Medicare Monthly Review

Issue No. MMR 2015-01 January 2015

Contents

National Government Services – Articles for Part A and Part B Providers Page
New, Revised and Updated Local Coverage Determinations and Articles 3

Centers for Medicare & Medicaid Services – Articles for Part A and Part B Providers Page
Revisions to Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 (MM8810) 13
Preventive and Screening Services — Update - Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy (MM8874) 15
Incorporation of Certain Provider Enrollment Policies in CMS-4159-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15 (MM8901) 21
Home Health Prospective Payment System Rate Update for Calendar Year 2015 (MM8969 Revised) 24
Calendar Year 2015 Rural Health Clinic and Federally Qualified Health Centers Updates: Payment Rate Increases for RHCs and FQHCs Billing Under the All-Inclusive Rate System, and Urban and Rural Designations for FQHCs Billing Under the AIR (MM8980) 34
Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes Rule - Update from CAQH CORE (MM8983) 37
Claim Status Category and Claim Status Codes Update (MM8994) 39
Transcatheter Mitral Valve Repair - National Coverage Determination (MM9002) 41
Calendar Year 2015 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment (MM9028) 49
Summary of Policies in the Calendar Year 2015 Medicare Physician Fee Schedule Final Rule and Telehealth Originating Site Facility Fee Payment Amount (MM9034) 55
Medicare Fee-For-Service International Classification of Diseases, 10th Edition (ICD-10) Testing Approach (SE1409 Revised) 61
FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing (SE1435 Revised) 66
Certifying Patients for the Medicare Home Health Benefit (SE1436 Revised) 71

Centers for Medicare & Medicaid Services – Articles for Part A Providers Page
Rescind/Replace Reclassification of Certain Durable Medical Equipment from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category (MM8566 Revised) 86
Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program - April 2015 (MM8918) 95
Correction to Remittance Information When Health Insurance Prospective Payment System Codes are Re-Coded by Medicare Systems (MM8950 Revised) 97
Home Health Prospective Payment System Rate Update for Calendar Year 2015 (MM8969) 100

CPT codes and descriptors are only copyright 2014 American Medical Association (or such other date publication of CPT)
Centers for Medicare & Medicaid Services – Articles for Part A Providers

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of Changes in the End-Stage Renal Disease Prospective Payment System for Calendar Year 2015 (MM8978 Revised)</td>
<td>110</td>
</tr>
<tr>
<td>2015 Update of the Medicare Benefit Policy Manual, Chapter 13 – Rural Health Clinic and Federally Qualified Health Center Services (MM8981)</td>
<td>115</td>
</tr>
<tr>
<td>January 2015 Update of the Hospital Outpatient Prospective Payment System (MM9014 Revised)</td>
<td>121</td>
</tr>
</tbody>
</table>

Centers for Medicare & Medicaid Services – Articles for Part B Providers

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Update to the Correct Coding Initiative (CCI) Edits, Version 21.1, Effective April 1, 2015 (MM8908)</td>
<td>141</td>
</tr>
<tr>
<td>New Waived Tests (MM8951)</td>
<td>143</td>
</tr>
<tr>
<td>2015 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System Code Jurisdiction List (MM9018)</td>
<td>146</td>
</tr>
<tr>
<td>Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs (SE1434 Revised)</td>
<td>148</td>
</tr>
</tbody>
</table>

CMS MLN Connects™ Weekly Provider eNews

<table>
<thead>
<tr>
<th>Title</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MLN Connects™ Provider eNews for December 4, 2014</td>
<td></td>
</tr>
<tr>
<td>MLN Connects™ Provider eNews for December 11, 2014</td>
<td></td>
</tr>
<tr>
<td>CMS Announces Timeline for the DMEPOS Competitive Bidding Round 2 Recompete/National Mail-Order Recompete</td>
<td></td>
</tr>
<tr>
<td>MLN Connects™ Provider eNews for December 18, 2014</td>
<td></td>
</tr>
<tr>
<td>ICD-10 Testing Results and DMEPOS Competitive Bidding Registration Reminder</td>
<td></td>
</tr>
<tr>
<td>Holding of 2015 Date-of-Service Claims and DMEPOS Competitive Bidding Registration Reminder</td>
<td></td>
</tr>
</tbody>
</table>

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

CPT five-digit codes, descriptions, and other data only are copyright 2013 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for data contained or not contained herein. Applicable FARS/DFARS clauses apply.

This bulletin should be shared with all health care practitioners and managerial members of the providers/suppliers staff. Bulletins issued during the last two years are available at no cost from our Web site at [http://www.NGSMedicare.com](http://www.NGSMedicare.com).
New, Revised and Updated Local Coverage Determinations and Articles

November-December 2014 and January 2015

November 16, 2014

• Noncovered Services (L32456)
  The LCD was returned for comment in the JK and J6 MACs, from 6/5–7/19/2014. Noncoverage provisions were added for prostatic urethral lift and vestibular autorotation testing. Sources reviewed as the basis for noncoverage were added to the LCD. Provisions related to preoperative testing for prothrombin testing (PT) and partial thromboplastin testing (PTT) have been deleted from the LCD.

  LCD revised during the notice period to add two sources to the policy. No change in coverage or effective date has been made.

December 2014 New LCDs

• Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy (L35336)
  Facet joints are paired diarthrodial articulations of the superior and inferior articular processes of adjacent vertebrae. The medial branches (MB) of the dorsal rami of the segmental nerves innervate facet joints and the MB nerves from the two adjacent dorsal rami innervate each joint. [Exceptions to this rule are the C2-3 facet joint, which is innervated by the third occipital nerve; and the L5-S1 facet joint, which is innervated by the L4 MB and the L5 dorsal ramus.]

• Lumbar Epidural Injections (L35338)
  Lumbar epidural injections are generally performed to treat pain arising from spinal nerve roots. These procedures may be performed via three distinct techniques, each of which involves introducing a needle into the epidural space by a different route of entry. These are termed the interlaminar, caudal, and transforaminal approaches. The procedures involve the injection of a solution containing local anesthetic with or without corticosteroids.

December 2014 Revisions

• Biologic Products for Wound Treatment and Surgical Interventions (L26003)
  LCD published 12/1/2014. Based on a reconsideration request, effective for dates of service on or after 10/20/2014, Grafix® will be covered for the treatment of diabetic foot ulcers. No separate coverage article will be added at this time.

  Minor template changes were made to reflect current template language. No comment and notice periods required and none given.

• Colorectal Cancer Screening - Medical Policy Article (A50548)
  Based on CMS Transmittal No. 3096, CMS IOM Publication 100-04, Medicare Claims Processing Manual, CR8881, 10/17/2014, the following requirement was revised to include a physician assistant, nurse practitioner, or clinical nurse specialist:

  This screening requires a written order from the beneficiary’s attending physician, or effective for dates of service on or after 1/27/2014, the beneficiary’s attending physician assistant, nurse practitioner, or clinical nurse specialist.

• Computed Tomographic (CT) Colonography for Diagnostic Uses (L25233)
  LCD title revised for clarity. Removed references to CPT code 74263 in the “Limitations” and “CPT/HCPCS Codes” sections on the basis screening services which are statutory exclusions should not be addressed in LCDs.

  Minor template changes were made to reflect current template language. No comment and notice periods required and none given.
• Erythropoiesis Stimulating Agents (ESA) (L25211)
The Iron Sucrose, Iron Dextran, Ferumoxytol and Sodium Ferric Gluconate, (Intravenous Iron Therapy) article related to LCD L25820 (A48420) was retired on 11/1/2014. Therefore, the reference to the article has been removed. Obsolete coding information was removed from the explanatory note. HCPCS codes C9399 and J3490 as well as the obsolete corresponding explanatory notes have been removed from the “CPT/HCPCS Codes” section. An obsolete explanatory note was also removed for HCPCS code Q2047. Due to a provider request, ICD-9-CM code 238.76 has been added to the LCD effective for dates of service on or after 12/1/2014. HCPCS code J0882 was added to the explanatory note in Group 1 in the “ICD-9-CM Codes that Support Medical Necessity” section. Minor template changes were made to reflect current template language. No comment and notice periods required and none given.

• Erythropoiesis Stimulating Agents (ESA) - SIA (A44399)
The following coding guidelines were removed due to obsolete information:

For dates of service 3/27/2012 through 6/30/2012, HCPCS code J3490 should be reported on claims submitted to the carrier or Part B MAC for OMONTYS® (peginesatide) Injection along with the name of the drug and the dosage in Item 19 of the CMS-1500 claim form or the electronic equivalent.

For dates of service 3/27/2012 through 6/30/2012, HCPCS code C9399 should be reported on hospital outpatient perspective payment system (OPPS) claims submitted to the FI or Part A MAC for OMONTYS® (peginesatide) Injection along with the National Drug Code (NDC), the quantity of the drug that was administered (milligrams) and the date the drug was administered in FL 80, remarks for the CMS-1450 or the electronic equivalent.

ICD-9-CM code 238.76 was added to the following coding guideline:

Patients with myelodysplastic syndrome - ICD-9-CM codes 238.72, or 238.74 or 238.76. Note: No ICD-9-CM code for anemia is required.

HCPCS codes C9399 and J3490 as well as the obsolete corresponding explanatory notes have been removed from the “CPT/HCPCS Codes” section. An obsolete explanatory note was also removed for HCPCS code Q2047.

• Implantable Miniature Telescope (IMT) (L32454)
LCD published 12/1/2014. Effective 10/8/2014, FDA has lowered the telescope implant eligible age from 75 to 65 years of age. The indication has been revised to reflect this change. The updated Premarket Approval (PMA) Supplement dated 10/8/2014 was added to the “Sources of Information and Basis for Decision” section. CPT code 66999 as well as the obsolete corresponding explanatory note has been removed from the “CPT/HCPCS Codes” section. An obsolete explanatory note was also removed for HCPCS code C9732.

Minor template changes were made to reflect current template language. No comment and notice periods required and none given.

• Implantable Miniature Telescope (IMT) - SIA (A51615)
Article published 12/1/2014. The following coding guidelines were removed due to obsolete information:

Effective 1/1/2012 through 6/30/2012, claims submitted by Part A providers and ambulatory surgical centers for device pass-through category C1840 must be billed with HCPCS code C9732 (insertion of ocular telescope prosthesis including removal of crystalline lens) to receive pass-through payment.

For dates of services from 6/1 through 6/30/2012, claims for the physician’s professional service should be submitted to the carrier or Part B MAC under CPT code 66999 (unlisted procedure, anterior segment of eye) with the terminology implantable miniature telescope reported in Item 19 of the CMS-1500 claim form or the electronic equivalent.
The following coding guidelines were revised to remove obsolete information:

Claims submitted by Part A providers and ambulatory surgical centers for device pass-through category C1840 must be billed with CPT code 0308T (Insertion of ocular telescope prosthesis including removal of crystalline lens) to receive pass-through payment.

CPT code 0308T should be reported for an insertion of ocular telescope prosthesis including removal of crystalline lens. CPT code 0308T should not be reported in conjunction with codes 65800-65815, 66020, 66030, 66600-66635, 66761, 66825, 66982-66986 and 69990.

Claims for CPT code 0308T are payable under Medicare Part B in the following places of service: inpatient hospital (21), outpatient hospital (22) and ambulatory surgical center (24).

CPT code 66999 as well as the obsolete corresponding explanatory note has been removed from the "CPT/HCPCS Codes" section. An obsolete explanatory note was also removed for HCPCS code C9732.

