treated as hospital inpatients are either not entitled to Part A at all, or are entitled to Part A but have exhausted their Part A benefits, hospitals may only bill for the limited set of Part B inpatient services specified in the "Medicare Benefit Policy Manual", Chapter 6, Section 10, which is available at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf) on the Centers for Medicare & Medicaid Services (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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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

MLN Matters® Number: MM8978
Related Change Request (CR) #: CR 8978
Related CR Release Date: November 14, 2014 Effective Date: January 1, 2015
Related CR Transmittal #: R199BP Implementation Date: January 5, 2015

Implementation of Changes in the End-Stage Renal Disease Prospective Payment System (ESRD PPS) for Calendar Year (CY) 2015

Provider Types Affected

This MLN Matters® Article is intended for End Stage Renal Disease (ESRD) facilities submitting claims to Medicare Administration Contractors (MACs) for renal dialysis services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8978 which implements the CY 2015 rate updates for the ESRD Prospective Payment System (PPS). Make sure that your billing staffs are aware of these changes for CY 2015.

Background

In accordance with the Medicare Improvements for Patients and Providers Act (MIPPA; section 153(b)), the Centers for Medicare & Medicaid Services (CMS) implemented the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) effective January 1, 2011.

The Affordable Care Act (section 3401(h) amended MIPPA (section 153(b)); see http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf), and states that for 2012 and each subsequent year, CMS will reduce the ESRD bundled (ESRDB) market basket increase factor by a productivity adjustment described in the Social Security Act (section 1886(b)(3)(B)(xi)(II); see http://www.ssa.gov/OP_Home/ssact/title18/1886.htm). The ESRDB market basket increase factor minus the productivity adjustment will update the ESRD PPS base rate.

For CY 2015, CMS rebased and revised the ESRDB market basket so that the cost weights and price proxies reflect the mix of goods and services that underlie ESRD bundled operating and capital costs for CY 2012. A payment provision for CY 2015 that is affected by the rebase and revision is an increase in the labor-related share, which is used when adjusting payments for geographic locality. CMS is implementing a 2-year transition under which a 50/50 blended labor-related share will apply to all ESRD facilities.

In addition, the Protecting Access to Medicare Act of 2014 (PAMA; section 217; see http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf on the Internet) includes several provisions that apply to the ESRD PPS. The most significant provisions for CY 2015 are the elimination of the drug utilization adjustment transition, a 0.0 percent update to the ESRD PPS base rate, and a delay in the inclusion of oral-only drugs used for the treatment of ESRD into the bundled payment until January 1, 2024.

The CY 2015 ESRD PPS final rule adopts the most recent core-based statistical area (CBSA) delineations as described in the February 28, 2013, Office of Management and Budget (OMB) Bulletin No. 13-01. In addition, CMS is implementing a 2-year transition under which a 50/50 blended wage index will apply to all ESRD facilities. As a result, several counties now have new CBSA numbers. In addition, for CY 2015 only, there are several special wage index values that need to be sent to the ESRD PPS pricer in order to apply correct payments to certain ESRD facilities.

ESRD facilities can confirm their CY 2015 CBSA delineation status and wage index value at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment on the CMS website.

The consolidated billing requirements for drugs and biologicals included in the ESRD PPS will be updated to include Health Care Procedure Coding System (HCPCS) code J3480 (Injection, potassium chloride, per 2 meq). It is a composite rate drug and therefore, is not eligible for outlier consideration.
Regarding the calculation for outlier payments, there is a correction to the mean unit cost associated with the oral equivalent drug, Hectorol (doxercalciferol) 0.5 mcg capsule and 1 mcg capsule, applicable to claims with dates of service in 2014. Facilities that believe the mean unit cost corrections may impact their outlier payments for claims in 2014, should submit adjustments to their claims within 6 months from the effective date of CR8978. MACs will be instructed to override timely filing if necessary.

Finally, in an effort to enhance the ESRD claims data for possible future refinements to the ESRD PPS, CMS is requiring ESRD facilities to begin reporting composite rate drugs and biologicals on the claim. Specifically, ESRD facilities should only report the composite rate drugs identified on the consolidated billing drug list provided in Attachment B of CR 8978. The ESRD PPS payment policy remains the same for composite rate drugs, therefore, no separate payment is made and these drugs will not be included in the outlier policy.

Calendar year (CY) 2015 ESRD PPS Updates:

**ESRD PPS base rate:**
A zero percent update to the payment rate results in a CY 2015 ESRD PPS base rate of $239.02 in accordance with section 217(b)(2) of PAMA. With a wage index budget neutrality adjustment factor of 1.001729, the CY 2015 ESRD PPS base rate is $239.43 ($239.02 x 1.001729 = $239.43).

**Wage index:**
The wage index adjustment will be updated to reflect the latest available wage data. New CBSA delineations are being implemented with a 50/50 blend of wage indices and the wage index floor will be reduced from 0.45 to 0.40.

**Labor-related share:**
The revised labor-related share is 50.673 percent, an increase from 41.737 percent. CMS will implement the revised labor-related share with a 50/50 blend under a 2-year transition which results in a labor-related share value of 46.205 percent for CY 2015.

**Outlier Policy:**
CMS will make the following updates to the adjusted average outlier service Medicare Allowable Payment (MAP) amount per treatment:

1. For adult patients, the adjusted average outlier service MAP amount per treatment is $51.29.
2. For pediatric patients, the adjusted average outlier service MAP amount per treatment is $43.57.

CMS will make the following updates to the fixed dollar loss amount that is added to the predicted MAP to determine the outlier threshold:
1. The fixed dollar loss amount is $86.19 for adult patients.
2. The fixed dollar loss amount is $54.35 for pediatric patients.

