# Medicare Monthly Review

Issue No. MMR 2015-10  October 2015

## Contents

<table>
<thead>
<tr>
<th>Centers for Medicare &amp; Medicaid Services – Articles for Part A and Part B Providers</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Processing Medicare Secondary Payer Policy and Procedures Regarding Ongoing Responsibility for Medicals (MM8984)</td>
<td>4</td>
</tr>
<tr>
<td>Implementation of Long-Term Care Hospital Prospective Payment System Based on Specific Clinical Criteria (MM9015)</td>
<td>8</td>
</tr>
<tr>
<td>National Coverage Determination for Screening for Colorectal Cancer Using Cologuard™ - A Multitarget Stool DNA Test (MM9115)</td>
<td>11</td>
</tr>
<tr>
<td>Claim Status Category and Claim Status Codes Update (MM9276)</td>
<td>16</td>
</tr>
<tr>
<td>Influenza Vaccine Payment Allowances - Annual Update for 2015-2016 Season (MM9299)</td>
<td>18</td>
</tr>
<tr>
<td>2016 Annual Update of Healthcare Common Procedure Coding System Codes for Skilled Nursing Facility Consolidated Billing Update (MM9340)</td>
<td>21</td>
</tr>
<tr>
<td>January 2016 Quarterly Average Sales Price Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM9351 Revised)</td>
<td>23</td>
</tr>
<tr>
<td>Skilled Nursing Facility Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa) (SE0434 Revised)</td>
<td>25</td>
</tr>
<tr>
<td>Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696 and 6856) (SE1305 Revised)</td>
<td>28</td>
</tr>
<tr>
<td>Claims Submission Alternatives for Providers Who Have Difficulties Submitting ICD-10 Claims (SE1522)</td>
<td>41</td>
</tr>
<tr>
<td>2015-2016 Influenza Resources for Health Care Professionals (SE1523)</td>
<td>47</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Centers for Medicare &amp; Medicaid Services – Articles for Part A Providers</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2015 Integrated Outpatient Code Editor (I/OCE) Specifications Version 16.3 (MM9290 Revised)</td>
<td>53</td>
</tr>
<tr>
<td>October 2015 Update of the Hospital Outpatient Prospective Payment System (MM9298 Revised)</td>
<td>57</td>
</tr>
<tr>
<td>Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for Fiscal Year 2016 (MM9301)</td>
<td>63</td>
</tr>
<tr>
<td>Physicians and Nonphysician Practitioners Reported on Part A Critical Access Hospital Claims (SE1505 Revised)</td>
<td>71</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Centers for Medicare &amp; Medicaid Services – Articles for Part B Providers</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Rehabilitation Facility Annual Update: Prospective Payment System Pricer Changes for FY 2016 (MM9236)</td>
<td>75</td>
</tr>
<tr>
<td>Quarterly Update to the Correct Coding Initiative Edits, Version 22.0, Effective January 1, 2016 (MM9326)</td>
<td>79</td>
</tr>
<tr>
<td>Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries (SE1311 Revised)</td>
<td>81</td>
</tr>
</tbody>
</table>
Contact information can be found on our website at http://www.NGSMedicare.com. Medicare policies can be accessed from the Medical Policy Center section of our website. 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 website at http://www.NGSMedicare.com.
Centers for Medicare & Medicaid Services
Articles for Part A&B Providers
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

MLN Matters® Number: MM8984
Related Change Request (CR) #: CR 8984
Related CR Release Date: September 18, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R114MSP and R3358CP
Implementation Date: October 5, 2015

Claims Processing Medicare Secondary Payer (MSP) Policy and Procedures Regarding Ongoing Responsibility for Medicals (ORM)

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8984, through which the Centers for Medicare & Medicaid Services (CMS) outlines its Medicare claims processing requirements specific to Ongoing Responsibility for Medicals (ORM) for liability insurance (including self-insurance), no-fault insurance, and workers' compensation in Medicare Secondary Payer (MSP) situations.

Liability insurance (including self-insurance), no-fault insurance, and workers’ compensation laws or plans are required to report settlements, judgments, awards, or other payments to CMS, including ORM. The purpose of CR 8984 is to educate and instruct

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providers and the MACs about the policy and procedures related to ORM reporting. Make sure that your billing staffs are aware of these changes.

NOTE: MSP claims impacted by employer Group Health Plan coverage will be not affected by this change.

**Background**

Pursuant to section 1862(b)(8) of the Social Security Act, “applicable plans” (liability insurance (including self-insurance), no-fault insurance, and workers’ compensation laws or plans) are required to report settlements, judgments, awards or other payments involving individuals who are or were Medicare beneficiaries to CMS. The applicable plan is the “Responsible Reporting Entity” (RRE) for this process. The required reporting includes instances where the RRE has ORM associated with specified medical conditions. This information is collected to determine primary claims payment responsibility. Examples of ORM include, but are not limited to, a no-fault insurer agreeing to pay medical bills submitted to it until the policy in question is exhausted or a workers’ compensation plan being required under a particular state law to pay associated medical costs until there is a formal decision on a pending workers’ compensation claim.

The RRE may assume responsibility for ORM for one or more alleged injuries/illnesses without assuming ORM for all alleged injuries/illnesses in an individual’s liability insurance (including self-insurance), no-fault insurance, or workers’ compensation claim. For example, if an individual is alleging both a broken leg and a back injury, the RRE might assume responsibility for the broken leg but continue to dispute the alleged back injury.

When ORM ends (for example, a policy limit is reached or a settlement occurs which terminates the RRE responsibility to pay on an ongoing basis), the RRE reports an ORM Termination Date, and this information is uploaded to Medicare's Common Working File (CWF) by the Benefit Coordination & Recovery Center (BCRC).

**NOTE:** An ORM report is not a guarantee that medicals will be paid indefinitely or through a particular date.

Pursuant to section 1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment “has been made, or can reasonably be expected to be made…” under liability insurance (including self-insurance), no-fault insurance, or a workers’ compensation law or plan, hereafter, referred to as Non-Group Health Plan (NGHP). Where ORM has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted.

CR 8984 includes modifications to Medicare systems to automate the fact that ORM responsibility is assumed, exists, or did exist for a particular period of time. All MACs shall
reference the modified CWF MSPD screen to determine if ORM exists in association with MSPD (No-Fault – 14), E (Workers Compensation -15), and L (Liability - 47) records for the date(s) of service at issue. When claims are processed, Medicare will compare the diagnosis code(s) on the claim with the diagnosis code(s) associated with the ORM record. All MACs shall deny claims where the ORM indicator is present for the period covered by the claim and the diagnosis code(s) match(es) (or match(ed)) within the family of diagnosis codes. As stated, documentation from the RRE that the ORM terminated or is otherwise exhausted may require that the previously denied claim be reprocessed. (Any claim will also process for a potential Workers’ Compensation Medicare Set-Aside (WCMSA) denial where there is no denial based upon the ORM indicator.)

As stated above, MACs shall deny payment for claim lines with open ORM for the date of service for the associated diagnosis code(s) or family of diagnosis codes. The prompt payment rules do not override this requirement; therefore, a conditional payment cannot be made to providers when ORM exists for the item or service in question. However, as stated, the reported ORM is not a guarantee that medicals will be paid indefinitely or through a particular date. Consequently, if a claim is denied on the basis of ORM and the MAC receives information that the policy limit has been appropriately exhausted -- even though the claim in question is for services prior to the ORM termination date -- the claim may be paid if it is otherwise covered and reimbursable. This type of situation could occur where there has been a delay in billing to the RRE or where part of a group of claims submitted to the RRE was sufficient to exhaust the policy.

When Medicare denies claims due to the ORM indicator, the remittance advice for the denied claim will reflect one of the following Claims Adjustment Reason Codes (CARC) and Remittance Advice Remarks Codes (RARC):

- **CARC 19** - “This is a work-related injury/illness and thus the liability of the Workers’ Compensation Carrier.” Also, RARC N728 – “A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis” — will appear. (NOTE: To be used with Group Code PR.)

- **CARC 20** – “This injury/illness is covered by the liability carrier.” Also, RARC N725 – “A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis” — will appear. (NOTE: To be used with Group Code PR.)

- **CARC 21** - “This injury/illness is the liability of the no-fault carrier.” Also, RARC N727 – “A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis” — will appear. (NOTE: To be used with Group Code PR.)

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However, Medicare payment will be made for services if the following codes and conditions are met (assumption: primary payer did not pay for an acceptable reason; for example, benefits appropriately exhausted, or benefits no longer covered due to state imposed limits, etc.):

- Any of the following CARCs are found on the ORM claim: 26, 27, 31, 32, 35, 49, 50, 51, 53, 55, 56, 60, 96, 119, 149, 166, 167, 170, 184, 200, 201, 204, 242, 256, B1 (if a Medicare covered visit), B14; and

- The service is covered and otherwise reimbursable by Medicare.

**Additional Information**

**Important:** Providers, physicians, and other suppliers should know that CMS is implementing use of the ORM indicator on a gradual basis, beginning in January 2016. Appeal rights apply to all claims denied due to ORM as part of MSP claims processing.


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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Implementation of Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Based on Specific Clinical Criteria

Provider Types Affected

This MLN Matters® Article is intended for Long-Term Care Hospitals (LTCHs) that submit claims to Medicare Administrative Contractors (MACs) for Long-Term Care Hospital services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 9015, which informs you that Section 1206(a) of Public Law 113–67 (2013 Bipartisan Budget Act) amended Section 1886(m) of the Social Security Act (the Act) to establish patient-level criteria for standard payments under the LTCH PPS for implementation beginning for cost reporting periods beginning on or after October 1, 2015.

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CAUTION – What You Need to Know

This revision to payments under the existing LTCH PPS will establish two separate payment categories for LTCH patients: Standard and Site Neutral. See the Background and Policy Sections below for details.

GO – What You Need to Do

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

Background

Medicare currently pays for inpatient hospital services for LTCH discharges under the LTCH PPS.

- Under this payment system, the Centers for Medicare & Medicaid Services (CMS) largely sets payment rates prospectively for inpatient stays based on the patient’s diagnosis and severity of illness. A hospital generally receives a single payment for the case based on the payment classification, that is, the MS-LTC-DRGs assigned at discharge.
- LTCHs are required to meet the same Medicare Conditions of Participation (COPs) as acute care hospitals that are paid under the Inpatient Prospective Payment System (IPPS). Under existing law, the primary criteria for a hospital to be designated as an LTCH for Medicare payment purposes is a “greater than 25 day average length of stay” requirement.

Until the enactment of the 2013 Bipartisan Budget Act (Public Law 113-67), however, there were no clinical criteria concerning the patients treated in LTCHs. Specifically, Section 1206 of this Act establishes two distinct payment categories under the LTCH PPS:

- “Standard” payments for patient discharges meeting specific clinical criteria; and
- “Site Neutral” payments for those discharges that do not meet the specified clinical criteria.

This revision to payments under the existing LTCH PPS will establish two separate payment categories for LTCH patients:

- Upon discharge, LTCH cases meeting specific clinical criteria will be paid a standard LTCH PPS payment (that is, what is generally paid under existing LTCH PPS policy); and
- Upon discharge, those cases not meeting specific clinical criteria will be paid based on a "site neutral" basis, which is the lesser of an “IPPS-comparable” payment amount or 100 percent of the estimated cost of the case.