- **Pain Management (L25829)**
  The LCD has been revised during the Notice period to add the following limitation for trigger point injections - Dry needling is not a covered service. The following limitation has been added for sacroiliac (SI) joint injections - Radiofrequency ablation used for sacro-iliac joint pain is considered not medically necessary/investigational whether performed using traditional, cooled, or pulsed radiofrequency. This information was included in the "Response to Comments" but inadvertently missed when the LCD was published for the Notice period.

  The LCD was returned for comment in the JK and J6 MACs, from 6/5-7/19/2014.

  All references to facet joint injections, epidural and intrathecal injections, transforaminal epidural injections, paravertebral joint/nerve blocks and paravertebral joint/nerve denervation has been removed from the LCD. Please refer to LCD L35336 for Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy and L35338 for Lumbar Epidural Injections.

  "Failed back syndrome" has been added to the fifth paragraph in the Abstract of the LCD:

  Postlaminectomy syndrome /failed back syndrome or pain following operative procedures of the spine, sometimes known as failed management syndrome, is becoming an increasingly common entity in modern medicine. Other spinal conditions causing pain include various degenerative disorders such as spinal stenosis, spondyloysis, spondylolisthesis, degenerative spondylosis, idiopathic vertebrogenic sclerosis, diffuse idiopathic spinal hyperostosis, and segmental instability. Degenerative conditions other than disc disruption and facet arthritis may contribute to approximately 5% to 10% of spinal pain.

  Under the "Indications for Sacroiliac (SI) Joint Injections: the reference to (2 to 3 ml) has been removed and the percentage has been changed from 80%-90% to 75%-100% in the following paragraph:

  Diagnostic blocks of a sacroiliac joint can be performed to determine whether it is the source of low back pain. Arthropathy (joint disease) is diagnosed through a double-comparative local anesthetic blockade of the joint by the intra-articular injection of a small volume of local anesthetics of different durations of actions. A positive response should demonstrate initial pain relief greater than or equal to (> /=) 75% - 100% and the ability to perform previously painful maneuvers. Steroids may be injected in addition to the local anesthetic.

  Provider qualifications have been added.

  The following paragraph has been added under the "Documentation Requirements" section:

  A procedure note must be legible and include sufficient detail to allow reconstruction of the procedure. Required elements of the note include a description of the techniques employed, and sites(s) of injections, drugs and doses with volumes and concentrations as well as pre- and post-procedural pain assessments.
Under the specific requirements for SI joint injections the following statement has been revised:

Document the total amount of injectate for all medications used. The amount of injectate should be such that the synovial lining of the joint is not burst and the injectate does not disperse beyond the confines of the target joint.

In the "Utilization Guidelines" section for "Injection Tendon Sheath, Ligament, Ganglion Cyst, Carpal and Tarsal Tunnel" frequency and number of injections or intervention guidelines have been added.

Sources have been added to the "Sources of Information and Basis for Decision" section.

- **Pain Management – SIA (A48042)**
  
  **Article published December 2014:** All information in the “Article Text” and “CPT/HCPC Code” section related to epidural and intrathecal injections, intrathecal baclofen administration, epidural injections – transforaminal, paravertebral/joint nerve blocks, paravertebral joint/nerve denervation has been removed from this Supplemental Instruction Article. The following statement has been added to the section for “Trigger Point Injections and Injections of Tendon Sheath, Ligament, Ganglion Cyst, Carpal and Tarsal Tunnels - Dry needling should be reported with CPT code 20999 (Unlisted procedure, musculoskeletal system, general). The following paragraph has been revised from:

  Use CPT code 64999 (Unlisted procedure, nervous system) for pulsed radiofrequency and the denervation procedures of the sacro-iliac joint/nerves. Pulsed radiofrequency for denervation is considered investigational and therefore, not medically necessary. Sacro-iliac joint/nerve denervation procedures are also considered investigational and not medically necessary.

  to:

  Use CPT code 64999 (Unlisted procedure, nervous system) for pulsed radiofrequency and the denervation procedures of the sacro-iliac joint/nerves. Pulsed radiofrequency for denervation is considered investigational and therefore, not medically necessary. Sacro-iliac joint/nerve denervation procedures using traditional or cooled radiofrequency are also considered investigational and not medically necessary and should be billed with CPT code 64999.

  This paragraph has been moved to the “Sacroiliac (SI) Joint Injections” section.

- **Psychiatry and Psychology Services (L26895)**

  The following ICD-9-CM diagnosis codes were added to the "Other Medical Diagnoses Not Included in DSM-IV™ section": 331.83, 331.9, 438.0, effective for services rendered on or after 12/01/2014.

- **Varicose Veins of the Lower Extremity, Treatment of (L25519)**

  Revised verbiage in the “Abstract” section for foam sclerotherapy of the saphenous vein at its junction with the deep venous system to state that it lacks “sufficient” rather than “significant” evidence to support its widespread use. Added two (2) references to the “Sources of Information and Basis for Decision” section. No comment and notice periods required and none given.

### January 2015 Revisions

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

  **Article published January 2015:** The first paragraph in the “Article Text” has been revised to remove out-dated information. The indication for ovarian cancer has been revised to include new FDA approval language. HCPCS code C9399 has been removed from the “CPT/HCPCS Codes” section of the article.

- **Biologic Products for Wound Treatment and Surgical Interventions (L26003)**

  Based on a practitioner request, the following language has been added to the “Indications” section as a clarification regarding a failed response:

  Applied to wounds that have demonstrated a failed or insufficient response to no fewer than four
weeks of conservative wound care measures. For initial applications of skin
substitutes/replacements, a failed response to conservative measures is defined as an ulcer that
has increased in size or depth or for which there has been less than 30% closure from baseline.

The following article has been added: Grafix® which is effective 10/20/2014 (published 1/1/2015). No comment or notice periods required and none given.

- **Bone Mass Measurement - Medical Policy Article (A51974)**
  Annual HCPCS update: the article was revised to add CPT code 77085 to provisions for bone mass
screening, and to replace references to deleted CPT code 77082 with CPT code 77086, for vertebral fracture assessment. Payable places of service were added for CPT code 77085, all components.

- **Breast Imaging Mammography/Breast Echography (Sonography)/Breast MRI/Ductography (L26890)**
  Due to the annual HCPCS update for 2015, CPT code 76645 was deleted and removed from the “CPT/HCPCS Codes” section. An explanatory note regarding the code deletion was added to this section. CPT codes 76641 and 76642 were added as replacement codes. HCPCS code G0279 was added to the “CPT/HCPCS Codes” section. The descriptors were changed for HCPCS codes G0204 and G0206. HCPCS code G0279 was added to Group 1 and CPT codes 76642 and 76642 to Group 2 in the “ICD-9-CM Codes that Support Medical Necessity” section. Based on the National Coverage Determination (NCD), all references to a screening mammography were removed from the LCD. No comment and notice periods required and none given.

- **Breast Imaging Mammography/Breast Echography (Sonography)/Breast MRI/Ductography - SIA (A48362)**
  Due to the annual HCPCS update for 2015, CPT code 76645 was deleted and removed from the “CPT/HCPCS Codes” section. An explanatory note regarding the code deletion was added to this section. CPT codes 76641 and 76642 were added as replacement codes. HCPCS code G0279 was added to the “CPT/HCPCS Codes” section. The descriptors were changed for HCPCS codes G0204 and G0206.

  The following coding guideline was added regarding add-on codes:

  HCPCS code G0279 must be billed with the primary code of G0204 or G0206.

  The following coding guideline was revised:

  For dates of service prior to 1/1/2015, use CPT code 76645 when reporting breast sonography, unilateral or bilateral. It would be inappropriate to use a 50 modifier or to increase the units field, as reimbursement for this code is already based on the procedure being performed bilaterally. The replacement codes are 76641 and 76642.

  HCPCS code G0279 was added to the following coding guideline:

  Claims for the global billing of a diagnostic mammography (77051, 77055, 77056, G0204, G0206 and G0279), a breast sonography (76641 and 76642 for dates of service on or after 1/1/2015 and 76645 for dates of service through 12/31/2014), a breast MRI (77058 and 77059) and a ductography (77053 and 77054) are payable under Medicare Part B in the following places of service: office (11), mobile unit (15) and independent clinic (49). When a mobile unit (place of service 15) is sent to other sites such as a nursing facility, adult home or physician office, the place of service reported on the claim should be that of the site where the service was performed such as office (11), nursing facility (32), custodial care facility (33).

  CPT codes 76641 and 76642 were added to the following coding guidelines:

  Claims for the technical component of a diagnostic mammography (77051, 77055, 77056, G0204 and G0206), a breast sonography (codes 76641 and 76642 for dates of service on or after 1/1/2015 and 76645 for dates of service through 12/31/2014), a breast MRI (77058 and 77059) and a ductography (77053 and 77054) are payable under Medicare Part B in the following places of
service: office (11), mobile unit (15), independent clinic (49), federally qualified health center (FQHC) (50) and rural health clinic (RHC) (72). When a mobile unit (place of service 15) is sent to other sites such as a nursing facility, adult home or physician office, the place of service reported on the claim should be that of the site where the service was performed such as office (11), nursing facility (32), custodial care facility (33).

Claims for the professional component (codes 76641-26 and 76642-26 for dates of service on or after 1/1/2015 and 76645-26 for dates of service through 12/31/2014), 77053-26, 77054-26, 77055-26, 77056-26, 77058-26, 77059-26, G0204-26 and G0206-26) are payable under Medicare Part B in the following places of service: office (11), mobile unit (15), inpatient hospital (21), outpatient hospital (22), emergency room (23) and independent clinic (49). When a mobile unit (place of service 15) is sent to other sites such as a skilled nursing facility, adult home or physician office, the place of service reported on the claim should be that of the site where the service was performed such as office (11), skilled nursing facility (31), nursing facility (32), custodial care facility (33).

CPT codes 76641 and 76642 were added to the following coding guideline:

For Part A billing of breast sonography, use the following:

Bill types 12x, 13x, 22x, 23x, and 85x
Revenue code 402
CPT codes 76641 and 76642 for dates of service on or after 1/1/2015 and 76645 for dates of service through 12/31/2014

Based on the NCD, all references to a screening mammography were removed from the article.

- **Cardiovascular Nuclear Medicine (L26859)**
  LCD revised for annual HCPCS update for 2015. Effective for dates of service on or after 01/01/2015, HCPCS code J0151 is deleted and is replaced by code J0153.

- **Category III CPT® Codes (L25275)**
  The content in articles A46075 and A51453, which were formerly attached to L25275, have been incorporated into LCD 25275; therefore, A46075 and A51453, effective for services rendered on or after 1/1/2015 will be retired.

  Category III CPT Codes, considered to be not medically necessary, have been listed in the CPT/HCPCS Codes section (Group 1).

  Category III CPT Codes that represent items, services, or procedures that have been determined to be medically necessary when criteria of coverage have been met are listed under the Indications and Limitations section of the LCD.

  All sources of information were consolidated into the attached document, titled “Sources of Information”.

  The following Category III codes have been deleted, effective for services rendered prior to 1/1/2015: 0073T, 0092T, 0181T, 0197T, 0226T, 0227T, 0239T, 0245T-0248T, 0319T-0334T, 0343T-0344T.

  CPT Code 0197T has been deleted; therefore, Article A51453 will be retired, effective for services rendered on or after 1/1/2015.

  Sources of information are now listed in an attachment.