CMS will make the following changes to the list of outlier services:
1. Renal dialysis drugs, that are oral equivalents to injectable drugs are based on the most recent prices retrieved from the Medicare Prescription Drug Plan Finder, will be updated to reflect the most recent mean unit cost. In addition, CMS will add or remove any renal dialysis items and services that are eligible for outlier payment. See Attachment A of CR8978 which provides a list of 2015 Oral and Other Equivalent Forms of Injectable Drugs.
2. The mean dispensing fee of the National Drug Codes (NDC) qualifying for outlier consideration is revised to $1.15 per NDC per month for claims with dates of service on or after January 1, 2015. See Attachment A of CR8978.

Claims Reporting:
ESRD facilities shall begin reporting the composite rate drugs itemized on the consolidated billing list (see Attachment B of CR8978) when provided, on ESRD claims with dates of service on or after January 1, 2015.

CR 8978 also revises the "Medicare Benefit Policy Manual" (Chapter 11 (End Stage Renal Disease (ESRD), sections 10, 20, 30, 40, 50, and 60) and the "Medicare Claims Processing Manual" (Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), section 50.3 (Required Information for In-Facility Claims Paid Under the Composite Rate and the ESRD PPS). These manual revisions are included as attachments to CR 8978.

As part of the manual changes, ESRD facilities are required, effective January 1, 2015, to report on the claim the composite rate drugs identified on the consolidated billing list provided at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDPayment/Consolidated_Billing.html on the CMS website. No other composite rate drugs, items, or services are to be reported on the claim.

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


**Hospice Related Services - Part B**

**Note:** This article was revised on November 6, 2014, to make certain clarifications, mostly to change references to terminal diagnosis to terminal prognosis.

**Provider Types Affected**

This MLN Matters® Special Edition (SE) is intended for physicians submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries who are in a hospice period of coverage.

**What You Need to Know**

This article informs you that Recovery Auditors conducted automated claim reviews of medical services provided as separate services, when the Centers for Medicare & Medicaid Services (CMS) regulation or policy, or local practice dictates that they should have been billed together, rather than individual services for Medicare patients in hospice care.
Provider Action Needed

CMS is publishing this article to alert providers that they should identify if a beneficiary is enrolled in hospice. Providers can ask the beneficiary or his/her legal representative if he or she is enrolled in Hospice. This information should be documented in the beneficiaries medical record. Providers should educate beneficiaries and their families that once the beneficiary is enrolled in Hospice, they should contact the Hospice provider to arrange for any care they need. If the Hospice provider does not arrange the services the beneficiary needs, the beneficiary may be financially responsible for the services. The beneficiary and their family should also be aware that the beneficiary or his/her legal representative may revoke the election of hospice care at any time in writing. To revoke the election of hospice care, the beneficiary must file a document with the hospice that includes a signed statement that the beneficiary revokes the election for Medicare coverage of hospice care for the remainder of that election period and the effective date of that revocation. Note that a verbal revocation of benefits is NOT acceptable. CMS emphasizes that the revocation of the hospice election must be done in writing. A beneficiary may not designate an effective date of the revocation, that is earlier than the date that the revocation is made.

Upon revoking the election of Medicare coverage of hospice care for a particular election period, a beneficiary resumes Medicare coverage of the benefits waived when hospice care was elected. A beneficiary may at any time elect to receive hospice coverage as long as he or she continues to meet the eligibility criteria, meaning the beneficiary is entitled to Medicare Part A and has been certified as terminally ill with a medical prognosis of six months or less. For more information regarding Hospice services, please see the references listed in the Additional Information section of this article.

Services related to a Hospice terminal prognosis provided during a Hospice period are included in the Hospice payment and are not paid separately.

For beneficiaries enrolled in hospice, MACs should deny any Part B services furnished on or after January 1, 2002, that are submitted without either GV modifier, meaning the attending physician is not employed or paid under arrangement by the beneficiary's hospice provider and professional services provided are related to the terminal prognosis, or GW modifier, meaning the service is not related to the hospice beneficiary's terminal prognosis. MACs should deny services that are submitted with the GW modifier when the service is determined to be related to the terminal prognosis. Also, MACs should deny services that are submitted with the GV modifier if it is determined that the Physician services were furnished by Hospice-employed physicians and Nurse Practitioners (NP) or by other physicians under arrangement with the Hospice.

Case Studies

Here are some examples to give a better understanding of the use of these modifiers:

Example 1: A beneficiary is enrolled in Hospice and goes to a physician's office for closed treatment of a metatarsal fracture, CPT code 28470.

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Resolution: If the procedure is unrelated to the terminal prognosis (Non-Hospice related), the physician's bill should contain GW modifier (Service not related to the hospice patients terminal condition). If this modifier is not appended, the procedure is related to the terminal prognosis and should not be reimbursed under the part B benefit. Thus, the claim is in error, since the services are considered included with payments under the hospice benefit.

Example 2: The patient is listed as being on hospice starting August 1, 2010 through August 31, 2010. Then a provider billed CPT code 45378, Diagnostic Colonoscopy with no modifiers on August 3, 2010 to Part B.

Resolution: The billing of code 45378 would be incorrect since the beneficiary was enrolled in hospice and there can be no separate reimbursement unless the service was unrelated to the terminal prognosis or the attending physician was otherwise entitled to separate reimbursement, which would be reflected by GV modifier (Attending physician not employed or paid under arrangement by the patients hospice provider) or GW modifier (Service not related to the hospice patients terminal condition). MACs should also deny services that are submitted with the modifier but for which, during medical review, the service is determined to be related to the terminal prognosis.

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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