In order to be paid at the standard LTCH PPS amount, an LTCH patient must either:
• Have been admitted directly from an IPPS hospital during which at least 3 days were spent in an Intensive Care Unit (ICU) or Coronary Care Unit (CCU), but the discharge must not be assigned to a psychiatric or rehabilitation MS-LTC-DRG in the LTCH; or
• Have been admitted directly from an IPPS hospital and the LTCH discharge includes the procedure code for ventilator services of at least 96 hours (ICD-10-CM procedure code 5A195Z) but must not be assigned to a psychiatric or rehabilitation MS-LTC-DRG in the LTCH.

Existing LTCH PPS policies, such as the Short-Stay Outlier (SSO) policy and the Interrupted Stay policy, will continue to apply in determining the standard LTCH PPS payment for those discharges meeting specific clinical criteria.

The “site neutral” amount will be paid for patients discharged from the LTCH that do not meet one or both of the above criteria. Where a site neutral payment is made, MACs will place Remittance Advice Remarks Code N741 (This is a site neutral payment.) on the remittance advice.

Site Neutral payments shall not change the beneficiary’s out of pocket costs. Coinsurance, if applicable, is payable by the beneficiary for the number of days used. The hospital subtracts the coinsurance amount from the Medicare payment. Days after benefits are exhausted are not charged against the beneficiary's utilization whether or not the hospital receives the full MS-LTC-DRG payment.

If there is at least 1 day of utilization left at the time of admission and that day is also a day of entitlement (for example, a day before the beneficiary discontinued voluntary Part A entitlement by not paying the premium), if a site neutral payment is made, the remaining "inlier" days of the stay will be considered covered until the site neutral high cost outlier is reached even though the beneficiary is not using any Medicare covered days. The beneficiary shall not be responsible for non-utilization days. Once the beneficiary reaches the site neutral high cost outlier threshold, the beneficiary may choose to use life-time reserve days.

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 under - How Does It Work?

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National Coverage Determination (NCD) for Screening for Colorectal Cancer Using Cologuard™ - A Multitarget Stool DNA Test

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 9115 which announces effective October 9, 2014, the Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is sufficient to cover Cologuard™ - a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, aged 50 to 85 years.
CAUTION – What You Need to Know

CR9115 instructs the MACs that effective for claims with dates of service on or after October 9, 2014, Medicare will recognize new Healthcare Common Procedure Coding System (HCPCS) code G0464, (Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (for example, KRAS, NDRG4 and BMP3)) as a covered service. Only laboratories authorized by the manufacturer to perform the Cologuard™ test may bill for this service.

GO – What You Need to Do

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

Background

The Social Security Act (the Act) (Sections 1861(s)(2)(R) and 1861(pp) - see http://www.ssa.gov/OP_Home/ssact/title18/1861.htm and regulations at 42 CFR 410.37 (see http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-37.pdf) authorize coverage for screening colorectal cancer (CRC) tests under Medicare Part B. The statute and regulations authorize the Secretary to add other tests and procedures (and modifications to such tests and procedures for colorectal cancer screening) as the Secretary determines appropriate in consultation with appropriate experts and organizations.

As part of the CMS – Food and Drug Administration (FDA) Parallel Review Pilot Program, CMS finalized a NCD for Screening for CRC Using Cologuard™ - A Multitarget Stool DNA Test. After considering public comments and consulting with appropriate organizations, effective October 9, 2014, CMS has determined that the evidence is sufficient to cover Cologuard™ - a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, who are ages 50 to 85 years.

Effective for claims with dates of service on or after October 9, 2014, MACs will recognize the new HCPCS code G0464 as a covered service. Be aware that claims for HCPCS code G0464 must also include ICD-9 diagnosis codes V76.41 and V76.51. Once ICD-10 is implemented, the claim must reflect ICD-10 diagnosis codes Z12.12 and Z12.11.

MACs will only pay for HCPCS code G0464 when it is submitted on Types of Bill (TOB) 13X hospital outpatient departments), 14X (hospital non-patient laboratories), or 85X (critical access hospitals. Payments will be made on TOB 13X and 14X based on the clinical laboratory fee schedule (CLFS). Payment for TOB 85X will be based on reasonable cost.
Note: HCPCS code G0464 is in the January 1, 2015 CLFS and Integrated Outpatient Code Editor (IOCE) updates with an effective date of October 9, 2014. Therefore, MACs shall apply contractor pricing to claims containing HCPCS G0464 with dates of service October 9, 2014, through December 31, 2014.

You can refer to the revised Pub. 100-03, Medicare NCD Manual, Chapter 1, Section 210.3, Colorectal Cancer Screening Tests, for coverage policy. For claims processing instructions, refer to revised Pub. 100-04, Medicare Claims Processing Manual, Chapter 18, Section 60, Colorectal Cancer Screening. Both of these revised manuals are included as attachments to CR9115.

Effective for dates of service on or after October 9, 2014, Medicare Part B will cover the Cologuard™ test once every 3 years for Medicare beneficiaries that meet all of the following criteria:

- Age 50 to 85 years;
- Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test); and
- At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn’s Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

There is no coinsurance or deductible for tests paid under the CLFS. Therefore, there is no coinsurance or deductible for HCPCS code G0464.

Medicare will pay for this service for eligible beneficiaries only once every 3 years. Next eligible dates will be displayed on all Common Working File (CWF) provider query screens. Subsequent claim lines for HCPCS code G0464 received in the same 3-year period will be denied using the following:

- Claim Adjustment Reason Code (CARC) 119 - “Benefit maximum for this time period has been reached;”
- Remittance Advice Remarks Code (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. If you do not have web access, you may contact the contractor to request a copy of the NCD;” and
- Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed Advance Beneficiary Notice (ABN) is on file.

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To be eligible for this service, beneficiaries must be aged 50-85 or the claim line item will be denied with the following messages:

- CARC 6 - “The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N129 - “Not eligible due to the patient’s age.”
- Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Failure to include the required ICD-9 or ICD-10 codes on the claim line will result in denial of the claim line with the following messages:

- 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.”
- 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 assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Claim line items submitted on TOBs other than 13X, 14X, or 85X will be denied with the following messages:

- CARC 170: “Payment is 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.”
- RARC N95 – “This provider type/provider specialty may not bill this service.”
- Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

All other indications for colorectal cancer screening not otherwise specified in the Act and regulations, or otherwise specified in Section 210.3 of the NCD Manual, remain nationally non-covered.

Additional Information

The official instruction, CR9115, was issued to your MAC regarding this change via two transmittals. The first updates the “Medicare National Coverage Determinations Manual” and it is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Transmittals/Downloads/R183NCD.pdf on the CMS website. The

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

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REVISED product from the Medicare Learning Network® (MLN)

- “PECOS Technical Assistance Contact Information” Fact Sheet, ICN 903766, downloadable

MLN Matters® Number: MM9276
Related Change Request (CR) #: CR 9276
Related CR Release Date: August 28, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3344CP
Implementation Date: January 4, 2016

Claim Status Category and Claim Status Codes Update

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9276 informs MACs about the changes to the Claim Status Category and Claim Status Codes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and
responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.


All code changes approved during the September/October 2015 committee meeting will be posted on those sites on or about November 1, 2015. MACs must complete entry of all applicable code text changes, add new codes, and terminate use of deactivated codes by the implementation date of CR9276.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR9276.

**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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Providers and Suppliers — Browse the MLN Connects® Call Program

Collection of Resources - The CMS MLN Connects® National Provider Call Program has hosted many educational conference calls for the health care community on a variety of topics, including ICD-10, PQRS, Chronic Care Management, Open Payments (the Sunshine Act), 2-Midnight Rule, Medicare Shared Savings Program, ESRD QIP, and Dementia Care in Nursing Homes — just to name a few. Check out our Calls and Events web page for links to slide presentations, audio recordings, written transcripts, and a list of upcoming calls, or view one of our videos on the Medicare Learning Network® Playlist on the CMS YouTube Channel. Become more informed about the Medicare program by reading, listening, or viewing these information-packed programs at your convenience. Visit www.cms.govnpc for more information on the MLN Connects® National Provider Call Program.

MLN Matters® Number: MM9299 Related Change Request (CR) #: CR 9299
Related CR Release Date: August 28, 2015 Effective Date: August 1, 2015
Related CR Transmittal #: R3341CP Implementation Date: No later than November 24, 2015

Influenza Vaccine Payment Allowances - Annual Update for 2015-2016 Season

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9299 informs MACs about the payment allowances for seasonal influenza virus vaccines. These payment allowances are updated on an annual basis.
effective August 1st of each year. Make sure that your billing staffs are aware that the payment allowances are being updated.

The pending payment allowances will be updated in the influenza vaccine pricing webpage. Providers may visit the webpage at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html) for the updated prices.

**Background**

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

The Medicare Part B payment allowances for the following Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes below apply for the effective dates of August 1, 2015-July 31, 2016:

- CPT 90655 Payment allowance is pending;
- CPT 90656 Payment allowance is pending;
- CPT 90657 Payment allowance is pending;
- CPT 90661 Payment allowance is pending;
- CPT 90685 Payment allowance is pending;
- CPT 90686 Payment allowance is pending;
- CPT 90687 Payment allowance is pending;
- CPT 90688 Payment allowance is pending;
- HCPCS Q2035 Payment allowance is pending;
- HCPCS Q2036 Payment allowance is pending;
- HCPCS Q2037 Payment allowance is pending; and
- HCPCS Q2038 Payment allowance is pending.

Payment for the following CPT/HCPCS codes may be made if your MAC determines their use is reasonable and necessary for the beneficiary, for the effective dates of August 1, 2015-July 31, 2016:

- CPT 90630 Payment allowance is pending;
- CPT 90654 Payment allowance is pending;
- CPT 90662 Payment allowance is pending;
- CPT 90672 Payment allowance is pending; and
• CPT 90673 Payment allowance is pending.

Payment allowances will be published in the Centers for Medicare & Medicaid Services (CMS) influenza vaccine pricing webpage at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html) on the CMS website.

HCPCS Q2039 Flu Vaccine Adult - Not Otherwise Classified payment allowance is to be determined by your MAC with effective dates of August 1, 2015-July 31, 2016.

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

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

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

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

Note: MACs will not search their files either to retract payment for claims already paid or to retroactively pay claims prior to the implementation date of CR9299. However, they will adjust claims that you bring to their attention.

**Additional Information**


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

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REVISED product from the Medicare Learning Network® (MLN)

- “HIPAA EDI Standards” Web-based Training (WBT)

MLN Matters® Number: MM9340  Related Change Request (CR) #: CR 9340
Related CR Release Date: September 11, 2015  Effective Date: January 1, 2016
Related CR Transmittal #: R3349CP  Implementation Date: January 4, 2016

2016 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in Change Request (CR) 9340 could impact your payments.
CAUTION – What You Need to Know

CR 9340 provides the 2016 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and explains how the updates affect edits in Medicare claims processing systems. By the first week in December 2015, the new code files for Part B processing, and the new Excel and PDF files for Part A processing will be available at http://www.cms.gov/SNFConsolidatedBilling on the Centers for Medicare & Medicaid Services (CMS) website; and become effective on January 1, 2016.

GO – What You Need to Do

It is important and necessary for the provider community to read the "General Explanation of the Major Categories" PDF file located at the bottom of each year’s MAC update in order to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

Background

The Common Working File (CWF) currently has edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. These edits allow only those services that are excluded from consolidated billing to be separately paid.