- **Colorectal Cancer Screening - Medical Policy Article (A50548)**
  Article published January 2015: Due to the annual HCPCS update for 2015, HCPCS code G0464 was added to the “CPT/HCPCS Codes” section. HCPCS code G0464 was added to the following coding guidelines:

  Claims for colorectal cancer screening services (CPT code 82270 and HCPCS codes G0104, G0105, G0106-26, G0120-26, G0121, G0328, G0328-QW and G0464) are payable under Medicare
Part B in the following places of service: office (11), urgent care facility (20), outpatient hospital (22), hospital emergency room (23), ambulatory surgical center (24), skilled nursing facility (31), nursing facility (32) and independent clinic (49).

Note: HCPCS codes G0105 and G0121 are allowed a facility fee when performed in an ambulatory surgical center (24).

Claims for codes 82270, G0328, G0328-QW and G0464 are also payable under Medicare Part B in the following places of service: federally qualified health center (50), independent laboratory (81) and rural health clinic (72).

Based on CMS Transmittal No. 3146, CMS IOM Publication 100-04, Medicare Claims Processing Manual, CR8874, 12/11/2014, the following requirement was added:

Effective 1/1/2015, anesthesia professionals who furnish a separately payable anesthesia service (CPT code 00810) in conjunction with a screening colonoscopy shall include the following on the claim for the services that qualify for the waiver of coinsurance and deductible:

Modifier 33 – Preventive Services: when the primary purpose of the service is the delivery of an evidence based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

- Denosumab (Prolia®, Xgeva®) - Related to LCD L25820 (A50361)
  Article published January 2015: The first paragraph in the “Article Text” has been revised to remove out-dated information. The article has been revised to include FDA indication hypercalcemia of malignancy refractory to bisphosphonate therapy for denosumab (Xgeva®) effective for dates of service on or after 12/05/2014. ICD-9-CM code 275.42 has been added to the Group 1: Codes in the “Covered ICD-9 Code” section of the article effective for dates of service on or after 12/05/2014. The documentation requirements have been re-written for clarity and information for hypercalcemia of malignancy has been added for denosumab(Xgeva®). The "Utilization" guideline has also been revised. Outdated information has been removed.

- Erythropoiesis Stimulating Agents (ESA) (L25211)
  Due to the annual HCPCS update for 2015, HCPCS codes J0887 and J0888 were added to the “CPT/HCPCS Codes” section. HCPCS code J0887 was added to the explanatory note for Group 1 in the "ICD-9-CM Codes that Support Medical Necessity" section. No comment and notice periods required and none given.

- Erythropoiesis Stimulating Agents (ESA) - SIA (A44399)
  Due to the annual HCPCS update for 2015, HCPCS codes J0887 and J0888 were added to the “CPT/HCPCS Codes” section.Obsolete date information was removed from seven (7) Part A coding guidelines.

- Hyaluronans Intra-articular Injections of - Related to LCD L25820 (A46100)
  Article published January 2015: Based on the annual CPT/HCPCS update, CPT code 20611 and HCPCS code J7327 have been added effective for dates of service on or after 01/01/2015. The description for CPT code 20610 has changed. An indication for Monovisc™ and Gel-Syn™ have been added to the indications for “Sodium hyaluronate.” Monovisc™ and Gel-Syn™ have been added to the “Documentation Requirements” paragraph. Gel-Syn™ has been added to the second paragraph in the “Utilization” section. HCPCS code J3490 has been added to the CPT/HCPCS Codes section to report services for Gel-Syn™. The “Sources of Information” section has been revised to add the links to the U.S. Food and Drug Administration Premarket Notification for all of the devices included in the article.

- Hyperbaric Oxygen (HBO) Therapy - Medical Policy Article (A52174)
  Due to the annual HCPCS update for 2015, HCPCS code C1300 was deleted and removed from the “CPT/HCPCS Codes” section. An explanatory note regarding the code deletion was added to
this section. HCPCS code G0277 was added as a replacement code. Added a statement “For dates of service prior to 1/1/2015” to all references to HCPCS code C1300.

- **Investigational Device Exemption Requests** - Medical Policy Article (A45910)
The article has been revised to include new approval process guidelines based on information in Transmittal 3105 effective 01/01/2015.

- **LCD Reconsideration Process** - Medical Policy Article (A47355)
  **Article published January 2015:** Added a clarification that scientific data or research studies published in peer-reviewed medical journals must be indexed on PubMed (from the US National Library of Medicine, National Institute of Health).

- **Luteinizing Hormone-Releasing Hormone (LHRH) Analogs** – Related to LCD L25820 (A49923)
  **Article published January 2015:** The first paragraph in the “Article Text” has been revised to remove out-dated information. The “Indications” section has been revised to group the indications for leuprolide acetate together and to list the drugs in numerical order. The following statement has been added to the “Limitations” section:

  Doses that exceed those listed in the “Indications” section above or found in the FDA-approved label may be denied as not medically necessary unless there is documentation to justify the medical necessity in the individual case.

  The “Coding Information” section and the table listing the drug, administration and coding has been removed.

- **Noncovered Services** (L32456)
  LCD revised for annual HCPCS update for 2015. For prostatic urethral lift (PUL), CPT code 55899 has been replaced by CPT codes 52441 and 52442 for Part B claims.

- **Noninvasive Vascular Studies** (L27355)
The effective date for credentialing requirements listed under Credentialing and Accreditation Standards has been revised to January 1, 2016.

- **Outpatient Physical and Occupational Therapy Services** (L26884)
  LCD revised for annual HCPCS update for 2015. HCPCS codes G0456 and G0457 have been deleted and replaced by CPT codes 97607 and 97608. In addition the descriptions for CPT codes 97605 and 97606 have been revised to specify that they should be reported when utilizing DME equipment.

  The Medical Necessity and Skilled Therapy sections of the LCD have been revised to eliminate duplicative language and clarify coverage relating to rehabilitative and maintenance therapy.

- **Paclitaxel** (e.g., Taxol®/Abraxane ™) - Related to LCD L25820 (A46758)
  **Article published January 2015:** Based on the annual HCPCS update, HCPCS code J9265 has been deleted and replaced with HCPCS code J9267 effective for dates of service on or after 01/01/2015. The article text paragraph has been revised to remove out-dated information. Minor revisions were made to the abstract.

- **Psychiatry and Psychology Services** (L26895)
  HCPCS code M0064 was discontinued due to the annual HCPCS 2015 update, effective for services rendered on or after 01/01/2015. All language associated with the Outpatient Mental Health Treatment Limitation has been deleted.

- **Qualitative Drug Screening** (L28145)
  CPT code 80102 was replaced by HCPCS Code G6058 due to annual HCPCS 2015 update. Other Comments section deleted.
• **Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (L33390) – J6 only**
  LCD revised for annual HCPCS update for 2015. HCPCS codes G0173 and G0251 have been deleted effective 01/01/2015.

• **Transesophageal Echocardiography (TEE) (L27381)**
  LCD revised to extend the date for meeting credentialing requirements, as listed in the Training Requirements section of the LCD, to 1/1/2017.

• **Transthoracic Echocardiography (TTE) (L27360)**
  LCD revised to add ICD-9 codes 401.9, 402.90, 427.89, 447.71, 785.0, and V72.81 as payable for CPT codes 93306, 93307, 93308, 93321, 93325, C8923, C8924, and C8929. ICD-9 codes 401.1, 427.31, 785.1, and V72.81 have been added as payable for CPT codes 93350, 93351, 93352, C8928 and C8930.

• **Vertebroplasty and Vertebral Augmentation (Percutaneous) (L26439)**
  LCD revised for annual HCPCS update for 2015. CPT codes 22520-22525, and CPT codes 72291, 72292 and 72295 have been deleted and replaced by CPT codes 22510-22515 effective 01/01/2015. The Other Comments section of the LCD was deleted.

• **Vertebroplasty and Vertebral Augmentation (Percutaneous) - SIA (A45937)**
  Article revised for annual HCPCS update for 2015. CPT codes 22520-22525, and CPT codes 72291, 72292 and 72295 have been deleted and replaced by CPT codes 22510-22515 effective 01/01/2015. Coding guidelines have been revised to reflect the new coding.

• **Zoledronic Acid (Zometa ®, Reclast® ) – Related to LCD L25820 (A46096)**
  **Article published January 2015:** The first paragraph in the “Article Text” has been revised to remove outdated information. The article has been revised to remove language specific to Reclast® and Zometa®. The “Utilization” section has been revised to indicate that the dose and frequency of administration should be consistent with the FDA-approved package insert. Bulleted examples have been added. Primary, secondary and tertiary diagnosis code groups have been removed and all payable diagnoses have been added to the Group 1: Code list in the “Covered ICD-9 Code” section effective for dates of service on or after 1/1/2015.
Centers for Medicare & Medicaid Services
Articles for Part A&B Providers
REVISED product from the Medicare Learning Network® (MLN)

- “Medicare Fraud and Abuse: Prevention, Detection, and Reporting” Fact Sheet, ICN 006827, Downloadable

MLN Matters® Number: MM8810 Related Change Request (CR) #: CR 8810
Related CR Release Date: November 26, 2014 Effective Date: December 29, 2014
Related CR Transmittal #: R556PI Implementation Date: December 29, 2014

Revisions to Pub. 100-08, Program Integrity Manual (PI M), Chapter 15

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8810 to make several clarifications to Chapter 15 of the “Medicare Program Integrity Manual”. Most of these changes were editorial in nature to clarify other Medicare manuals being referenced in Chapter 15. The revised Chapter 15 is attached to CR8810.

Disclaimer

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

### Seasonal Flu Vaccinations


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

Disclaimer

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

- “Affordable Care Act Provider Compliance Programs: Getting Started” Web-Based Training (WBT)

MLN Matters® Number: MM8874 Related Change Request (CR) #: CR 8874
Related CR Release Date: December 11, 2014 Effective Date: January 1, 2015
Related CR Transmittal #: R3146CP Implementation Date: January 5, 2015

Preventive and Screening Services — Update - Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy

Provider Types Affected

This MLN Matters® Article is intended for Medicare practitioners providing preventive and screening services to Medicare beneficiaries and billing Medicare Administrative Contractors (MACs) for those services.

Provider Action Needed

Change Request (CR) 8874 is an update from the Centers for Medicare & Medicaid Services (CMS) to ensure accurate program payment for three screening services. The coinsurance and deductible for these services are currently waived, but due to coding changes and additions, the payments for Calendar Year (CY) 2015 would not be accurate without updated CR8874 for intensive behavioral group therapy for obesity, digital breast tomosynthesis, and anesthesia associated with screening colonoscopy. Make sure billing staffs are aware of these updates.

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

The following outlines the CMS updates:

**Intensive Behavioral Therapy for Obesity**

Intensive behavioral therapy for obesity became a covered preventive service under Medicare, effective November 29, 2011. It is reported with HCPCS code G0447 (Face-to-face behavioral counseling for obesity, 15 minutes). Coverage requirements are in the “Medicare National Coverage Determinations (NCDs) Manual,” Chapter 1, Section 210.

To improve payment accuracy, in CY 2015 Physician Fee Schedule (PFS) Proposed Rule, CMS created a new HCPCS code for the reporting and payment of behavioral group counseling for obesity -- HCPCS codes G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes).

For coverage requirements of intensive behavioral therapy for obesity, see the NCD for Intensive Behavioral Therapy for Obesity.

The same claims editing that applies to G0447 applies to G0473. Therefore, effective for claims with dates of service on or after January 1, 2015, MACs will recognize HCPCS code G0473, but only when billed with one of the ICD-9 codes for Body Mass Index (BMI) 30.0 and over (V85.30-V85.39, V85.41-V85.45). (Once ICD-10 is effective, the related ICD-10 codes are Z68.30-Z68.39 and Z68.41-Z68.45.) When claims for G0473 are submitted without a required diagnosis code, they will be denied using the following remittance codes:

- **Claim Adjustment Reason Code (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.
- **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.mcd.search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Effective for claims with dates of service on or after January 1, 2015, beneficiary coinsurance and deductible do not apply to claim lines with HCPCS code G0473.