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

Additional Information


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

- “Medicare Claim Review Programs” Booklet, (ICN 006973) Downloadable

MLN Matters® Number: MM9351 Revised  Related Change Request (CR) #: CR 9351
Related CR Release Date: September 18, 2015  Effective Date: January 1, 2016
Related CR Transmittal #: R3354CP  Implementation Date: January 4, 2016

**January 2016 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files**

**Note:** This article was revised on September 23, 2015, to correct the title of the article. 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 Durable Medical Equipment MACs (DME MACs) and Home Health & Hospice MACs (HH&H MACs) for Part B drugs provided to Medicare beneficiaries.

**Provider Action Needed**

Medicare will use the January 2016 quarterly Average Sales Price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2016, with dates of services from January 1, 2016, through March 31, 2016.

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Change Request (CR) 9351, from which this article is taken, instructs MACs to implement the January 2016 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised October 2015, July 2015, and April 2015, and January 2015 files. Make sure your billing personnel are aware of these changes.

**Background**

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Medicare Claims Processing Manual, Chapter 4, Section 50, Outpatient Code Editor (OCE).

The following table shows how the files will be applied.

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective for Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2016 ASP and ASP NOC</td>
<td>January 1, 2016, through March 31, 2016</td>
</tr>
<tr>
<td>October 2015 ASP and ASP NOC</td>
<td>October 1, 2015, through December 31, 2015</td>
</tr>
<tr>
<td>July 2015 ASP and ASP NOC</td>
<td>July 1, 2015, through September 30, 2015</td>
</tr>
<tr>
<td>April 2015 ASP and ASP NOC</td>
<td>April 1, 2015, through June 30, 2015</td>
</tr>
<tr>
<td>January 2015 ASP and ASP NOC</td>
<td>January 1, 2015, through March 31, 2015</td>
</tr>
</tbody>
</table>

**Additional Information**


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

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Skilled Nursing Facility Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa)

Note: This article was revised on September 11, 2015, to reflect the updated regulation reference in the first paragraph of the Background section of the article and to update several Web addresses. All other information remains the same.

Provider Types Affected
Skilled Nursing Facilities (SNF), physicians, suppliers, and providers.

Provider Action Needed
This Special Edition describes SNF Consolidated Billing (CB) as it applies to Erythropoietin (EPO, Epoetin Alfa) and related services.

Background
The original Balanced Budget Act of 1997 list of exclusions from the PPS and consolidated billing for SNF Part A residents specified the services described in section 1861(s)(2)(O) of the Social Security Act—the Part B erythropoietin (EPO) benefit. This benefit covers EPO and items related to its administration for those dialysis patients who can self-administer the drug, subject to methods and standards established by the Secretary for its safe and effective use (see 42 CFR 494.80(a)(2) and (a)(4), 494.90(a)(4), and 494.100). (See MLN Matters article SE0431 for an overview of SNF CB and a list of “excluded services.”)

Regulations at 42 CFR 414.335 describe payment for EPO and require that EPO be furnished by either a Medicare approved End Stage Renal Disease (ESRD) facility or a supplier of home dialysis equipment and supplies. The amount that Medicare pays is established by law. Thus, the law and implementing regulations permit a SNF to unbundle the cost of the Epogen drug...
when it is furnished by an ESRD facility or an outside supplier, which can then bill for it under Part B.

An SNF that elects to furnish EPO to its Part A resident itself cannot be separately reimbursed over and above the Part A SNF PPS per diem payment amount for the Epogen drug. As explained above, the exclusion of EPO from CB and the SNF PPS applies only to those services that meet the requirements for coverage under the separate Part B EPO benefit, i.e., those services that are furnished and billed by an approved ESRD facility or an outside dialysis supplier.

By contrast, if the SNF itself elects to furnish EPO services (including furnishing the Epogen drug) to a resident during a covered Part A stay (either directly with its own resources, or under an “arrangement” with an outside supplier in which the SNF itself does the billing), the services are no longer considered Part B EPO services, but rather, become Part A SNF services. Accordingly, they would no longer qualify for the exclusion of Part B EPO services from CB, and would instead be bundled into the PPS per diem payment that the SNF receives for its Part A services.

**Note**: EPO (Epoetin Alfa, trade name Epogen)/DPA (Darbepoetin Alfa, trade name Aranesp) are not separately billable when provided as treatment for any other illness or condition. In this case, the SNF is responsible for reimbursing the supplier. The SNF should include the charges on the Part A bill filed for that beneficiary.

**Additional Information**


It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a non-covered stay; and
• All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

Lastly, the CMS Skilled Nursing Facility Prospective Payment System (SNF PPS) website can be found at [http://www.cms.hhs.gov/SNFPPS/05_ConsolidatedBilling.asp](http://www.cms.hhs.gov/SNFPPS/05_ConsolidatedBilling.asp) on the CMS website.
In September 2012, the Centers for Medicare & Medicaid Services (CMS) announced the availability of a new electronic mailing list for those who refer Medicare beneficiaries for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Referral agents play a critical role in providing information and services to Medicare beneficiaries. To ensure you give Medicare patients the most current DMEPOS Competitive Bidding Program information, CMS strongly encourages you to review the information sent from this new electronic mailing list. In addition, please share the information you receive from the mailing list and the link to the “mailing list for referral agents” subscriber webpage with others who refer Medicare beneficiaries for DMEPOS. Thank you for signing up!

MLN Matters® Number: SE1305 Revised

Related Change Request (CR) #: 6421, 6417, 6696, 6856

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: R642OTN, R643OTN, R328PI, and R781OTN

Implementation Date: N/A

Note: This article was revised on September 24, 2015, to change the link to the “Ordering Referring Report” on page 3 and page 5. That link was changed to https://data.cms.gov on the CMS website. For a complete list of any other changes to this article, please refer to the Document History Section. All other information remains the same.

Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)

Provider Types Affected

This MLN Matters® Special Edition Article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA), the Department of Defense (DoD), or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries,

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- Part B providers and suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare Administrative Contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and
- Part A Home Health Agency (HHA) services who submit claims to Regional Home Health Intermediaries (RHHIs), Fiscal Intermediaries (FIs, who still maintain an HHA workload), and Part A/B MACs.
- Optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.

**Provider Action Needed**

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) or by completing the paper enrollment application (CMS-855O). Review the background and additional information below and make sure that your billing staff is aware of these updates.

**What Providers Need to Know**

**Phase 1:** Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication.

**Phase 2:** Effective January 6, 2014, CMS will turn on the edits to deny Part B clinical laboratory and imaging, DME, and Part A HHA claims that fail the ordering/referring provider edits.

Claims submitted identifying an ordering/referring provider and the required matching NPI is missing will continue to be rejected. Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit will not expose a Medicare beneficiary to liability. Therefore, **an Advance Beneficiary Notice is not appropriate in this situation.** This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services, including home health, DMEPOS, imaging and clinical laboratory.

Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the...
edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name. **When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found on https://data.cms.gov on the CMS website. Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the ordering/referring fields.**

All enrollment applications, including those submitted over the Internet, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application. Waiting too long to begin this process could mean that your enrollment application may not be processed prior to the implementation date of the ordering/referring Phase 2 provider edits.

**Background**

The Affordable Care Act, Section 6405, “Physicians Who Order Items or Services are required to be Medicare Enrolled Physicians or Eligible Professionals,” requires physicians or other eligible professionals to be enrolled in the Medicare Program to order or refer items or services for Medicare beneficiaries. Some physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program. Also, effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the NPI. The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B clinical laboratory and imaging, DME, and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:

- Claims from clinical laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures;
- Claims from suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for ordered DMEPOS; and
- Claims from Part A Home Health Agencies (HHA).

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

- Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.)
• Physician Assistants,
• Clinical Nurse Specialists,
• Nurse Practitioners,
• Clinical Psychologists,
• Interns, Residents, and Fellows,
• Certified Nurse Midwives, and
• Clinical Social Workers.

CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

• Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.

• Home Health Agency (HHA) services may only be ordered or referred by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Doctor of Podiatric Medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.

• Optometrists may only order and refer DMEPOS products/services, and laboratory and X-Ray services payable under Medicare Part B.

Questions and Answers Relating to the Edits

1. What are the ordering and referring edits?
The edits will determine if the Ordering/Referring Provider (when required to be identified in Part B clinical laboratory and imaging, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and contains a valid NPI (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. Why did Medicare implement these edits?
These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. How and when will these edits be implemented?
These edits were implemented in two phases:
Phase 1 - **Informational messaging:** Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication. The informational messages used are identified below:

For Part B providers and suppliers who submit claims to carriers:

| N264 | Missing/incomplete/invalid ordering provider name |
| N265 | Missing/incomplete/invalid ordering provider primary identifier |

For adjusted claims, the Claims Adjustment Reason Code (CARC) code 16 (Claim/service lacks information which is needed for adjudication.) is used. DME suppliers who submit claims to carriers (applicable to 5010 edits):

| N544 | Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future |

For Part A HHA providers who order and refer, the claims system initially processed the claim and added the following remark message:

| N272 | Missing/incomplete/invalid other payer attending provider identifier |

For adjusted claims the CARC code 16 and/or the RARC code N272 was used.

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**CMS has taken actions to reduce the number of informational messages.** In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs. On January 28, 2010, CMS made available to the public, via the Downloads section of the “Ordering Referring Report” page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the Report twice a week. At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report and to download it, go to [https://data.cms.gov](https://data.cms.gov) on the CMS website.

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1 NPIs were added only when the matching criteria verified the NPI.

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Phase 2: Effective January 6, 2014, CMS will turn on the Phase 2 edits. In Phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral.

Below are the denial edits for Part B providers and suppliers who submit claims to Part A/B MACs, including DME MACs:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>254D or 001L</td>
<td>Referring/Ordering Provider Not Allowed To Refer/Order</td>
</tr>
<tr>
<td>255D or 002L</td>
<td>Referring/Ordering Provider Mismatch</td>
</tr>
</tbody>
</table>

CARC code 16 or 183 and/or the RARC code N264, N574, N575 and MA13 shall be used for denied or adjusted claims. Claims submitted identifying an ordering/referring provider and the required matching NPI is missing (edit 289D) will continue to be rejected. CARC code 16 and/or the RARC code N265, N276 and MA13 shall be used for rejected claims due to the missing required matching NPI.

Below are the denial edits for Part A HHA providers who submit claims:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| 37236 | This reason code will assign when:  
- The statement “From” date on the claim is on or after the date the phase 2 edits are turned on  
- The type of bill is '32' or '33'  
- Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code |
Effect of Edits on Providers

I order and refer. How will I know if I need to take any sort of action with respect to these two edits?

In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, you, the ordering/referring provider, need to ensure that:

a. You have a current Medicare enrollment record.
   - If you are not sure you are enrolled in Medicare, you may:
     i. Check the Ordering Referring Report and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI;
     ii. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or
     iii. Use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare).
     iv. If you choose iii, please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.

b. If you do not have an enrollment record in Medicare.
   - You need to submit either an electronic application through the use of internet-based PECOS or a paper enrollment application to Medicare.
     i. For paper applications - fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor.
     ii. For electronic applications – complete the online submittal process and either e-sign or mail a printed, signed, and dated Certification Statement and digitally submit any required supporting paper documentation to your designated Medicare enrollment contractor.
     iii. In either case, the designated enrollment contractor cannot begin working on your

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application until it has received the signed and dated Certification Statement.

iv. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment web page to learn more about the web-based system before you attempt to use it. Go to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html, click on “Internet-based PECOS” on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.

v. If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via internet-based PECOS or .pdf for downloading from the CMS forms page (http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html).

c. You are an opt-out physician and would like to order and refer services. What should you do?

If you are a physician who has opted out of Medicare, you may order items or services for Medicare beneficiaries by submitting an opt-out affidavit to a Medicare contractor within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit).

d. You are of a type/specialty that can order or refer items or services for Medicare beneficiaries. When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty (Chiropractors are excluded) and only the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.

e. I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the Ordering/Referring Provider edits?

- You need to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the Ordering Referring Report described earlier in this article.

- Ensure you are correctly spelling the Ordering/Referring Provider’s name.

- If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the Ordering/Referring Provider edits.

- The Ordering Referring Report will be replaced twice a week to ensure it is current. It is possible that you may receive an order or a referral from a physician or non-physician

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f. **Make sure your claims are properly completed.**

- On paper claims (CMS-1500), in item 17, only include the first and last name as it appears on the Ordering and Referring file found on CMS.gov.
- On paper claims (CMS-1450), you would capture the attending physician’s last name, first name and NPI on that form in the applicable sections. On the most recent form it would be fields in FL 76.
- On paper claims (CMS-1500 and CMS-1450), do not enter “nicknames”, credentials (e.g., “Dr.”, “MD”, “RNPA”, etc.) or middle names (initials) in the Ordering/Referring name field, as their use could cause the claim to fail the edits.
- Ensure that the name and the NPI you enter for the Ordering/Referring Provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral.
- Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer.

If there are additional questions about the informational messages, Billing Providers should contact their local A/B MAC, or DME MAC.

Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit shall not expose a Medicare beneficiary to liability. Therefore, an **Advance Beneficiary Notice is not appropriate in this situation**. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services including home health, DMEPOS, imaging and clinical laboratory.

g. **What if my claim is denied inappropriately?**

If your claim did not initially pass the Ordering/Referring provider edits, you may file an appeal through the standard claims appeals process or work through your A/B MAC or DME MAC.

h. **How will the technical vs. professional components of imaging services be affected by the edits?**

Consistent with the Affordable Care Act and 42 CFR 424.507, suppliers submitting claims for imaging services must identify the ordering or referring physician or practitioner. Imaging suppliers covered by this requirement include the following: IDTFs, mammography centers, portable x-ray facilities and radiation therapy centers. The rule applies to the technical component of imaging services, and the professional component will be excluded from the edits. However, if billing globally, both components will be impacted.
by the edits and the entire claim will deny if it doesn’t meet the ordering and referring requirements. It is recommended that providers and suppliers bill the global claims separately to prevent a denial for the professional component.

i. **Are the Phase 2 edits based on date of service or date of claim receipt?**
The Phase 2 edits are effective for claims with dates of service on or after January 6, 2014.

j. **A Medicare beneficiary was ordered a 13-month DME capped rental item. Medicare has paid claims for rental months 1 and 2. The equipment is in the 3rd rental month at the time the Phase 2 denial edits are implemented. The provider who ordered the item has been deactivated. How will the remaining claims be handled?**
Claims for capped rental items will continue to be paid for up to 13 months from the physician’s date of deactivation to allow coverage for the duration of the capped rental period.

---

**Additional Guidance**

1. **Terminology:** Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred, or certified an item or service reported in that claim. The final rule uses technically correct terms: 1) a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services to a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/refferred" in materials directed to a broad provider audience.

2. **Orders or referrals by interns or residents:** The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that State-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if States provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with State law.

3. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense (DoD)/Tricare:** These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
4. **Orders or referrals by dentists:** Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

**Additional Information**

For more information about the Medicare enrollment process, visit [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html) or contact the designated Medicare contractor for your State. Medicare provider enrollment contact information for each State can be found at [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf) on the CMS website.


**Additional Article Updates**


MLN Matters® Article MM6421, “Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and


MLN Matters Article SE1311, " Opting out of Medicare and/or Electing to Order and Refer Services" is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf) informs ordering and referring providers about the information they must provide in a written affidavit to their Medicare contractor when they opt-out of Medicare.

If you have questions, please contact your Medicare Carrier, Part A/B MAC, or DME MAC, at their toll-free numbers, 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.


### Document History

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<td>This article was revised to change the link to the “Ordering Referring Report” page. That link was changed to <a href="https://data.cms.gov">https://data.cms.gov</a> on the CMS website.</td>
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<tr>
<td>January 26, 2015</td>
<td>This article was revised to include a link to article SE1311, which includes important information for physicians and non-physician practitioners who opt out of Medicare and/or elect to order and certify services to Medicare beneficiaries.</td>
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<td>This article was previously revised to add references to the CMS-1450 form and to add question H. on page 9. Previously, it was revised on April 3, 2013, to advise providers not to include middle names and suffixes of ordering/referring providers on paper claims. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid National Provider Identifier (NPI) and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name. When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found at <a href="http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html">http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html</a> on the CMS website.</td>
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</tbody>
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NEW product from the Medicare Learning Network® (MLN)

- “HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules” Fact Sheet, ICN 909001, downloadable

**Claims Submission Alternatives for Providers Who Have Difficulties Submitting ICD-10 Claims**

**Provider Types Affected**

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

**Provider Action Needed**

This MLN Matters® Special Edition article offers physicians, providers, and suppliers information that will assist them in avoiding claims processing disruptions after implementation of International Classification of Diseases, Tenth Edition (ICD-10) on October 1, 2015. It provides information for providers who have difficulties submitting ICD-10 claims due to being unable to complete necessary systems changes or having issues with billing software, vendor(s), or clearinghouse(s).

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Background

For FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use ICD-10 code sets adopted under HIPAA.

ICD-10 Claims Submission Alternatives

If you have difficulties submitting ICD-10 claims due to being unable to complete the necessary systems changes or having issues with your billing software, vendor(s), or clearinghouse(s), the following claims submission alternatives are available:

- Free billing software;
- Provider internet portals;
- Direct Data Entry (DDE); and
- Paper claims.

Each claims submission alternative is discussed in more detail below.

Please note that these claims submission alternatives REQUIRE THE USE OF ICD-10 code sets for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015.

FREE BILLING SOFTWARE

Providers Who Submit Claims to MACs

You may download the free billing software that the Centers for Medicare & Medicaid Services (CMS) A/B MACs offer on their web pages. The software has been updated to support ICD-10 codes and requires either a Network Service Vendor (NSV) or dial-up or both to transmit claims. The software download is free, but there may be fees associated with submitting claims through an NSV or dial-up. The MAC web pages also provide information about NSVs.

This billing software only works for submitting Fee-For-Service (FFS) claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance.

Information about the free billing software is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled Contractors’ ICD-10 Claims Submission Alternatives Web Pages on the CMS website.

Please note that submitting electronic claims to Medicare using the free billing software does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service (on professional claims) or dates of
DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015. Any claims containing ICD-9 codes for FROM dates of service (on professional claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, will be rejected by Medicare.

Providers Who Submit Claims to DME MACs

DME suppliers may download the free billing software that CMS offers via the Common Electronic Data Interchange (CEDI) website. The software has been updated to support ICD-10 codes and requires NSV connectivity to transmit Medicare DME claims to CEDI. The software download is free, but there may be fees associated with submitting claims through an NSV. The list of approved NSVs and an NSV Frequently Asked Questions document is available at http://www.ngscedi.com/nsv on the CEDI website. You must also have a CEDI Trading Partner/Submitter ID to use the free billing software to submit claims to CEDI.

- If you currently do not have a CEDI Trading Partner ID (begins with A08, B08, C08, or D08) to submit claims directly to CEDI (for example, you submit claims through a clearinghouse or billing service), you will need to complete the necessary CEDI enrollment forms to obtain a CEDI Trading Partner ID.

- If you currently have a CEDI Trading Partner ID, you will use that to submit claims with the free billing software.

You can find CEDI enrollment forms at http://www.ngscedi.com/forms/formsindex.htm on the CEDI website. You should submit the forms to CEDI as soon as possible, but no later than September 15, 2015, to allow CEDI time to process your request and for any testing you might want to do prior to the October 1, 2015, ICD-10 implementation. You will also need to allow for any additional time to sign up and establish connectivity to CEDI through the NSV that you choose.

This billing software only works for submitting FFS claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance.

Information about the free billing software is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled Contractors’ ICD-10 Claims Submission Alternatives Web Pages on the CMS website.

Please note that submitting electronic claims to Medicare using the free billing software does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service on or after October 1, 2015. Any claims containing ICD-9 codes for FROM dates of service on or after October 1, 2015, will be rejected by Medicare.

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PROVIDER INTERNET PORTALS

In some cases, you may be able to use your MAC’s provider internet portal to submit ICD-10 compliant professional claims. All MACs offer the portals, and a subset of these MAC portals offer claims submission. Provider portal internet claim submission is not available for institutional or supplier claims.

Information about registering for access to provider internet portals is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled Contractors’ ICD-10 Claims Submission Alternatives Web Pages on the CMS website.

Please note that claims submitted via our provider portal must contain ICD-10 codes for FROM dates of service on or after October 1, 2015. Those submitted containing ICD-9 codes for FROM dates of service on or after October 1, 2015, will be rejected through normal claims editing processes. ICD-9 codes will still be accepted for FROM dates prior to October 1, 2015.

DDE

Providers that bill institutional claims are also permitted to submit claims electronically via DDE screens. DDE requires a connectivity service provided by an external company to establish the connection.

Information about registering to submit claims via DDE and lists of DDE service vendors is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled Contractors’ ICD-10 Claims Submission Alternatives Web Pages on the CMS website.

Please note that claims submitted via DDE must contain ICD-10 codes for dates of DISCHARGE/THROUGH dates on or after October 1, 2015. Those submitted containing ICD-9 codes for dates of DISCHARGE/THROUGH dates on or after October 1, 2015, will be Returned to Provider (RTP).

PAPER CLAIMS

In limited situations, you may submit paper claims with ICD-10 codes to Medicare. To find more information on when you may submit paper claims, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCAWaiver.html on the CMS website. Please note that to submit paper claims, you must meet the requirements to qualify for a waiver of the Administrative Simplification Compliance Act (ASCA) provisions.

Information about submitting paper claims and ordering claim forms is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled Contractors’ ICD-10 Claims Submission Alternatives Web Pages on the CMS website.

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Waivers Subject to MAC Evaluation

Providers must apply for and meet all of the following requirements to qualify for a waiver of the ASCA provisions:

- Your software vendor is not ICD-10 ready, and it will cause a financial hardship for you to switch to another vendor; or
- Your software is not ICD-10 ready, and it will cause a financial hardship for you to switch to new software; and
- Your MAC’s provider internet portal does not support electronic claims submissions; and
- It would cause financial hardship for you to procure the services of a billing agent/clearinghouse.

It is the provider’s responsibility to submit all of the following documentation to the MAC to establish the validity of a waiver request:

- A letter from the vendor stating that their software is not ICD-10 compliant; or
- Attestation from the provider stating that your software is not ready for ICD-10; and
- Attestation of provider financial hardship; and
- Acknowledgement that paper claims must be submitted in a machine scannable format.