Note that Medicare pays claims with code G0473 only when submitted by the following provider specialty types as found on the provider's Medicare enrollment record:

- 01 - General Practice
- 08 - Family Practice
- 11 - Internal Medicine
- 16 - Obstetrics/Gynecology
- 37 - Pediatric Medicine

Disclaimer

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

CPT only copyright 2013 American Medical Association.
• 38 - Geriatric Medicine
• 50 - Nurse Practitioner
• 89 - Certified Clinical Nurse Specialist
• 97 - Physician Assistant

Claim lines submitted with G0473, but without an appropriate provider specialty will be denied with the following remittance codes:

• CARC 8: The procedure code is inconsistent with the provider type/specialty (taxonomy). 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 (if GZ modifier present) or PR (if modifier GA is present).

Further, effective for dates of service on or after January 1, 2015, claim lines with G0473 are only payable for the following Places of Service (POS) codes:

• 11 - Physician’s Office
• 22 - Outpatient Hospital
• 49 - Independent Clinic
• 71 - State or local public health clinic

Claim lines for G0473 will be denied without an appropriate POS code using the following remittance codes:

• CARC 5: The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
• RARC M77: Missing/incomplete/invalid place of service.
• Group Code CO (if GZ modifier present) or PR (if modifier GA is present).

Remember that Medicare will deny claim lines billed for HCPCS codes G0447 and G0473 if billed more than 22 times in a 12-month period using the following codes:

• CARC 119: Benefit maximum for this time period or occurrence has been reached.
• RARC N362: The number of days or units of service exceeds our acceptable maximum.
• Group Code CO (if GZ modifier present) or PR (if modifier GA is present).

Note: MACs will display the next eligible date for obesity counseling on all MAC provider inquiry screens.
MACs will allow both a claim for the professional service and a claim for a facility fee for G0473 when that code is billed on type of bill (TOB) 13X or on TOB 85X when revenue code 096X, 097X, or 098X is on the TOB 85X. Payment on such claims is based on the following:

- TOB 13X paid based on the OPPS:
- TOB 85X in Critical Access Hospitals based on reasonable cost; except
- TOB 85X Method II hospitals based on 115 percent of the lesser of the fee schedule amount or the submitted charge.

Institutional claims submitted on other than TOB 13X or 85X will be denied using:

- CARC 171: Payment is denied when performed by this type of provider on this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N428: Not covered when performed in this place of service.
- Group Code CO (if GZ modifier present) or PR (if modifier GA is present).

**Digital Breast Tomosynthesis**

In the CY 2015 PFS Final Rule with comment period, CMS established a payment rate for the newly created CPT code 77063 for screening digital breast tomosynthesis mammography. The same policies that are applicable to other screening mammography codes are applicable to CPT code 77063. In addition, since this is an add-on code it should only be paid when furnished in conjunction with a 2D digital mammography.

Effective January 1, 2015, HCPCS code 77063 (Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)), must be billed in conjunction with the screening mammography HCPCS code G0202 (Screening mammography, producing direct digital image, bilateral, all views, 2D imaging only. Effective January 1, 2015, beneficiary coinsurance and deductible does not apply to claim lines with 77063 (Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure).

Payment for 77063 is made only when billed with an ICD-9 code of V76.11 or V76.12 (and when ICD-10 is effective with ICD-10 code Z12.31). When denying claim lines for 77063 that are submitted without the appropriate diagnosis code, the claim lines are denied using 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.mcd.search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

- Group Code CO (if GZ modifier present) or PR (if modifier GA is present).

On institutional claims:

- MACs will pay for tomosynthesis, HCPCS code 77063, on TOBs 12X, 13X, 22X, 23X based on MPFS, and TOB 85X with revenue code other than 096x, 097x, or 098x based on reasonable cost. TOB 85X claims with revenue code 096x, 097x, or 098x are paid based on MPFS (115% of the lesser of the fee schedule amount and submitted charge).
- MACs will pay for tomosynthesis, HCPCS code 77063 with revenue codes 096X, 097X, or 098X when billed on TOB 85X Method II based on 115% of the lesser of the fee schedule amount or submitted charge.
- MACs will return to the provider any claim submitted with tomosynthesis, HCPCS code 77063 when the TOB is not 12X, 13X, 22X, 23X, or 85X.
- MACs will pay for tomosynthesis, HCPCS code 77063, on institutional claims TOBs 12X, 13X, 22X, 23X, and 85X when submitted with revenue code 0403 and on professional claims TOB 85X when submitted with revenue code 096X, 097X, or 098X.
- Effective for claims with dates of service on or after January 1, 2015, MACs will RTP claims for HCPCS code 77063 that are not submitted with revenue code 0403, 096X, 097X, or 098X.

**Anesthesia Furnished in Conjunction with Colonoscopy**

Section 4104 of the Affordable Care Act defined the term “preventive services” to include “colorectal cancer screening tests” and as a result it waives any coinsurance that would otherwise apply under Section 1833(a)(1) of the Act for screening colonoscopies. In addition, the Affordable Care Act amended Section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies. These provisions are effective for services furnished on or after January 1, 2011.

In the CY 2015 PFS Proposed Rule, CMS proposed to revise the definition of “colorectal cancer screening tests” to include anesthesia separately furnished in conjunction with screening colonoscopies; and in the CY 2015 PFS Final Rule with comment period, CMS finalized this proposal. The definition of “colorectal cancer screening tests” includes anesthesia separately furnished in conjunction with screening colonoscopies in the Medicare regulations at Section 410.37(a)(1)(iii). As a result, beneficiary coinsurance and deductible does not apply to anesthesia services associated with screening colonoscopies.

As a result, effective for claims with dates of service on or after January 1, 2015, anesthesia professionals who furnish a separately payable anesthesia service in conjunction with a screening colonoscopy (HCPCS code 00810 performed in conjunction with G0105 and G0121) shall include the following on the claim for the services that qualify for the waiver of coinsurance and deductible:
• **Modifier 33 – Preventive Services:** when the primary purpose of the service is the delivery of an evidence based service in accordance with a USPSTF A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not 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.

**Seasonal Flu Vaccinations** - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit [MLN Matters® Article MM8890](http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3146CP.pdf), “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season” and [MLN Matters® Article SE1431](http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3146CP.pdf), “2014-2015 Influenza (Flu) Resources for Health Care Professionals.”

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

**Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
Incorporation of Certain Provider Enrollment Policies in CMS-4159-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15

Provider Types Affected

This MLN Matters® Article is intended for physicians and eligible professionals who prescribe Medicare Part D drugs, and for providers and suppliers that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 8901 incorporates into Chapter 15 of the “Program Integrity Manual” (PIM) several provider enrollment policies in the final rule titled, “Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs.”

Key Points of CR8901

The key points of the updated Chapter 15 of the “Medicare Program Integrity Manual” are as follows:
• If a MAC approves a provider’s or supplier’s Form CMS-855 reactivation application or Reactivation Certification Package (RCP) for a Part B non-certified supplier, the reactivation effective date will be the date the MAC received the application or RCP that was processed to completion. Also, upon reactivating billing privileges for a Part B non-certified supplier, the MAC will issue a new Provider Transaction Access Number (PTAN).

• CMS may deny a physician’s or eligible professional’s Form CMS-855 enrollment application under § 424.530(a)(11) if:
  • The physician’s or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked; or
  • The applicable licensing or administrative body for any state in which the physician or eligible professional practices has suspended or revoked the physician’s or eligible professional's ability to prescribe drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits his or her enrollment application to the Medicare contractor.

• CMS may revoke a physician’s or eligible professional’s Medicare enrollment under § 424.535(a)(13) if:
  • The physician’s or eligible professional's DEA Certificate of Registration is suspended or revoked; or
  • The applicable licensing or administrative body for any state in which the physician or eligible professional practices has suspended or revoked the physician’s or eligible professional's ability to prescribe drugs.

• CMS may revoke a physician’s or eligible professional’s Medicare enrollment under § 424.535(a)(14) if CMS determines that the physician or eligible professional has a pattern or practice of prescribing Part D drugs that falls into one of the following categories:
  • The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both.
  • The pattern or practice of prescribing fails to meet Medicare requirements.
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.

Seasonal Flu Vaccinations - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit [MLN Matters® Article MM8890](http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R561PI.pdf), “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season” and [MLN Matters® Article SE1431](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html), “2014-2015 Influenza (Flu) Resources for Health Care Professionals.”

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

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

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

MLN Matters® Number: MM8969 Related Change Request (CR) #: CR 8969
Related CR Release Date: December 9, 2014 Effective Date: January 1, 2015
Related CR Transmittal #: R3145CP Implementation Date: January 5, 2015

Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2015

Note: This article was revised on December 12, 2014, to reflect a updated Change Request (CR). That CR corrected the wage index budget neutrality factors listed in the Policy Section of the Recurring Update Notification. The wage index budget neutrality factors listed in the payment rate tables were correct. The transmittal number, CR release date link to the CR also was changed. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

CR 8969 informs MACs about the changes and updates to the 60-day national episode rates, the national per-visit amounts, Low-Utilization Payment Adjustment (LUPA) add-on amounts, and the non-routine medical supply payment amounts under the HH PPS for Calendar Year (CY) 2015. Make sure that your billing staffs are aware of these changes.
Background

The Affordable Care Act of 2010 mandated several changes to Section 1895(b) of the Social Security Act (or the Act) and hence the HH PPS Update for CY 2014.

Section 3131(a) of the Affordable Care Act mandates that, starting in CY 2014, the Secretary must apply an adjustment to the national, standardized 60-day episode payment rate and other amounts applicable under Section 1895(b)(3)(A)(i)(III) of the Act to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. In addition, Section 3131(a) of the Affordable Care Act mandates that this rebasing must be phased in over a 4-year period in equal increments, not to exceed 3.5 percent of the amount (or amounts), as of the date of enactment, applicable under Section 1895(b)(3)(A)(i)(III) of the Act, and be fully implemented by CY 2017.

Also, Section 3131(c) of the Affordable Care Act amended Section 421(a) of the Medicare Modernization Act (MMA), which was amended by Section 5201(b) of the Deficit Reduction Act (DRA). The amended Section 421(a) of the MMA provides an increase of 3 percent of the payment amount otherwise made under Section 1895 of the Act for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2016. The statute waives budget neutrality related to this provision, as the statute specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under Section 1895 of the Act applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

Market Basket Update

The Multi-Factor Productivity (MFP) adjusted Home Health (HH) market basket update for CY 2015 is 2.1 percent. HHAs that do not report the required quality data will receive a 2-percentage point reduction to the MFP adjusted HH market basket update of 2.1 percent for CY 2015.

National, Standardized 60-Day Episode Payment

As described in the CY 2015 final rule, to determine the CY 2015 national, standardized 60-day episode payment rate, the Centers for Medicare & Medicaid Services (CMS) starts with the CY 2014 national, standardized 60-day episode rate ($2,869.27). CMS applies a wage index budget neutrality factor of 1.0024 and a case-mix weight budget neutrality factor of 1.0366. CMS then applies an $80.95 reduction (which is 3.5 percent of the CY 2010 national, standardized 60-day episode rate of $2,312.94). Lastly, the national, standardized 60-day episode payment rate is updated by the CY 2015 MFP adjusted HH market basket update of 2.1 percent for HHAs that do submit the required quality data and by 0.1 percent for HHAs that do not submit quality data. The updated CY 2015 national standardized 60-day episode payment rate for HHAs that do submit the required quality data is shown in

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
Table 1 below and for HHAs that do not submit the required quality data are shown in Table 2 below. These payments are further adjusted by the individual episode’s case-mix weight and wage index.