If the MAC determines that the waiver request meets the criteria described above and proper documentation has been provided, the MAC will grant the waiver request.

Corrective Action Plan (CAP)

A provider who qualifies for a waiver to submit paper claims will be placed on a CAP not to exceed 120 days and must submit a CAP detailing the steps, with associated timelines, being taken to become ICD-10 compliant.

Please note that submitting paper claims to Medicare, even if approved for an ASCA waiver, does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015. Any paper claims containing ICD-9 codes for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, will be returned as unprocessable by Medicare.

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Information and Resources

Visit the following web pages to find information and resources that will assist you in submitting ICD-10 codes to Medicare:

- ICD-10 Fee-For-Service provider resources including claims processing and billing, coding, unspecified ICD-10-CM codes, home health provider information, NCDs and LCDs, testing and results, features and benefits, and calls and background: [https://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-for-Service-Provider-Resources.html]
- General Equivalence Mappings: [http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html] and

Additional Information

If you have any questions, please contact your MAC at their toll-free number. To find MAC toll-free numbers, please refer to the Review Contractor Interactive Map located at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index.html] on the CMS website.

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2015-2016 Influenza (Flu) Resources for Health Care Professionals

Provider Types Affected

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

What You Need to Know

- Keep this Special Edition MLN Matters® article and refer to it throughout the 2015-2016 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the new year.
- Remember to immunize yourself and your staff.

Introduction

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their...

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administration. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)

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

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

**Know What to Do About the Flu!**

### Payment Rates for 2015-2016

Each year, CMS updates the Medicare Healthcare Common Procedure Coding System (HCPCS) and Current Procedure Terminology (CPT) codes and payment rates for personal influenza (flu) and pneumococcal vaccines. Payment allowance limits for such vaccines are 95 percent of the Average Wholesale Price (AWP), except where the vaccine is furnished in a hospital outpatient department, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). In these cases, the payment for the vaccine is based on reasonable cost.

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

Effective for services provided on August 1, 2015, through those provided on July 31, 2016, the following Medicare Part B payment allowances for HCPCS and CPT codes apply.

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</tr>
<tr>
<td>Q2038</td>
<td>8/1/2015 – 7/31/2016</td>
<td>$12.044</td>
</tr>
<tr>
<td>Q2039</td>
<td>8/1/2015 – 7/31/2016</td>
<td>Flu Vaccine Adult – Not Otherwise Classified: Payment allowance is to be determined by the local claims processing contractor.</td>
</tr>
</tbody>
</table>

The above pricing, and any required updates, will be available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html) on the CMS website.

**Educational Products for Health Care Professionals**

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

1. **MLN Influenza Related Products for Health Care Professionals**
2. Other CMS Resources

- Immunizations web page -
  http://www.cms.gov/Medicare/Prevention/Immunizations/index.html
- Prevention General Information -
  http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html
- Medicare Benefit Policy Manual - Chapter 15, Section 50.4.4.2 – Immunizations
- Medicare Claims Processing Manual – Chapter 18, Preventive and Screening Services

3. Other Resources

The following non-CMS resources are just a few of the many available in you may find useful information and tools for the 2015 – 2016 flu season:

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

National Network for Immunization Information - http://www.immunizationinfo.org;

National Vaccine Program - http://www.hhs.gov/nvpo;


Partnership for Prevention - http://www.prevent.org; and

World Health Organization - http://www.who.int/en

Beneficiary Information

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

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Centers for Medicare & Medicaid Services
Articles for Part A Providers
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Revised product from the Medicare Learning Network®
• “Medicare Claim Review Programs” Booklet, (ICN 006973) Downloadable

MLN Matters® Number: MM9290 Revised
Change Request (CR) #: CR 9290
Related CR Release Date: September 23, 2015
Effective Date: October 1, 2015
Related Transmittal #: R3359CP
Implementation Date: October 5, 2015

October 2015 Integrated Outpatient Code Editor (I/OCE)
Specifications Version 16.3

Note: This article was revised on September 24, 2015, to reflect the revised CR9290 issued on September 23. In the article, the table on pages 2-3 has been updated to include the modification to edit 68 for HCPCS code Q5101 and to clarify the entry in that table regarding edit 87. In addition, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

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Provider Action Needed

STOP – Impact to You

Be aware that the Integrated/Outpatient Code Editor (I/OCE) is being updated for October 1, 2015. Change Request (CR) 9290 details those changes.

CAUTION – What You Need to Know

CR 9290 provides the instructions and specifications for the I/OCE to be used under the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System (PPS) or to a hospice patient for the treatment of a non-terminal illness. This notification applies to Chapter 4, Section 40.1 of the “Medicare Claims Processing Manual,” which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

GO – What You Need to Do

Make sure that your billing staffs are aware of the updated I/OCE for October 1, 2015.

Background

CR 9290 provides the I/OCE instructions and specifications for the Integrated OCE that will be utilized under the OPPS and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health PPS or to a hospice patient for the treatment of a non-terminal illness. The I/OCE specifications will be posted online and can be found at http://www.cms.gov/OutpatientCodeEdit/ on the CMS website.

The modifications of the I/OCE for the October 2015 release (V16.3) are summarized in the table below. Some I/OCE modifications in this update may be retroactively added to prior releases. If so, the retroactive date appears in the “Effective Date” column.

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<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/3/2015</td>
<td>68</td>
<td>Implement mid-quarter National Coverage Determination (NCD) edit effective date for HCPCS Q5101.</td>
</tr>
<tr>
<td>10/1/2015</td>
<td>87</td>
<td>Modify the program logic to not ignore skin substitute product code(s) present with line item action flag 2 in order to process edit 87. Corrects effective date to 10/1/2015 from erroneous date in program logic of 4/1/2015. No change to documentation.</td>
</tr>
<tr>
<td>10/1/2015</td>
<td>87</td>
<td>Update to the skin substitute product list (move HCPCS Q4151 from List A to List B – Appendix P, list E of CR9290).</td>
</tr>
<tr>
<td>10/1/2015</td>
<td>88, 89</td>
<td>Modify the program logic to not assign edits 88 and 89 for Federally Qualified Health Center (FQHC) PPS claims when only FQHC non-covered services are present with edit 91 (page 11; Appendix M processing steps and flowchart).</td>
</tr>
<tr>
<td>10/1/2015</td>
<td>2, 3, 86</td>
<td>Update the diagnosis/age and diagnosis/sex conflict, and manifestation edits based on the official ICD-10-CM diagnosis code editing content for the MCE.</td>
</tr>
<tr>
<td>10/1/2015</td>
<td></td>
<td>Modify the diagnosis code content to replace all preliminary ICD-10-CM content with the official ICD-10-CM code content effective for 10/1/2015; restrict the use of ICD-9-CM code content for historical claims with From Dates through 9/30/2015.</td>
</tr>
<tr>
<td>10/1/2015</td>
<td></td>
<td>Updates to FQHC non-covered procedures and flu/PPV vaccine lists (see quarterly data file changes).</td>
</tr>
<tr>
<td>10/1/2015</td>
<td></td>
<td>Make Healthcare Common Procedure Coding System (HCPCS)/Ambulatory Payment Classification (APC)/Status Indicator (SI) changes as specified by CMS (data change files).</td>
</tr>
<tr>
<td>10/1/2015</td>
<td>20, 40</td>
<td>Implement version 21.3 of the NCCI (as modified for applicable institutional providers).</td>
</tr>
<tr>
<td>10/1/2015</td>
<td></td>
<td>Update page 3 and Table 1 (OCE Control Block) to indicate ICD-10-CM diagnosis codes as the primary diagnosis code set with ICD-9-CM diagnosis codes remaining for historical claims.</td>
</tr>
</tbody>
</table>

**Note:** Readers should also read through the entire CR9290 document and note the highlighted sections, which also indicate changes from the prior release of the software. A

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full summary of data changes in I/OCE V16.3, including diagnosis, HCPCS, Current Procedural Terminology (CPT) and APC codes, is attached to the CR.

**Additional Information**


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

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Revised product from the Medicare Learning Network® (MLN)

- **ICD-10-CM/PCS Billing and Payment Frequently Asked Questions**, Fact Sheet (ICN 908974)

MLN Matters® Number: MM9298 Revised  
Related Change Request (CR) #: CR 9298

Related CR Release Date: September 15, 2015  
Effective Date: October 1, 2015

Related CR Transmittal #: R3352CP  
Implementation Date: October 5, 2015

**October 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS)**

Note: This article was revised on September 17, 2015, to reflect the revised CR9298, issued on September 15. In the article, information on HCPCS Code Q5101 has been added via subsection g. and Table 6 on pages 5-6. Also, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 9298 describes changes to and billing instructions for various payment policies implemented in the October 2015 OPPS update. Make sure that your billing staffs are aware of these changes.
Background

The October 2015 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR9298.


Key changes to and billing instructions for various payment policies implemented in the October 2015 OPPS update are as follows:

**New Separately Payable Procedure Code**

Effective October 1, 2015, a new HCPCS code C9743 has been created. See Table 1 below which provides the short and long descriptors and the APC placement for this new code.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9743</td>
<td>Bulking/spacer material impl</td>
<td>Injection/implantation of bulking or spacer material (any type) with or without image guidance (not to be used if a more specific code applies)</td>
<td>S</td>
<td>0310</td>
<td>10/01/2015</td>
</tr>
</tbody>
</table>

**Compounded Drugs**

Effective June 30, 2015, modifier JF (Compounded drug) was discontinued and replaced with HCPCS code Q9977 (Compounded Drug, Not Otherwise Classified) effective July 1, 2015. HCPCS code Q9977 should be used to report compounded drug combinations.

**Revised Coding Guidance for Intraocular or Periocular Injections of Combinations of Anti-Inflammatory Drugs and Antibiotics**

Intraocular or periocular injections of combinations of anti-inflammatory drugs and antibiotics are being used with increased frequency in ocular surgery (primarily cataract surgery). One example of combined or compounded drugs includes triamcinolone and moxifloxacin with or without vancomycin. Such combinations may be administered as separate injections or as a single combined injection. Because such injections may obviate the need for post-operative anti-inflammatory and antibiotic eye drops, some have referred to cataract surgery with such injections as “dropless cataract surgery.”

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As stated in the Calendar Year (CY) 2015 National Correct Coding Initiative (NCCI) Policy Manual (Chapter VIII, section D, item 20; see http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=), injection of a drug during a cataract extraction procedure or other ophthalmic procedure is not separately reportable. Specifically, no separate procedure code may be reported for any type of injection during surgery or in the perioperative period. Injections are a part of the ocular surgery and are included as a part of the ocular surgery and the HCPCS code used to report the surgical procedure.

According to the “Medicare Claims Processing Manual (Chapter 17, Section 90.2; see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf), the compounded drug combinations described above and similar drug combinations should be reported with HCPCS code Q9977, regardless of the site of service of the surgery, and are packaged as surgical supplies in both the Hospital Outpatient Department (HOPD) and the Ambulatory Surgical Center (ASC). Although these drugs are a covered part of the ocular surgery, no separate payment will be made. In addition, these drugs and drug combinations may not be reported with HCPCS code C9399.

According to the “Medicare Claims Processing Manual” (Chapter 30, Section 40.3.6; see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf), physicians or facilities should not give Advance Beneficiary Notices (ABNs) to beneficiaries for either these drugs or for injection of these drugs because they are fully covered by Medicare. Physicians or facilities are not permitted to charge the patient an extra amount (beyond the standard copayment for the surgical procedure) for these injections or the drugs used in these injections because they are a covered part of the surgical procedure. Also, physicians or facilities cannot circumvent packaged payment in the HOPD or ASC for these drugs by instructing beneficiaries to purchase and bring these drugs to the facility for administration.

**Drugs, Biologicals, and Radiopharmaceuticals**

**a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective October 1, 2015**

For CY 2015, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2015, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective October 1, 2015 and drug price restatements can be found in the October 2015 update of the
b. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates
Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS website.

Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

c. Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2015
Two drugs and biologicals have been granted OPPS pass-through status effective October 1, 2015. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

Table 2 – Drugs and Biologicals with OPPS Pass-Through Status Effective October 1, 2015

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9456</td>
<td>Injection, isavuconazonium sulfate, 1 mg</td>
<td>9456</td>
<td>G</td>
</tr>
<tr>
<td>C9457</td>
<td>Injection, sulfur hexafluoride lipid microsphere, per ml</td>
<td>9457</td>
<td>G</td>
</tr>
</tbody>
</table>

d. New HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Biosimilar Biological Products
Effective October 1, 2015 a new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. This new code is listed in Table 3 below.

Table 3 – New HCPCS Code Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9979</td>
<td>Injection, alemtuzumab, 1 mg</td>
<td>K</td>
<td>1809</td>
</tr>
</tbody>
</table>
e. Corrected Dosage Descriptor for HCPCS Code Q9976

The correct dosage descriptor for Q9976 is 0.1 mg of iron. The short and long descriptor are included in Table 4 below.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Revised Short Descriptor</th>
<th>Revised Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>9976</td>
<td>Inj Ferric Pyrophosphate Cit</td>
<td>Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron</td>
</tr>
</tbody>
</table>

f. Reassignment of Skin Substitute Products from the Low Cost Group to the High Cost Group

One existing skin substitute product has been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. This product is listed in Table 5 below.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Status Indicator</th>
<th>Low/High Cost Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4151</td>
<td>AmnioBand, guardian 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
</tbody>
</table>

g. Revised Status Indicator for HCPCS Code Q5101

Effective September 3, 2015, the status indicator for HCPCS code Q5101 (Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram) will change from SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (Paid under OPPS; separate APC payment). APC 1822 is assigned to Q5101 as shown in Table 6 below. If you had claims for Q5101 for dates of service on or after September 3, 2015, that were processed prior to the installation of the October 2015 OPPS Pricer, your MAC will adjust those claims if you bring them to the attention of your MAC.
Table 6 – Drug and Biological with Revised Status Indicator
Effective September 3, 2015

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5101</td>
<td>Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram</td>
<td>1822</td>
<td>K</td>
</tr>
</tbody>
</table>

**Coverage Determinations**

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

**Additional Information**


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

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MLN Matters® Number: MM9301  Related Change Request (CR) #: CR 9301
Related CR Release Date: September 4, 2015  Effective Date: October 1, 2015
Related CR Transmittal #: R3345CP  Implementation Date: October 5, 2015

Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for Fiscal Year (FY) 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9301 informs MACs about changes that update the hospice payment rates, hospice wage index and Pricer software for FY 2016. The CR also updates the hospice cap amount for the cap year ending October 31, 2015. Make sure your billing staffs are aware of these changes.

Background

The law governing the payment rates for hospice care, the hospice aggregate cap amount, and the hospice wage index requires that these rates are updated annually. Section 18149(i)(1)(C)(ii) of the Social Security Act (the Act) stipulates that the
payment rates for hospice care for FYs after 2002 will increase by the market basket percentage increase for the FY.

Therefore, the FY 2016 payment rates will be increased by 1.6 percent. The 1.6 percent hospice payment update is equivalent to the FY 2016 hospital market basket update (2.4 percent) less a productivity adjustment of 0.5 percentage point, less a 0.3 percentage point. The productivity adjustment and 0.3 percentage point reduction are both mandated by Section 3401(g) of the Affordable Care Act. Beginning in FY 2014, the payment rates for hospices which fail to report the required quality data are updated by the hospice payment update minus 2 percentage points.

**FY 2016 Hospice Payment Rates**

Between October 1, 2015, and December 31, 2015, hospices will continue to be paid a single routine home care (RHC) per diem payment amount when routine home care is furnished. Effective January 1, 2016, two separate payment rates will replace the single RHC rate:

1) A higher RHC rate for days 1 through 60; and
2) A lower RHC rate for days 61 and beyond.

For hospice patients who are discharged and readmitted to hospice within 60 days of that discharge, a patient’s prior hospice days would continue to follow the patient and count toward his or her patient days for the new hospice election. The hospice days would continue to follow the patient solely to determine whether the receiving hospice would receive payment at the day 1 through 60 RHC rate or day 61 and beyond RHC rate.

CMS will calculate the patient’s episode day count based on the total number of days the patient has been receiving hospice care, separated by no more than a 60 day gap in hospice care, regardless of level of care or whether those days were billable or not. This calculation includes hospice days that occurred prior to January 1, 2016.

Effective January 1, 2016, hospices will receive a SIA payment on RHC days when direct patient care is provided by a Registered Nurse (RN) or social worker during the last seven days of the patient's life. The SIA payment will be made in addition to the per diem rate for the RHC level of care. It will equal the Continuous Home Care (CHC) hourly rate multiplied by the hours of nursing/social work service (for at least 15 minutes and up to 4 hours total), that occurred on RHC days during the last seven days of life. (For more information regarding the SIA payment policy, please refer to MLN Matters® Article MM9201.)

The FY 2016 hospice payment rates are effective for care and services furnished on or after October 1, 2015, through September 30, 2016. The hospice payment rates are discussed further in the “Medicare Claims Processing Manual,” Chapter 11 (Processing Hospice Claims), Section 30.2 (Payment Rates). The updated payment rates are shown in following tables and in the attachment to CR9301.

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### Table 1: FY 2016 Hospice Payment Rate for RHC for October 1, 2015, through December 31, 2015

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rate</th>
<th>Labor Share</th>
<th>Non-Labor Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care</td>
<td>$161.89</td>
<td>$111.23</td>
<td>$50.66</td>
</tr>
</tbody>
</table>

### Table 2: FY 2016 Hospice Payment Rates for RHC for January 1, 2016, through September 30, 2016

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rate</th>
<th>Labor Share</th>
<th>Non-Labor Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care (days 1-60)</td>
<td>$186.84</td>
<td>$128.38</td>
<td>$58.46</td>
</tr>
<tr>
<td>651</td>
<td>Routine Home Care (days 61+)</td>
<td>$146.83</td>
<td>$100.89</td>
<td>$45.94</td>
</tr>
</tbody>
</table>

### Table 3: FY 2016 Hospice Payment Rates for CHC, Inpatient Respite Care IRC, and General Inpatient (GIP) Care

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rate</th>
<th>Labor Share</th>
<th>Non-Labor Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>652</td>
<td>Continuous Home Care Full Rate= 24 hours of care $=39.37 hourly rate</td>
<td>$944.79</td>
<td>$649.17</td>
<td>$295.62</td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$167.45</td>
<td>$90.64</td>
<td>$76.81</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$720.11</td>
<td>$460.94</td>
<td>$259.17</td>
</tr>
</tbody>
</table>

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Beginning in FY 2014, hospices which fail to report quality data will have their market basket update reduced by two percentage points. Tables 4, 5, and 6 display the rates for these hospices.

**Table 4: FY 2016 Hospice Payment Rate for RHC for October 1, 2015, through December 31, 2015, for Hospices That DO NOT Submit the Required Quality Data**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rate</th>
<th>Labor Share</th>
<th>Non-Labor Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care</td>
<td>$158.70</td>
<td>$109.04</td>
<td>$49.66</td>
</tr>
</tbody>
</table>

**Table 5: FY 2016 Hospice Payment Rates for RHC for January 1, 2016, through September 30, 2016, for Hospices That DO NOT Submit the Required Quality Data**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rate</th>
<th>Labor Share</th>
<th>Non-Labor Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care (days 1-60)</td>
<td>$183.17</td>
<td>$125.86</td>
<td>$57.31</td>
</tr>
<tr>
<td>651</td>
<td>Routine Home Care (days 61+)</td>
<td>$143.94</td>
<td>$98.90</td>
<td>$45.04</td>
</tr>
</tbody>
</table>

**Table 6: FY 2016 Hospice Payment Rates for CHC, IRC, and GIP for Hospices That DO NOT Submit the Required Quality Data**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2016 Payment Rate</th>
<th>Labor Share</th>
<th>Non-Labor Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>652</td>
<td>Continuous Home Care Full Rate= 24 hours of care $=38.59 hourly rate</td>
<td>$926.19</td>
<td>$636.39</td>
<td>$289.80</td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$164.15</td>
<td>$88.85</td>
<td>$75.30</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$705.93</td>
<td>$451.87</td>
<td>$254.06</td>
</tr>
</tbody>
</table>

**Hospice Cap**

The hospice aggregate cap amount for the 2015 cap year ending October 31, 2015, is $27,382.63. In computing the cap, CMS used the medical care expenditure category of the March 2015 Consumer Price Index for all Urban consumers, published by the Bureau of Labor Statistics (http://www.bls.gov/cpi/home.htm), which was 444.020.
Hospice Wage Index

On February 28, 2013, the Office of Management and Budget (OMB) issued OMB Bulletin No. 13-01, announcing revisions to the delineation of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combines Statistical Areas, and guidance on uses of the delineation in these areas. These revisions will be incorporated into the hospice wage index for FY 2016. In order to provide a transition to the revised geographic area delineations, CMS will use a blended wage index for hospice payments for one year (FY 2016). The transition wage index is a 50/50 blend of the wage index values using OMB's old area delineations and the wage index values using OMB's new area delineations.

That is, for each county, a blended wage index is calculated equal to fifty percent of the FY 2016 wage index using the old labor market area delineation and fifty percent of the FY 2016 wage index using the new labor market area delineation. This results in an average of the two values. The hospice floor calculation is applied to the wage index values prior to blending.

Because of how the transition wage index is calculated, some Core Based Statistical Areas (CBSAs) and statewide rural areas will have more than one transition wage index value associated with that CBSA or rural area. However, each county will have only one transition wage index. For counties located in CBSAs and rural areas that correspond to more than one transition wage index value, the CBSA number will not be able to be used for FY 2016 claims. These CBSA numbers are listed in Table 7, which follows.