**Table 1: For HHAs that DO Submit Quality Data -- National 60-Day Episode Amounts Updated by the MFP adjusted Home Health Market Basket Update for CY 2015 Before Case-Mix Adjustment, Wage Index Adjustment Based on the Site of Service for the Beneficiary**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,869.27</td>
<td>X 1.0024</td>
<td>X 1.0366</td>
<td>-$80.95</td>
<td>X 1.021</td>
<td>=$2,961.38</td>
</tr>
</tbody>
</table>

**Table 2: For HHAs that DO NOT Submit Quality Data -- National 60-Day Episode Amounts Updated by the MFP adjusted Home Health Market Basket Update for CY 2015 Before Case-Mix Adjustment, Wage Index Adjustment Based on the Site of Service for the Beneficiary**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,869.27</td>
<td>X 1.0024</td>
<td>X 1.0366</td>
<td>-$80.95</td>
<td>X 1.001</td>
<td>=$2,903.37</td>
</tr>
</tbody>
</table>

**National Per-Visit Rates**

To calculate the CY 2015 national per-visit payment rates, CMS starts with the CY 2014 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0012 to ensure budget neutrality for LUPA per-visit payments after applying the CY 2014 wage index, and then applies the maximum rebasing adjustments to the 2014 per-visit rates. The per-visit rates for each discipline are then updated by the MFP adjusted CY 2015 HH market basket update of 2.1 percent for HHAs that do submit the required quality data and by 0.1 percent for HHAs that do not submit quality data. The CY 2015 national per-visit rates per discipline for HHAs that do submit the required quality data are shown in

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
Table 3 below and for HHAs that do not submit the required quality data are shown in Table 4 below.

**Table 3: For HHAs that DO Submit Quality Data – CY 2015 National Per-Visit Amounts for LUPAs and Outlier Calculations Updated by the MFP adjusted HH Market Basket Update, Before Wage Index Adjustment**

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2014 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2015 Rebasing Adjustment</th>
<th>CY 2015 HH Payment Update Percentage</th>
<th>CY 2015 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$54.84</td>
<td>X 1.0012</td>
<td>+$1.79</td>
<td>X 1.021</td>
<td>$57.89</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$194.12</td>
<td>X 1.0012</td>
<td>+$6.34</td>
<td>X 1.021</td>
<td>$204.91</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$133.30</td>
<td>X 1.0012</td>
<td>+$4.35</td>
<td>X 1.021</td>
<td>$140.70</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$132.40</td>
<td>X 1.0012</td>
<td>+$4.32</td>
<td>X 1.021</td>
<td>$139.75</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$121.10</td>
<td>X 1.0012</td>
<td>+$3.96</td>
<td>X 1.021</td>
<td>$127.83</td>
</tr>
<tr>
<td>Speech- Language Pathology</td>
<td>$143.88</td>
<td>X 1.0012</td>
<td>+$4.70</td>
<td>X 1.021</td>
<td>$151.88</td>
</tr>
</tbody>
</table>

**Table 4: For HHAs that DO NOT Submit Quality Data – CY 2015 National Per-Visit Amounts for LUPAs and Outlier Calculations Updated by the MFP adjusted HH Market Basket Update, Before Wage Index Adjustment**

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2014 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2015 Rebasing Adjustment</th>
<th>CY 2015 HH Payment Update Percentage Minus 2 Percentage Points</th>
<th>CY 2015 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$54.84</td>
<td>X 1.0012</td>
<td>+$1.79</td>
<td>X 1.001</td>
<td>$56.75</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$194.12</td>
<td>X 1.0012</td>
<td>+$6.34</td>
<td>X 1.001</td>
<td>$200.89</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$133.30</td>
<td>X 1.0012</td>
<td>+$4.35</td>
<td>X 1.001</td>
<td>$137.95</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$132.40</td>
<td>X 1.0012</td>
<td>+$4.32</td>
<td>X 1.001</td>
<td>$137.02</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$121.10</td>
<td>X 1.0012</td>
<td>+$3.96</td>
<td>X 1.001</td>
<td>$125.33</td>
</tr>
<tr>
<td>Speech- Language Pathology</td>
<td>$143.88</td>
<td>X 1.0012</td>
<td>+$4.70</td>
<td>X 1.001</td>
<td>$148.90</td>
</tr>
</tbody>
</table>

Disclaimer

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

CPT only copyright 2013 American Medical Association.
Low-Utilization Payment Adjustment Add-On Payments

Low-Utilization Payment Adjustment (LUPA) episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. Beginning in CY 2014, CMS calculates the payment for the first visit in a LUPA episode by multiplying the per-visit rate by a LUPA add-on factor specific to the type of visit (skilled nursing, physical therapy, or speech-language pathology). The specific requirements for the new LUPA add-on calculation are described in Transmittal 2796 dated September 27, 2013. The CY 2015 LUPA add-on adjustment factors are displayed in Table 5.

Table 5: CY 2015 LUPA Add-On factors

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>Add-On Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td>1.8451</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>1.6700</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>1.6266</td>
</tr>
</tbody>
</table>

Non-Routine Supply Payments

Payments for Non-Routine Supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by the NRS conversion factor. To determine the CY 2015 NRS conversion factor, CMS starts with the CY 2014 NRS conversion factor ($53.65) and applies a 2.82 percent rebasing adjustment calculated in the CY 2015 final rule (1 - 0.0282 = 0.9718). CMS then updates the conversion factor by the MFP adjusted HH market basket update of 2.1 percent for HHAs that do submit the required quality data and by 0.1 percent for HHAs that do not submit quality data. CMS does not apply a standardization factor as the NRS payment amount calculated from the conversion factor is not wage or case-mix adjusted when the final claim payment amount is computed. The NRS conversion factor for CY 2015 payments for HHAs that do submit the required quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b. The NRS conversion factor for CY 2015 payments for HHAs that do not submit quality data is shown in Table 7a and the payment amounts for the various NRS severity levels are shown in Table 7b.

Table 6a: CY 2015 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2014 NRS Conversion Factor</th>
<th>2015 Rebasing Adjustment</th>
<th>CY 2015 HH Payment Update Percentage</th>
<th>CY 2015 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$53.65</td>
<td>X 0.9718</td>
<td>X 1.021</td>
<td>$53.23</td>
</tr>
</tbody>
</table>
**Table 6b: CY 2015 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO Submit Quality Data**

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2015 NRS Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.36</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$51.86</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$142.19</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$211.25</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$325.76</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$560.27</td>
</tr>
</tbody>
</table>

**Table 7a: CY 2015 NRS Conversion Factor for HHAs that DO NOT Submit the Required Quality Data**

<table>
<thead>
<tr>
<th>CY 2014 NRS Conversion Factor</th>
<th>2015 Rebasin Adjustment</th>
<th>CY 2015 HH Payment Update Percentage minus 2 Percentage Points</th>
<th>CY 2015 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$53.65</td>
<td>X 0.9718</td>
<td>X 1.001</td>
<td>$52.19</td>
</tr>
</tbody>
</table>

**Table 7b: CY 2015 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO NOT Submit Quality Data**

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2015 NRS Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.08</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$50.84</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$139.41</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$207.12</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$319.39</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$549.32</td>
</tr>
</tbody>
</table>

**Rural Add-on**

Section 3131(c) of the Affordable Care Act applies a 3 percent rural add-on to the national standardized 60-day episode rate, national per-visit payment rates, LUPA add-on payments, and the NRS conversion factor when home health services are provided in rural (non-urban) areas.

**Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2016. The following tables show the CY 2015 rural payment rates.

**Table 8a: CY 2015 Payment Amounts for 60-Day Episodes for Services Provided in a Rural Area before Case-Mix and Wage Index Adjustment for HHAs that DO Submit Quality Data**

<table>
<thead>
<tr>
<th>CY 2015 National, Standardized 60-Day Episode Payment Rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural National, Standardized 60-Day Episode Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,961.38</td>
<td>X 1.03</td>
<td>$3,050.22</td>
</tr>
</tbody>
</table>

**Table 8b: CY 2015 Payment Amounts for 60-Day Episodes for Services Provided in a Rural Area before Case-Mix and Wage Index Adjustment for HHAs that DO NOT Submit Quality Data**

<table>
<thead>
<tr>
<th>CY 2015 National Standardized 60-Day Episode Payment Rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural National, Standardized 60-Day Episode Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,903.37</td>
<td>X 1.03</td>
<td>$2,990.47</td>
</tr>
</tbody>
</table>

**Table 9a: CY 2015 Per-Visit Amounts for Services Provided in a Rural Area, Before Wage Index Adjustment for HHAs that DO Submit Quality Data**

<table>
<thead>
<tr>
<th>Home Health Discipline Type</th>
<th>CY 2015 Per-visit rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural per-visit rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH Aide</td>
<td>$57.89</td>
<td>X 1.03</td>
<td>$59.63</td>
</tr>
<tr>
<td>MSS</td>
<td>$204.91</td>
<td>X 1.03</td>
<td>$211.06</td>
</tr>
<tr>
<td>OT</td>
<td>$140.70</td>
<td>X 1.03</td>
<td>$144.92</td>
</tr>
<tr>
<td>PT</td>
<td>$139.75</td>
<td>X 1.03</td>
<td>$143.94</td>
</tr>
<tr>
<td>SN</td>
<td>$127.83</td>
<td>X 1.03</td>
<td>$131.66</td>
</tr>
<tr>
<td>SLP</td>
<td>$151.88</td>
<td>X 1.03</td>
<td>$156.44</td>
</tr>
</tbody>
</table>
Table 9b: CY 2015 Per-Visit Amounts for Services Provided in a Rural Area, Before Wage Index Adjustment for HHAs that DO NOT submit quality data

<table>
<thead>
<tr>
<th>Home Health Discipline Type</th>
<th>CY 2015 Per-visit rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural per-visit rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH Aide</td>
<td>$56.75</td>
<td>X 1.03</td>
<td>$58.45</td>
</tr>
<tr>
<td>MSS</td>
<td>$200.89</td>
<td>X 1.03</td>
<td>$206.92</td>
</tr>
<tr>
<td>OT</td>
<td>$137.95</td>
<td>X 1.03</td>
<td>$142.09</td>
</tr>
<tr>
<td>PT</td>
<td>$137.02</td>
<td>X 1.03</td>
<td>$141.13</td>
</tr>
<tr>
<td>SN</td>
<td>$125.33</td>
<td>X 1.03</td>
<td>$129.09</td>
</tr>
<tr>
<td>SLP</td>
<td>$148.90</td>
<td>X 1.03</td>
<td>$153.37</td>
</tr>
</tbody>
</table>

Table 10a: CY 2015 Conversion Factor for Services Provided in Rural Areas for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>CY 2015 Conversion Factor</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$53.23</td>
<td>X 1.03</td>
<td>$54.83</td>
</tr>
</tbody>
</table>

Table 10b: CY 2015 Conversion Factor for Services Provided in Rural Areas for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>CY 2015 Conversion Factor</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$52.19</td>
<td>X 1.03</td>
<td>$53.76</td>
</tr>
</tbody>
</table>

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
### Table 10c: CY 2015 Relative Weights and Payment Amounts for the 6-Severity NRS System for Services Provided in Rural Areas for HHAs that DO submit quality data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>Total CY 2015 NRS Payment Amount for Rural Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.79</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$53.42</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$146.46</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$217.60</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$335.55</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$577.11</td>
</tr>
</tbody>
</table>

### Table 10d: CY 2015 Relative Weights and Payment Amounts for the 6-Severity NRS System for Services Provided in Rural Areas for HHAs that DO NOT submit quality data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>Total CY 2015 NRS Payment Amount for Rural Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.50</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$52.37</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$143.60</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$213.35</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$329.00</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$565.85</td>
</tr>
</tbody>
</table>

These changes are to be implemented through the Home Health Pricer software found in Medicare contractor standard systems.

HHAs should remember to:

- Submit the Core Based Statistical Area (CBSA) code or special wage index code corresponding to the state and county of the beneficiary’s place of residence in value code 61 on home health Requests for Anticipated Payments (RAPs) and claims;
- Use the wage index table attached to CR8969, which associates states and counties to CBSA codes (codes in the range 10020 – 49780 and 999xx rural state codes) to determine the code to report in value code 61;
- Use the codes in the range 50xxx in the wage index table attached to CR8969 to determine the code to report in value code 61 if the provider serves beneficiaries in areas where there is more than one unique CBSA due to the wage index transition.

**Additional Information**

Calendar Year (CY) 2015 Rural Health Clinic (RHC) and Federally Qualified Health Centers (FQHC) Updates: Payment Rate Increases for RHCs and FQHCs Billing Under the All-Inclusive Rate System (AIR), and Urban and Rural Designations for FQHCs Billing Under the AIR

Provider Types Affected

This MLN Matters® Article is intended for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8980 which informs MACs about instructions for the Calendar Year (CY) 2015 payment rate increases for RHCs and FQHCs billing under the all-inclusive rate (AIR) system, and updates to the urban and rural designations for FQHCs billing under the AIR. Make sure that your billing staffs are aware of these changes.
Background

CR8980 provides instructions to MACs for the CY 2015 payment rate increases for RHCs and FQHCs billing under the AIR. As authorized by §1833(f) of the Social Security Act (the Act), the payment limits for a subsequent year are increased in accordance with the rate of increase in the Medicare Economic Index (MEI). The RHC payment limit per visit for CY 2015 is $80.44 effective January 1, 2015, through December 31, 2015. The 2015 RHC rate reflects a 0.8 percent increase above the 2014 payment limit of $79.80. The FQHC payment limit per visit for urban FQHCs for CY 2015 is $130.05 and the payment limit per visit for rural FQHCs is $112.56 effective January 1, 2015, through December 31, 2015. The 2015 FQHC rates reflect a 0.8 percent increase above the 2014 rates of $129.02 and $111.67 in accordance with the rate of increase in the MEI.

CR8980 also provides instructions to the MACs regarding the urban and rural designations for FQHCs that are authorized to bill under the AIR system. Each FQHC site is designated as an urban or rural entity based on the urban and rural definitions in §1886(d)(2)(D) of the Act, which defines urban and rural for hospital payment purposes. If the FQHC is located within a Metropolitan Statistical Area (MSA), then the urban upper payment limit applies. If the FQHC is not in an MSA and cannot be classified as a large or other urban area, the rural payment limit applies. Rural FQHCs cannot be reclassified into an urban area for FQHC payment limit purposes.

The definition of urban and rural is based upon the most recent available data from the Bureau of Census and is issued by the Office of Management and Budget (OMB). OMB reviews its statistical area standards and delineations preceding each decennial census. On February 28, 2013, OMB issued “OMB Bulletin No. 13-01,” which established revised delineations for its statistical areas and provided guidance on the use of these delineations. OMB defines an MSA as a Core-based Statistical Area (CBSA) associated with at least one urbanized area that has a population of at least 50,000, and defines a Micropolitan Statistical Area as a CBSA associated with at least one urban cluster that has a population of at least 10,000 but less than 50,000 (75 FR 37252).

On August 22, 2014, CMS published the FY 2015 Hospital Inpatient Prospective Payment System (IPPS) Final Rule (79 FR 49952). This final rule states the Centers for Medicare & Medicaid Services (CMS) policy for using OMB’s revised CBSA delineations based on the 2010 Census data for updating the definitions of labor market or geographic areas for purposes of payment under the IPPS, effective October 1, 2014. For the IPPS, MSAs are defined as urban, and Micropolitan Statistical Areas and other non-urban areas are defined as rural. In addition, the IPPS definition of rural and urban is used to determine the rural or urban status of FQHC sites.
Additional Information


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

Seasonal Flu Vaccinations - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit MLN Matters® Article MM8890, “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season” and MLN Matters® Article SE1431, “2014-2015 Influenza (Flu) Resources for Health Care Professionals.”

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

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.
CPT only copyright 2013 American Medical Association.
Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE

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

Provider Action Needed

Change Request (CR) 8983 deals with the regular update in Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of CARCs and RARCs (835) Rule. CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2015, and CR8983 instructs the MACs to use that list as of April 1, 2015. This update is based on November 1, 2014, CARC and RARC updates as posted at the Washington Publishing Company (WPC) website.

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

**Background**

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

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

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

**Additional Information**


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

**Disclaimer**

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

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8994 informs MACs about the changes to Claim Status Category Codes and Claim Status Codes. Make sure that your billing staff are aware of these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care payers 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 format adopted as the standard for National use under HIPAA. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 to report...
claim status. The National Code Maintenance Committee meets at the beginning of each
ASC X12 trimester meeting (January, June, and October) and makes decisions about
additions of new codes, as well as modifications and retirement of existing codes. The
codes sets are available at [http://www.wpc-edi.com/reference/codelists/healthcare/claim-

These pages have previously been referenced at [http://www.wpc-edi.com/codes](http://www.wpc-edi.com/codes) on the Internet. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the January 2015 committee meeting shall be posted on
the previously mentioned websites on or about February 1, 2015. MACs must complete
entry of all applicable code text changes and new codes, and terminate use of deactivated
codes by the implementation date of CR 8994.

These code changes are to be used in the editing of all ASC X12 276 transactions processed
on or after the date of implementation and are to be reflected in ASC X12 277 transactions
issued on and after the date of implementation of CR 8994.

### Additional Information

The official instruction, CR 8994 issued to your MAC regarding this change is available at

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

- “Complying With Medical Record Documentation Requirements” Fact Sheet, ICN 909160, Downloadable

MLN Matters® Number: MM9002  Related Change Request (CR) #: CR 9002
Related CR Release Date: December 5, 2014  Effective Date: August 7, 2014
Related CR Transmittal #: R178NCD and R3142CP  Implementation Date: April 6, 2015

Transcatheter Mitral Valve Repair (TMVR)-National Coverage Determination (NCD)

Provider Types Affected

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

Provider Action Needed

Effective for claims with dates of service furnished on or after August 7, 2014, the Centers for Medicare & Medicaid Services (CMS) will reimburse claims for TMVR for Mitral Regurgitation (MR) when furnished under Coverage with Evidence Development (CED).

TMVR is non-covered for the treatment of MR when not furnished under CED according to the above-noted criteria. TMVR used for the treatment of any non-MR indications are non-covered by Medicare.
Background

TMVR is a new technology for use in treating MR. MR occurs when the leaflets of the mitral valve do not close properly and blood flows from the left ventricle back into the left atrium, causing the heart to work harder to pump. This, in turn, causes enlargement of the left ventricle and can lead to potential heart failure.

Abbott’s MitraClip, the only U.S. Food and Drug Administration (FDA)-approved TMVR device, involves clipping together a portion of the mitral valve leaflets. This is performed under general anesthesia, with delivery of the device typically through a percutaneous transvenous approach, via echocardiographic and fluoroscopic guidance. The procedure is performed in a cardiac catheterization laboratory or hybrid operating room/cardiac catheterization laboratory with advanced quality imaging. TMVR is covered for uses not listed as an FDA-approved indication when performed in approved clinical studies which meet certain study question requirements. The TMVR procedure must be performed by an interventional cardiologist or cardiac surgeon, or they may jointly participate in the intraoperative technical aspects, as appropriate.

On August 7, 2014, CMS issued a final decision memorandum covering TMVR for MR under CED for the treatment of MR when furnished for an FDA-approved indication with an FDA-approved device as follows:

- Treatment of significant, symptomatic, degenerative MR when furnished according to an FDA-approved indication, and all CMS coverage criteria are met; and
- TMVR for MR uses not expressly listed as FDA-approved indications but only within the context of an FDA-approved, randomized clinical trial that meets all CMS coverage criteria.

CED requires that each patient be entered into a qualified national registry. In addition, prior to receiving TMVR, face-to-face examinations of the patient are required by a cardiac surgeon and a cardiologist experienced in mitral valve surgery to evaluate the patient’s suitability for TMVR and determination of prohibitive risk, with documentation of their rationale.

The NCD lists the criteria that must be met prior to beginning a TMVR program and after a TMVR program is established. No NCD existed for TMVR for MR prior to August 7, 2014, and TMVR is non-covered outside CED or for non-MR indications. The Web address for accessing the NCD transmittal is available in the "Additional Information" section at the end of this article.

CR9002 revises the “Medicare Claims Processing Manual,” Chapter 32, Section 340 (Transcatheter Mitral Valve Repair (TMVR)), and the “National Coverage Determinations
Based on the NCD, TMVR must be furnished in a hospital with the appropriate infrastructure that includes but is not limited to:

- On-site active valvular heart disease surgical program with \( \geq 2 \) hospital-based cardiothoracic surgeons experienced in valvular surgery;
- Cardiac catheterization lab or hybrid operating room/catheterization lab equipped with a fixed radiographic imaging system with flat-panel fluoroscopy, offering catheterization laboratory-quality imaging;
- Non-invasive imaging expertise including transthoracic/transesophageal/3D echocardiography, vascular studies, and cardiac CT studies;
- Sufficient space, in a sterile environment, to accommodate necessary equipment for cases with and without complications;
- Post-procedure intensive care facility with personnel experienced in managing patients who have undergone open-heart valve procedures;
- Adequate outpatient clinical care facilities; and
- Appropriate volume requirements per the applicable qualifications below.

There are institutional and operator requirements for performing TMVR. The hospital must have the following:

- A surgical program that performs \( \geq 25 \) total mitral valve surgical procedures for severe MR per year of which at least 10 must be mitral valve repairs;
- An interventional cardiology program that performs \( \geq 1000 \) catheterizations per year, including \( \geq 400 \) Percutaneous Coronary Interventions (PCIs) per year, with acceptable outcomes for conventional procedures compared to National Cardiovascular Data Registry (NCDR) benchmarks;
- The heart team must include:

  1. An interventional cardiologist(s) who:
     - performs \( \geq 50 \) structural procedures per year including Atrial Septal Defects (ASD), Patent Foramen Ovale (PFO) and trans-septal punctures; and,
     - must receive prior suitable training on the devices to be used; and,
     - must be board-certified in interventional cardiology or board-certified/eligible in pediatric cardiology or similar boards from outside the United States;

  2. Additional members of the heart team, including cardiac echocardiographers, other cardiac imaging specialists, heart valve and heart failure specialists,
electrophysiologists, cardiac anesthesiologists, intensivists, nurses, nurse practitioners, physician assistants, data/research coordinators, and a dedicated administrator.