Table 7: List of CBSA codes that are invalid for Hospice for FY 2016 because of the wage index transition (these areas need to use 50xxx codes)

<table>
<thead>
<tr>
<th>CBSA Code</th>
<th>CBSA Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>10380</td>
<td>Aguadilla-Isabela, PR</td>
</tr>
<tr>
<td>11100</td>
<td>Amarillo, TX</td>
</tr>
<tr>
<td>12060</td>
<td>Atlanta-Sandy Springs-Roswell, GA</td>
</tr>
<tr>
<td>12260</td>
<td>Augusta-Richmond County, GA-SC</td>
</tr>
<tr>
<td>13140</td>
<td>Beaumont-Port Arthur, TX</td>
</tr>
<tr>
<td>13740</td>
<td>Billings, MT</td>
</tr>
<tr>
<td>13980</td>
<td>Blacksburg-Christiansburg-Radford, VA</td>
</tr>
<tr>
<td>14010</td>
<td>Bloomington, IL</td>
</tr>
<tr>
<td>14540</td>
<td>Bowling Green, KY</td>
</tr>
<tr>
<td>15764</td>
<td>Cambridge-Newton-Framingham, MA</td>
</tr>
<tr>
<td>16740</td>
<td>Charlotte-Concord-Gastonia, NC-SC</td>
</tr>
<tr>
<td>CBSA Code</td>
<td>CBSA Name</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>16820</td>
<td>Charlottesville, VA</td>
</tr>
<tr>
<td>17140</td>
<td>Cincinnati, OH-KY-IN</td>
</tr>
<tr>
<td>18140</td>
<td>Columbus, OH</td>
</tr>
<tr>
<td>18880</td>
<td>Crestview-Fort Walton Beach-Destin, FL</td>
</tr>
<tr>
<td>19660</td>
<td>Deltona-Daytona Beach-Ormond Beach, FL</td>
</tr>
<tr>
<td>20524</td>
<td>Dutchess County-Putnam County, NY</td>
</tr>
<tr>
<td>21060</td>
<td>Elizabethtown-Fort Knox, KY</td>
</tr>
<tr>
<td>21340</td>
<td>El Paso, TX</td>
</tr>
<tr>
<td>23104</td>
<td>Fort Worth-Arlington, TX</td>
</tr>
<tr>
<td>24340</td>
<td>Grand Rapids-Wyoming, MI</td>
</tr>
<tr>
<td>24860</td>
<td>Greenville-Anderson-Mauldin, SC</td>
</tr>
<tr>
<td>25060</td>
<td>Gulfport-Biloxi-Pascagoula, MS</td>
</tr>
<tr>
<td>26580</td>
<td>Huntington-Ashland, WV-KY-OH</td>
</tr>
<tr>
<td>26820</td>
<td>Idaho Falls, ID</td>
</tr>
<tr>
<td>26900</td>
<td>Indianapolis-Carmel-Anderson, IN</td>
</tr>
<tr>
<td>29180</td>
<td>Lafayette, LA</td>
</tr>
<tr>
<td>31140</td>
<td>Louisville/Jefferson County, KY-IN</td>
</tr>
<tr>
<td>31180</td>
<td>Lubbock, TX</td>
</tr>
<tr>
<td>31540</td>
<td>Madison, WI</td>
</tr>
<tr>
<td>32820</td>
<td>Memphis, TN-MS-AR</td>
</tr>
<tr>
<td>33260</td>
<td>Midland, TX</td>
</tr>
<tr>
<td>33460</td>
<td>Minneapolis-St. Paul-Bloomington, MN-WI</td>
</tr>
<tr>
<td>34820</td>
<td>Myrtle Beach-Conway-North Myrtle Beach, SC-NC</td>
</tr>
<tr>
<td>34980</td>
<td>Nashville-Davidson--Murfreesboro--Franklin, TN</td>
</tr>
<tr>
<td>35084</td>
<td>Newark, NJ-PA</td>
</tr>
<tr>
<td>35380</td>
<td>New Orleans-Metairie, LA</td>
</tr>
<tr>
<td>35614</td>
<td>New York-Jersey City-White Plains, NY-NJ</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>CBSA Code</th>
<th>CBSA Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>36260</td>
<td>Ogden-Clearfield, UT</td>
</tr>
<tr>
<td>37460</td>
<td>Panama City, FL</td>
</tr>
<tr>
<td>38660</td>
<td>Ponce, PR</td>
</tr>
<tr>
<td>39660</td>
<td>Rapid City, SD</td>
</tr>
<tr>
<td>40340</td>
<td>Rochester, MN</td>
</tr>
<tr>
<td>40380</td>
<td>Rochester, NY</td>
</tr>
<tr>
<td>41540</td>
<td>Salisbury, MD-DE</td>
</tr>
<tr>
<td>41980</td>
<td>San Juan-Carolina-Caguas, PR</td>
</tr>
<tr>
<td>43340</td>
<td>Shreveport-Bossier City, LA</td>
</tr>
<tr>
<td>43580</td>
<td>Sioux City, IA-NE-SD</td>
</tr>
<tr>
<td>43900</td>
<td>Spartanburg, SC</td>
</tr>
<tr>
<td>44060</td>
<td>Spokane-Spokane Valley, WA</td>
</tr>
<tr>
<td>46220</td>
<td>Tuscaloosa, AL</td>
</tr>
<tr>
<td>47260</td>
<td>Virginia Beach-Norfolk-Newport News, VA-NC</td>
</tr>
<tr>
<td>47380</td>
<td>Waco, TX</td>
</tr>
<tr>
<td>47894</td>
<td>Washington-Arlington-Alexandria, DC-VA-MD-WV</td>
</tr>
<tr>
<td>48620</td>
<td>Wichita, KS</td>
</tr>
<tr>
<td>49180</td>
<td>Winston-Salem, NC</td>
</tr>
<tr>
<td>49340</td>
<td>Worcester, MA-CT</td>
</tr>
<tr>
<td>99901</td>
<td>Alabama</td>
</tr>
<tr>
<td>99913</td>
<td>Idaho</td>
</tr>
<tr>
<td>99915</td>
<td>Indiana</td>
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<tr>
<td>99917</td>
<td>Kansas</td>
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<td>99918</td>
<td>Kentucky</td>
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<tr>
<td>99922</td>
<td>Massachusetts</td>
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<tr>
<td>99923</td>
<td>Michigan</td>
</tr>
<tr>
<td>99925</td>
<td>Mississippi</td>
</tr>
</tbody>
</table>

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In these cases, a number other than the CBSA number will be needed to identify the appropriate wage index value for claims for hospice care provided in FY 2016. These numbers are five digits in length and begin with “50”. These special 50xxx codes are shown in the last column of the FY 2016 hospice wage index file.

For counties located in CBSAs and rural areas that still correspond to only one wage index value, the CBSA number will still be used.

**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®

- “Independent Diagnostic Testing Facility (IDTF)” Fact Sheet, ICN 909060, Downloadable only. This fact sheet is designed to provide education on requirements for the Independent Diagnostic Testing Facility (IDTF). It includes information on enrollment, the effective date of billing privileges, billing issues, ordering of tests, place of service issues and requirements for multi-state IDTFs, physicians, and technicians.

MLN Matters® Number: SE1505 Revised  Related Change Request (CR) #: N/A
Related CR Release Date: N/A  Effective Date: N/A
Related CR Transmittal #: N/A  Implementation Date: N/A

Note: This article was revised on September 24, 2015 to change the link to Ordering Referring Report on page 3. That link was changed to https://data.cms.gov on the CMS website. For a complete list of any other changes to this article, please refer to the Document History Section. All other information remains the same.

Physicians and Non-Physician Practitioners Reported on Part A Critical Access Hospital (CAH) Claims

Provider Types Affected

This MLN Matters® Article is intended for Critical Access Hospitals (CAHs), Method II providers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This is a reminder that CAHs, Method II claims submitted to Medicare must contain an attending or rendering physician or non-physician practitioner who has a valid National Provider Identifier (NPI), is of an eligible specialty, and is enrolled in Medicare in an...
approved status. Failure to list a physician or non-physician practitioner, in the attending or referring fields that meet the above requirements will result in the rejection of the CAH Methods II claim.

**Background**

All Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entities (except small health plans), including enrolled Medicare providers and suppliers that are covered entities, are required to obtain an NPI and to use their NPI to identify themselves as “health care providers” in the HIPAA standard transactions that they conduct with Medicare and other covered entities.

Every provider or supplier that submits an enrollment application must furnish its NPI(s) in the applicable section(s) of the Form CMS-855. The Centers for Medicare & Medicaid Services (CMS) has implemented edits that verify that the NPI reported for physicians or non-physician practitioners in the attending or rendering physician fields on CAH Method II claims for payment has a valid NPI and that the provider for that NPI is enrolled in Medicare in an approved status, otherwise the claim will be rejected. If the physician or non-physician practitioner is not enrolled in Medicare, he/she will need to establish an enrollment record in the Provider Enrollment Chain and Ownership System (PECOS) with a valid NPI. He/she may submit their enrollment application electronically using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) located at https://pecos.cms.hhs.gov/pecos/login.do or by completing the paper CMS-855I or CMS-855O application, which is available at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html on the CMS website. Note that an application fee is not required as part of the physician's or non-physician practitioner's application submission.

Only physicians and certain types of non-physician practitioners are eligible as attending or rendering providers on CAH Method II claims. Those providers are as follows:

- Doctor of medicine or osteopathy;
- Dental Surgery;
- Podiatric Medicine;
- Optometry;
- Chiropractic Medicine;
- Physician Assistant;
- Certified Clinical Nurse Specialist;
- Nurse Practitioner;
- Clinical Psychologist;
- Certified Nurse Midwife;
- Licensed Clinical Social Worker;
- Certified Registered Nurse Anesthetist; and
- Registered Dietitian/Nutritional Professional.

If the attending or rendering provider is listed on the claim, the edits will compare the first four letters of the provider’s last name and validate that the physician or non-physician practitioner is enrolled in Medicare with a valid NPI. If the provider’s enrollment status cannot be validated the claim will be rejected with the following Claim Adjustment Reason Codes:

- N253 - Missing/incomplete/invalid attending provider primary identifier, and
- N290 - Missing/incomplete/invalid rendering provider primary identifier.

**Additional Information**

To assist providers, CMS provides an attending and rendering file that identifies those physicians and non-physician practitioners who are of a specialty type that is eligible to be listed as an attending or rendering provider on CAH Method II claims and is enrolled in Medicare in an approved status.

**When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the attending and rendering file available at [https://data.cms.gov](https://data.cms.gov) on the CMS website. Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the attending/rendering fields.**

### Document History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 24, 2015</td>
<td>This article was revised to change the link to the Ordering Referring Report on page 3. That link was changed to <a href="https://data.cms.gov">https://data.cms.gov</a> on the CMS website.</td>
</tr>
</tbody>
</table>

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Centers for Medicare & Medicaid Services
Articles for Part B Providers
Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9236 provides updated rates used to pay IRF Prospective Payment System (PPS) claims for Fiscal Year (FY) 2016. A new IRF PRICER software package will be released prior to October 1, 2015, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2015, through September 30, 2016. Make sure your billing staff are aware of these changes.

Background

that established the IRF PPS, as authorized under the Social Security Act (Section 1886(j); see http://www.ssa.gov/OP_Home/ssact/title18/1886.htm).

The FY 2016 IRF PPS Final Rule was issued on August 6, 2015, and it sets forth the prospective payment rates applicable for IRFs for FY 2016. You can review the FY 2016 IRF PPS Final Rule at http://www.gpo.gov/fdsys/pkg/FR-2015-08-06/pdf/2015-18973.pdf on the Internet.

**Transition Wage Index**

For FY 2016, all IRFs will receive a one-year transition policy that consists of a blended wage index (50 percent of their FY 2016 wage index based on the new Office of Management and Budget (OMB) delineations and 50 percent of their FY 2016 wage index based on the OMB delineations used in FY 2015).

This transition policy is effective for discharges occurring on or after October 1, 2015, and on or before September 30, 2016. The transition is designed to mitigate some of the negative impact for IRFs that experience a decrease in the wage index.

For FY 2016, some IRFs may have a special Core-Based Statistical Area (CBSA) Code to capture the transition wage index appropriate for their State and county combination. Please refer http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Data-Files.html for State and county combinations with a special CBSA Code in the 50,000 series for some areas.

**Phase Out of Rural Adjustment**

CMS will implement a 3 year budget neutral phase out of the rural adjustment for those IRFs that meet the definition in 42 CFR §412.602 as rural in FY 2015 and will become urban under the FY 2016 CBSA-based designations. You can review 42 CFR §412.602 at http://www.ecfr.gov/cgi-bin/text-idx?SID=c97ad2145949e2eebf13571206892d4&mc=true&node=pt42.2.412&rgn=div5#se42.2.412_1602 on the Internet.

CMS will afford a 3 year phase out to existing IRFs that were:

1. Designated in FY 2015 as rural IRFs (pursuant to 42 CFR §412.602), and
2. Re-designated as an urban facility in FY 2016 (pursuant to 42 CFR §412.602).

This will be done in order to mitigate the payment effect upon a rural facility that is re-designated as an urban facility (effective FY 2016) and thereby loses the rural adjustment of 1.149. This adjustment will be in addition to the one-year blended wage index for all IRFs.

**PRICER Updates for IRF PPS FY 2016**

The updated rates used to correctly pay IRF PPS claims for Fiscal Year (FY) 2016 are shown in the following table:

---

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PRICER Updates for IRF PPS FY 2016
(October 1, 2015 – September 30, 2016)

<table>
<thead>
<tr>
<th>Standard Federal rate</th>
<th>$15,478</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusted standard Federal rate</td>
<td>$15,174</td>
</tr>
<tr>
<td>Fixed loss amount</td>
<td>$8,658</td>
</tr>
<tr>
<td>Labor-related share</td>
<td>0.710</td>
</tr>
<tr>
<td>Non-labor related share :</td>
<td>0.290</td>
</tr>
<tr>
<td>Urban national average Cost to Charge Ratio (CCR)</td>
<td>0.435</td>
</tr>
<tr>
<td>Rural national average CCR</td>
<td>0.562</td>
</tr>
<tr>
<td>Low Income Patient (LIP) Adjustment</td>
<td>0.3177</td>
</tr>
<tr>
<td>Teaching Adjustment</td>
<td>1.0163</td>
</tr>
<tr>
<td>Rural Adjustment</td>
<td>1.149</td>
</tr>
</tbody>
</table>
Additional Information


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Quarterly Update to the Correct Coding Initiative (CCI) Edits, Version 22.0, Effective January 1, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9326 informs MACs about the release of the latest package of CCI edits, Version 22.0, which will be effective January 1, 2016. Make sure that your billing staffs are aware of these changes.

Background

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

The latest package of CCI edits, Version 22.0, effective January 1, 2016, will be available via the CMS Data Center (CDC). A test file will be available on or about November 2, 2015, and a final file will be available on or about November 17, 2015.

Version 22.0 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: Column 1/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two Correct Coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for OCE. It will only be necessary to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits. CMS no longer publishes a Mutually Exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single Column One/Column Two Correct Coding edit file on each website. The edits previously contained in the Mutually Exclusive edit file are NOT being deleted but are being moved to the Column One/Column Two Correct Coding edit file. Refer to the CMS NCCI webpage for additional information at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html on the CMS website.

Additional Information


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

Disclaimer

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NEW products from the Medicare Learning Network® (MLN)

- “Transitional Care Management Services,” Fact Sheet, ICN 908682, Downloadable only.

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Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries

Note: This article was revised on September 8, 2015, to eliminate references to a 2-year opt-out period. All other information is unchanged.

Provider Types Affected

This MLN Matters® Special Edition is intended for physicians and non-physician practitioners who opt out of Medicare and/or elect to order and refer services to Medicare beneficiaries and who would otherwise submit claims to Medicare contractors (carriers and Medicare Administrative Contractors (A/B MACs) for services to Medicare beneficiaries.

What You Need to Know

This MLN Matters® Special Edition Article informs physicians and non-physician practitioners who wish to opt-out of Medicare of the need to provide certain information in a written Affidavit to their Medicare contractor (Medicare Carrier or Medicare Administrative Contractor (MAC)). Make sure that your billing staffs are aware of this information.

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Background

Physicians and practitioners who do not wish to enroll in the Medicare program may “opt-out” of Medicare. This means that neither the physician, nor the beneficiary submits the bill to Medicare for services rendered. Instead, the beneficiary pays the physician out-of-pocket and neither party is reimbursed by Medicare. A private contract is signed between the physician and the beneficiary that states, that neither one can receive payment from Medicare for the services that were performed. The physician or practitioner must submit an affidavit to Medicare expressing his/her decision to opt-out of the program. The following shows physicians and other practitioners who are permitted by statute to opt-out of the Medicare program:

- Physicians who are:
  - Doctors of medicine or osteopathy;
  - Doctors of dental surgery or dental medicine;
  - Doctors of podiatry; or
  - Doctors of optometry; and
  - Who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the State in which such function or action is performed.

- Practitioners who are:
  - Physician assistants;
  - Nurse practitioners;
  - Clinical nurse specialists;
  - Certified registered nurse anesthetists;
  - Certified nurse midwives;
  - Clinical psychologists;
  - Clinical social workers; or
  - Registered dietitians or nutrition professionals; and
  - Legally authorized to practice by the State and otherwise meet Medicare requirements.

Filing an Affidavit to Opt-out

Physicians and non-physician practitioners who want to opt-out must file a written affidavit with Medicare in which they agree to opt-out of Medicare and to meet certain other criteria.
• In general, the law requires that during the opt out period, physicians and non-physician practitioners who have filed affidavits opting out of Medicare must sign private contracts with all Medicare beneficiaries to whom they furnish services that would otherwise be covered by Medicare, except those who are in need of emergency or urgently needed care.

• They cannot sign such contracts with beneficiaries in need of emergency or urgent care services.

• Moreover, physicians and non-physician practitioners who opt-out cannot choose to opt-out of Medicare for some Medicare beneficiaries but not others; or for some services and not others.

• The Centers for Medicare & Medicaid Services (CMS) does not have a standard affidavit form, however, many MACs have a form available on their website. To locate your MAC’s website, refer to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf on the CMS website. Otherwise, those physicians and practitioners who wish to opt-out must provide the information mentioned in writing to the MAC within their service jurisdiction. Currently there is not an option to submit an opt-out affidavit online.
  • The affidavit must be in writing and signed by the physician/non-physician practitioner.
  • It must include various statements to which the physician/non-physician practitioner must agree; for example, the physician/non-physician practitioner must agree not to submit claims to Medicare for any services furnished during the opt-out period, except for emergency or urgent care services furnished to beneficiaries with whom the physician/non-physician practitioner has not previously entered into a private contract.
  • It must identify the physician/non-physician practitioner sufficiently so that the Medicare contractor can ensure that no payment is made to the physician/non-physician practitioner during the opt-out period.
  • It must be filed with all Medicare contractors who have jurisdiction over the claims the physician/non-physician practitioner would have otherwise filed with Medicare and must be filed no later than 10 days after entering into the first private contract to which the affidavit applies.

The following specific information must be included in the affidavit:
  • The physician/non-physician practitioner’s legal name;
  • Medicare specialty;
- Taxpayer Identification Number (TIN) (Social Security Number (SSN)) (required if a National Payer Identifier (NPI) has not been assigned);
- Address (If the address in the affidavit is a P.O. Box, the Medicare contractor may request a different address);
- Telephone number;
- Medicare Billing ID/Provider Transaction Number (PTAN) (if the provider was previously enrolled and one had been assigned); and
- NPI (only if one has been assigned).

Physicians/non-physician practitioners who have never enrolled in Medicare are not required to enroll in Medicare before they can opt-out of Medicare.

A nonparticipating physician or practitioner may opt-out of Medicare at any time and the effective date of the affidavit record must comply with the following:

- The opt-out period begins the date the affidavit is signed, provided the affidavit is filed within 10 days after he or she signs his or her first private contract with a Medicare beneficiary.
- Physicians or practitioners that opt out in multiple contractor jurisdictions are required to file a separate affidavit with each contractor. If the physician or practitioner does not timely file all required affidavits, the opt-out period begins when the last such affidavit is filed. Any private contract entered into before the last required affidavit is filed becomes effective upon the filing of the last required affidavit. The furnishing of any items or services to a Medicare beneficiary under such contract before the last required affidavit is filed is subject to standard Medicare rules.

If the physician or non-physician practitioner had been enrolled in Medicare and had signed a Part B participation agreement and is now opting out, the participation agreement terminates at the same time the enrollment terminates. If an enrolled physician/non-physician practitioner is opting out, the existing enrollment record will be automatically end dated. The effective date of the opt-out affidavit shall comply with the following:

- A participating physician may properly opt-out of Medicare at the beginning of any calendar quarter, provided that the affidavit is submitted to the participating physician's Medicare contractor at least 30 days before the beginning of the selected calendar quarter.
- A private contract entered into before the beginning of the selected calendar quarter becomes effective at the beginning of the selected calendar quarter and the furnishing of any items or services to a Medicare beneficiary under such contract before the beginning of the selected calendar quarter is subject to standard Medicare rules.
Opt-Out Providers Who May Order and Certify Items and Services

There are differences between providers who are permitted to opt-out and providers who opt-out and elect to order and certify items and services. The following physicians and non-physician practitioners are permitted to order and certify:

- Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists) may only order and certify DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B;
- Physician Assistants;
- Clinical Nurse Specialists;
- Nurse Practitioners;
- Clinical Psychologists;
- Interns, Residents, and Fellows;
- Certified Nurse Midwives; and
- Clinical Social Workers.

CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or certified by providers or suppliers authorized by Medicare statute and regulation to do so. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or certified by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order supplies or services for Medicare beneficiaries. All services ordered by a chiropractor will be denied.
- Home Health Agency (HHA) services may only be ordered or certified by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Doctor of Podiatric Medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
- Optometrists may only order and certify DMEPOS products/services, and laboratory and X-Ray services payable under Medicare Part B.
- Residents who have provisional licenses from the State and are permitted to enroll in Medicare are also eligible to opt-out of Medicare. However, the opted out resident may only furnish under private contracts the types of services that he or she is specifically authorized to furnish under State law at the direction of his or her teaching institution. Although the opt-out option is available, CMS encourages licensed residents to enroll via the CMS-855O since their employment arrangement
could change and the opt-out status lasts for two years and cannot be terminated within that timeframe.

If an opt-out provider elects to order and certify services, Medicare contractors must develop for the following information through an additional information request:

- An NPI (if one is not contained on the affidavit voluntarily);
- Confirmation if an Office of Inspector General (OIG) exclusion exists (if not contained on the Affidavit);
- Date of Birth; and
- Social Security Number (if not contained on the Affidavit).

If the above information is not obtained, the opt-out provider will not be able to order and certify services. If the opt-out provider refuses to report the information listed immediately above, then the opt-out provider cannot order and certify, but the failure to report this additional information does not affect the provider’s right to opt out of Medicare.

The Medicare contractor must ask the opt-out physician or non-physician practitioner if he or she has been excluded by the OIG and may specifically ask for a copy of the private contract he or she uses in order to ascertain whether he or she has been excluded from the Medicare program.

**Additional Information**


If you have any questions, please contact your carrier or 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.