- All cases must be submitted to a single national database;
- Ongoing continuing medical education (or the nursing/technologist equivalent) of 10 hours per year of relevant material; and
- The cardiothoracic surgeon(s) must be board-certified in thoracic surgery or similar foreign equivalent.
- The heart team’s interventional cardiologist or a cardiothoracic surgeon must perform the TMVR. Interventional cardiologist(s) and cardiothoracic surgeon(s) may jointly participate in the intra-operative technical aspects of TMVR as appropriate.

The heart team and hospital must be participating in a prospective, national, audited registry that: 1) consecutively enrolls TMVR patients; 2) accepts all manufactured devices; 3) follows the patient for at least one year; and, 4) complies with relevant regulations relating to protecting human research subjects, including 45 Code of Federal Regulations (CFR) Part 46 and 21 CFR Parts 50 & 56. For complete details on the outcomes that must be tracked by the registry and the data that must be provided to the registry, see the CR9002 NCD transmittal. The Web address for that transmittal is in the "Additional Information" section at the end of this article.

**Coding Requirements/ Claims Processing Requirements**

**Coding Requirements for TMVR for MR Claims Furnished on or After August 7, 2014**

The Current Procedural Terminology (CPT) Codes for TMVR for MR Claims are:

- 0343T - Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; initial prosthesis. (Note: 0343T will be replaced by CPT code 33418 effective January 1, 2015.)

- 0344T - Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure). (Note: 0344T will be replaced by CPT code 33419 effective January 1, 2015.)

- 0345T - Transcatheter mitral valve repair percutaneous approach via the coronary sinus

- 33418 - Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis. (Note: CPT code 33418 is effective January 1, 2015.)
- 33419 - Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session. (List separately in addition to code for primary procedure.) (Note: CPT code 33419 is effective January 1, 2015.)

**ICD-9/ICD-10 Codes for TMVR for MR Claims**

The ICD-9 (and upon ICD-10 implementation)/ ICD-10 codes are:

- ICD-9 Procedure Code - 35.97 - Percutaneous mitral valve repair with implant - and ICD-10 procedure code is 02UG3JZ – Supplement mitral valve with synthetic substitute, percutaneous approach

- ICD-9 Diagnosis Code for TMVR for MR Claims is - 424.0 – Mitral valve disorder and ICD-10 diagnosis codes are I34.0 – Nonrheumatic mitral (valve) insufficiency or I34.8 – Other nonrheumatic mitral valve disorders

**Professional Claims Place of Service (POS) Codes for TMVR for MR Claims**

Effective for claims with dates of service on and after August 7, 2014, place of service (POS) code 21 is valid for use for TMVR for MR services. All other POS codes will be denied. MACs will supply the following messages when MACs denying TMVR for MR claims for invalid POS:

- Claim Adjustment Reason Code (CARC) 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

- Group Code CO (Contractual Obligation) 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.)

**Professional Claims Modifiers for TMVR for MR Claims**

Effective for claims with dates of service on or after August 7, 2014, MACs will pay TMVR for MR claim lines billed with CPT codes 0343T, 0344T, and 00345T when billed for two surgeons/co-surgeons only when the claim includes modifier -62. (Effective January 1, 2015, CPT codes 33418 and 33419 replace CPT codes 0343T and 0344T, respectively.) Claim lines for two surgeons/co-surgeons billed without modifier -62 shall be returned as unprocessable.

MACs will supply the following messages when returning TMVR for MR claim lines for two surgeons/co-surgeons billed without modifier -62 as unprocessable:
- CARC 4: “The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- Remittance Advice Remarks Code (RARC) N517: “Resubmit a new claim with the requested information.“
- Group Code: CO

Effective for claims with dates of service on or after August 7, 2014, MACs will pay claim lines for TMVR for MR billed with CPT codes 0343T, 0344T, and 0345T in a clinical trial when billed with modifier -Q0. (Effective January 1, 2015, CPT codes 33418 and 33419 replace CPT codes 0343T and 0344T, respectively.) TMVR for MR claim lines in a clinical trial billed without modifier -Q0 will be returned as unprocessable. MACs will supply the following messages when returning TMVR for MR claim lines in a clinical trial billed without modifier -Q0 as unprocessable:

- CARC 4: “The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N517: “Resubmit a new claim with the requested information.“
- Group Code: CO

**Professional Clinical Trial Diagnostic Coding for TMVR for MR Claims**

Effective for claims with dates of service on or after August 7, 2014, MACs will pay claim lines for TMVR for MR billed with CPT codes 0343T, 0344T, and 0345T in a clinical trial when billed with ICD-9 diagnosis code 424.0 (ICD-10 I34.0 or I34.8) and secondary ICD-9 diagnosis code V70.7 (ICD-10=Z00.6). (Effective January 1, 2015, CPT codes 33418 and 33419 replace CPT codes 0343T and 0344T, respectively.) TMVR for MR claim lines in a clinical trial billed without ICD-9 diagnosis code 424.0 (ICD-10 I34.0 or I34.8) and secondary ICD-9 diagnosis code V70.7 (ICD-10=Z00.6) will be denied.

MACs will supply the following messages when denying TMVR for MR claim lines in a clinical trial billed without secondary ICD-9 diagnosis code V70.7(ICD-10=Z00.6) as unprocessable:

- CARC 50: “These are non-covered services because this is not deemed a “medical necessity” by the payer.”

- 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 [http://www.cms.hhs.gov/mcd/search.asp](http://www.cms.hhs.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- Group Code: CO
**Mandatory National Clinical Trial (NCT) Number for TMVR for MR Claims**

Effective for claims with dates of service on or after August 7, 2014, contractors shall pay TMVR for MR claim lines billed with CPT codes 0343T, 0344T, and 0345T in a clinical trial only when billed with an 8-digit National Clinical Trial (NCT) number. (Effective January 1, 2015, CPT codes 33418 and 33419 replace CPT codes 0343T and 0344T, respectively.) MACs shall accept the numeric, 8-digit NCT number preceded by the two alpha characters of “CT” when placed in Field 19 of paper Form CMS-1500, or when entered WITHOUT the “CT” prefix in the electronic 837P in Loop 2300 REF02 (REF01=P4). **NOTE:** The “CT” prefix is required on a paper claim, but it is not required on an electronic claim. TMVR for MR claim lines in a clinical trial billed without an 8-digit NCT number shall be returned as unprocessable. MACs will supply the following messages when returning TMVR for MR claim lines as unprocessable when billed without an 8-digit NCT number:

- **CARC 16:** “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)”

- **RARC MA50:** “Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.”

- **Group Code:** CO

**Claims Processing Requirements for TMVR for MR on Inpatient Hospital Claims**

Inpatient hospitals shall bill for TMVR for MR on a 11X Type of Bill (TOB) effective for discharges on or after August 7, 2014. In addition to the ICD-9/10 procedure and diagnosis codes mentioned above, inpatient hospital discharges for TMVR for MR shall be covered when billed with the following clinical trial coding:

- Secondary ICD-9 diagnosis code V70.7/ICD-10 diagnosis code Z00.6;
- Condition Code 30; and
- An 8-digit NCT Number assigned by the National Library of Medicine (NLM) and displayed at [https://clinicaltrials.gov/](https://clinicaltrials.gov/) on the Internet.

Inpatient hospital discharges for TMVR for MR will be rejected when billed without the ICD-9/10 diagnosis and procedure codes and clinical trial coding mentioned above. Claims that do not include these required codes shall be rejected with the following messages:

- **CARC: 50** - “These are non-covered services because this is not deemed a “medical necessity” by the payer.”
- **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 http://www.cms.hhs.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.”

• Group Code - Contractual Obligation (CO)

Additional Information


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

Seasonal Flu Vaccinations - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit MLN Matters® Article MM8890, “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season” and MLN Matters® Article SE1431, “2014-2015 Influenza (Flu) Resources for Health Care Professionals.”

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

- “Medicare Appeals Process” Podcast, ICN 909016, downloadable only.

MLN Matters® Number: MM9028
Related Change Request (CR) #: CR 9028
Related CR Release Date: December 19, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3152CP
Implementation Date: January 5, 2015

Calendar Year (CY) 2015 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

Provider Types Affected

This MLN Matters® article is intended for clinical diagnostic laboratories who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9028 provides instructions for the CY 2015 clinical laboratory fee schedule, mapping for new codes for clinical laboratory tests, and updates for laboratory costs subject to the reasonable charge payment. Make sure your billing staffs are aware of these updates.

Background

In accordance with Section 1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, and further amended by Section 3401 of the Affordable Care Act of 2010, the annual update to the local clinical laboratory fees for CY 2015 is (-
0.25) percent. The annual update to local clinical laboratory fees for CY 2015 reflects an additional multi-factor productivity adjustment and a (-1.75) percentage point reduction as described by the Affordable Care Act.

The annual update to payments made on a reasonable charge basis for all other laboratory services for CY 2015 is 2.10 percent (See 42 CFR 405.509(b)(1)). Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the National Limitation Amount (NLA).

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount (described below). However, for a cervical or vaginal smear test (pap smear), payment may also not exceed the actual charge. The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

**Key Points of CR9028**

**National Minimum Payment Amounts**

For a cervical or vaginal smear test (pap smear), Section 1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge. The CY 2015 national minimum payment amount is $14.38 ($14.42 plus (-0.25) percent update for CY 2015).

The affected codes for the national minimum payment amount are 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175, G0123, G0143, G0144, G0145, G0147, G0148, and P3000.

**National Limitation Amounts (Maximum)**

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which the NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with Section 1833(h)(4)(B)(viii) of the Act.

**Access to Data File**

Internet access to the CY 2015 clinical laboratory fee schedule data file is available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html) on the Centers for Medicare & Medicaid Services (CMS) website. Other interested parties, such as the Medicaid State agencies, the Indian Health Service, the United Mine Workers, and the Railroad Retirement Board, may use the Internet to retrieve the CY 2015 clinical laboratory fee schedule; available in multiple formats, including Excel, text, and comma delimited.
Public Comments
On July 14, 2014, CMS hosted a public meeting to solicit input on the payment relationship between CY 2014 codes and new CY 2015 CPT codes. Notice of the meeting was published in the Federal Register on March 25, 2014, and on the CMS web site approximately April 1, 2014. Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. CMS posted a summary of the meeting and the tentative payment determinations on the web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html?redirect=/ClinicalLabFeeSched. Additional written comments from the public were accepted until October 30, 2014. CMS has posted a summary of the public comments and the rationale for the final payment determinations at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2015-CLFS-Codes-Final-Determinations.pdf on the CMS web site.

Pricing Information
The CY 2015 clinical laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615). The fees are established in accordance with Section 1833(h)(4)(B) of the Act.

The fees for clinical laboratory travel codes P9603 and P9604 are updated annually. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. If there is a revision to the standard mileage rate for CY 2015, CMS will issue a separate instruction on the clinical laboratory travel fees.

The CY 2015 clinical laboratory fee schedule also includes codes that have a “QW” modifier to both identify codes and to determine payment for tests performed by a laboratory having only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Organ or Disease Oriented Panel Codes
As in prior years, the CY 2015 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were derived by summing the lower of the clinical laboratory fee schedule amount or the NLA for each individual test code included in the panel code. The NLA field on the data file is zero-filled.

Mapping Information
Existing code 83516QW is priced at the same rate as code 83516.
New code 80163 is priced at the same rate as code 80162.
New code 80165 is priced at the same rate as code 80164.
New codes to be gap filled are 81161, 81246, 81287, 81288, 81313, 81410, 81411, 81415, 81416, 81417, 81420, 81425, 81426, 81427, 81430, 81431, 81435, 81436, 81440, 81445, 81450, 81455, 81460, 81465, 81470, and 81471.

New code 83006 is priced at the same rate as code 82777.
New code 87505 is priced at the same rate as code 87631.
New code 87506 is priced at the same rate as code 87632.
New code 87507 is priced at the same rate as code 87633.
New code 87623 is priced at the same rate as code 87621.
New code 87624 is priced at the same rate as code 87621.
New code 87625 is priced at the same rate as code 87621.
New code 87806 is priced at the same rate as code 87389.
New code G6030 is priced at the same rate as code 80152.
New code G6031 is priced at the same rate as code 80154.
New code G6032 is priced at the same rate as code 80160.
New code G6034 is priced at the same rate as code 80166.
New code G6035 is priced at the same rate as code 80172.
New code G6036 is priced at the same rate as code 80174.
New code G6037 is priced at the same rate as code 80182.
New code G6038 is priced at the same rate as code 80196.
New code G6039 is priced at the same rate as code 82003.
New code G6040 is priced at the same rate as code 82055.
New code G6041 is priced at the same rate as code 82101.
New code G6042 is priced at the same rate as code 82145.
New code G6043 is priced at the same rate as code 82205.
New code G6044 is priced at the same rate as code 82520.
New code G6045 is priced at the same rate as code 82646.
New code G6046 is priced at the same rate as code 82649.
New code G6047 is priced at the same rate as code 82651.
New code G6048 is priced at the same rate as code 82654.
New code G6049 is priced at the same rate as code 82666.
New code G6050 is priced at the same rate as code 82690.
New code G6051 is priced at the same rate as code 82742.
New code G6052 is priced at the same rate as code 83805.
New code G6053 is priced at the same rate as code 83840.
New code G6054 is priced at the same rate as code 83858.
New code G6055 is priced at the same rate as code 83887.
New code G6056 is priced at the same rate as code 83925.
New code G6057 is priced at the same rate as code 84022.
New code G6058 is priced at the same rate as code 80102.
New code G0464 is priced at the same rate as sum of codes 81315, 81275, and 82274.

The following existing codes are to be deleted: 80440, 82000, 82055, 82055QW, 82953, 82975, 82980, 83008, 83055, 83071, 83634, 83866, 84127, 87001, 87620, 87621, 87622, 80102, 80152, 80154, 80160, 80166, 80172, 80174, 80182, 80196, 82003, 82101, 82145, 82205, 82250, 82646, 82649, 82651, 82654, 82666, 82690, 82742, 83805, 83840, 83858, 83887, 83925, and 84022.

**Laboratory Costs Subject to Reasonable Charge Payment in CY 2011**

For outpatients, the following codes are paid under a reasonable charge basis. The reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable Consumer Price Index for the 12-month period ending June 30 of each year as set forth in 42 CFR 405.509(b)(1). The inflation-indexed update for CY 2015 is 2.1 percent.


When services described by the Healthcare Common Procedure Coding System (HCPCS) in the following list are performed for independent dialysis facility patients, the “Medicare Claims Processing Manual,” Chapter 8, Section 60.3, which is available at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf), instructs that the reasonable charge basis applies. When these services are performed for hospital-based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital Outpatient Prospective Payment System (OPPS).

**Blood Product Codes**


 NOTE: Biologic products not paid on a cost or prospective payment basis are paid based on Section 1842(o) of the Act. The payment limits based on Section 1842(o), including the payment limits for codes P9041, P9045, P9046, and P9047 should be obtained from the Medicare Part B drug pricing files

Transfusion Medicine Codes
Transfusion Medicine codes are 86850, 86860, 86870, 86880, 86885, 86890, 86891, 86900, 86901, 86902, 86904, 86905, 86906, 86920, 86921, 86922, 86923, 86927, 86930, 86931, 86932, 86945, 86950, 86960, 86965, 86970, 86971, 86972, 86975, 86976, 86977, 86978, and 86985.

Reproductive Medicine Procedures
Reproductive Medicine Procedure codes are 89250, 89251, 89253, 89254, 89255, 89257, 89258, 89259, 89260, 89261, 89264, 89268, 89272, 89280, 89281, 89290, 89291, 89335, 89342, 89343, 89344, 89346, 89352, 89353, 89354, and 89356.

MACs will not search their files to either retract payment or retroactively pay claims; however, they should adjust claims that you bring to their attention.

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?

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

CPT only copyright 2013 American Medical Association.
REVISED product from the Medicare Learning Network® (MLN)

- “Medicaid Program Integrity: Preventing Provider Medical Identity Theft” Fact Sheet, ICN 908265, Downloadable

MLN Matters® Number: MM9034  Related Change Request (CR) #: CR 9034
Related CR Release Date: December 24, 2014  Effective Date: January 1, 2015
Related CR Transmittal #: R3157CP  Implementation Date: January 5, 2015

Summary of Policies in the Calendar Year (CY) 2015 Medicare Physician Fee Schedule (MPFS) Final Rule and Telehealth Originating Site Facility Fee Payment Amount

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 9034 which provides a summary of the policies in the CY 2015 MPFS Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. Make sure that your billing staff are aware of these updates for 2015.
Background

The Social Security Act (Section 1848(b)(1); (see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm on the Internet) requires the Centers for Medicare & Medicaid Services (CMS) to establish a fee schedule of payment amounts for physicians’ services for the subsequent year. CMS issued a final rule with comment period on October 13, 2014 (see https://www.federalregister.gov/articles/2014/11/13 on the Internet), that updates payment policies and Medicare payment rates for services furnished by physicians and non-physician practitioners (NPPs) that are paid under the MPFS in CY 2015.

The final rule also addresses public comments on Medicare payment policies that were described in the proposed rule earlier this year: "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare & Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule" was published in the Federal Register on July 11, 2014. (See http://www.gpo.gov/fdsys/pkg/FR-2014-07-11/pdf/2014-15948.pdf on the Internet).

The final rule also addresses interim final values established in the CY 2014 MPFS final rule with comment period. (See http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf on the Internet). The final rule assigns interim final values for new, revised, and potentially misvalued codes for CY 2015 and requests comments on these values. CMS will accept comments on those items open to comment in the final rule with comment period until December 30, 2014.

Sustainable Growth Rate (SGR)

The Protecting Access to Medicare Act of 2014 (see http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf on the Internet) provides for a zero percent update from the CY 2014 rates for services furnished between January 1, 2015, and March 31, 2015. Adjusting by .06 percent to achieve required budget neutrality, the conversion factor for this period is $35.8013.

Under current law, the conversion factor will be adjusted on April 1, 2015. In the final rule CMS announced a conversion factor of $28.2239 for this period, resulting in an average reduction of 21.2 percent from the CY 2014 rates. In most prior years, Congress has taken action to avert large across-the-board reductions in PFS rates before they went into effect. The Administration supports legislation to permanently change SGR to provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care.

Screening and Diagnostic Digital Mammography

To ensure that the higher resources needed for 3D mammography are recognized, Medicare will pay for 3D mammography using add-on codes that will be reported in addition to the 2D mammography codes when 3D mammography is furnished. See MLN Matters® Article MM8874 for more information.
Primary Care and Chronic Care Management

Medicare continues to emphasize primary care by making payment for chronic care management (CCM) services -- non-face-to-face services to Medicare beneficiaries who have two or more chronic conditions -- beginning January 1, 2015. CCM services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management. CCM can be billed once per month per qualified beneficiary, provided the minimum level of services is furnished.

CMS is finalizing its proposal to allow greater flexibility in the supervision of clinical staff providing CCM services. The proposed application of the “incident to” supervision rules was widely supported by the commenters.

Payment for CCM is only one part of a multi-faceted CMS initiative to improve Medicare beneficiaries’ access to primary care. Models being tested through the Innovation Center will continue to explore other primary care innovations.

Finally, CMS will require that in order to bill CCM, a practitioner must use a certified electronic health record (EHR) that meets the requirements for the EHR Incentive Program as of December 31 of the prior calendar year.

Application of Beneficiary Cost Sharing To Anesthesia Related To Screening Colonoscopies

The Medicare statute waives the Part B deductible and coinsurance applicable to screening colonoscopy. In the CY 2015 final rule, CMS revised the definition of a “screening colonoscopy” to include separately provided anesthesia as part of the screening service so that the coinsurance and deductible do not apply to anesthesia for a screening colonoscopy, reducing beneficiaries’ cost-sharing obligations under Part B. For more information, review MLN Matters® Article MM8874 on the CMS website.

Enhanced Transparency in Setting PFS Rates

Since the beginning of the physician fee schedule in 1992, CMS adopted rates for new and revised codes for the following calendar year in the final rule on an interim basis subject to public comment. This policy was necessary because CMS did not receive the codes in time to include in the PFS proposed rule. Until recently, the only services that were affected by this policy were services with new and revised codes. In recent years, CMS began receiving new and revised codes and revaluing existing services under the misvalued codes initiative. Establishing payment in the final rule for misvalued codes often led to implementation of payment reductions before the public had the opportunity to comment. CMS finalized its proposal to change the process for valuing new, revised and potentially misvalued codes for CY 2016, so that payment for the vast majority of these codes goes through notice and comment rulemaking prior to being adopted. After a transition in CY 2016, the process will be fully implemented in CY 2017.
Potentially Misvalued Services

Consistent with amendments to the Affordable Care Act (see http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf on the Internet), CMS has been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes, and to make adjustments where appropriate.

The following are major misvalued code decisions for 2015:

- **Radiation Therapy and Gastroenterology:** Consistent with the final rule policy and in response to public comments, CMS is not adopting the CPT coding changes for CY 2015 for gastroenterology and radiation therapy services so that CMS can propose and obtain comments on the revised coding prior to using them for payment. As a result, CMS will not recognize some new CPT codes, and created G-codes in place of changed and new CPT codes.

- **Radiation Treatment Vault:** CMS proposed to refine the way it accounts for the infrastructure costs associated with radiation therapy equipment, specifically to remove the radiation treatment vault as a direct expense when valuing radiation therapy services. After considering public comments, CMS did not finalize this proposal.

- **Epidural Pain Injections:** CMS reduced payment for these services in 2014 under the misvalued code initiative. In response to concerns from pain physicians regarding the accuracy of the valuation, CMS proposed to raise the values in 2015 based on their prior resource inputs before adopting further changes after considering RUC recommendations. However, because the inputs for these services included those related to image guidance, CMS also proposed to prohibit separate billing for image guidance for CY 2015. CMS finalized the policy as proposed to avoid duplicate payment for image guidance. CMS has asked the RUC to further review this issue and make recommendations to us on how to value epidural pain injections.

- **Film to Digital Substitution:** CMS finalized its proposal to update the practice expense inputs for X-ray services to reflect that X-rays are currently done digitally rather than with analog film.

**Global Surgery**

The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) has identified a number of surgical procedures that include more visits in the global period than are being furnished. CMS is also concerned that post-surgical visits are valued higher than visits that were furnished and billed separately by other physicians such as general internists or family physicians.

CMS finalized a proposal to transform all 10-day and 90-day globals to 0-day globals, beginning with 10-day global services in CY 2017 and following with the 90-day global services in 2018. As CMS revalues these services as 0-day global periods, CMS will actively assess whether there is a
better construction of a bundled payment for surgical services that incentivizes care coordination and care redesign across an episode of care.

**Access to Telehealth Services**

CMS is adding the following services to the list of services that can be furnished to Medicare beneficiaries under the telehealth benefit:

- Annual wellness visits,
- Psychoanalysis,
- Psychotherapy, and
- Prolonged evaluation and management services.

For the list of telehealth services, visit: [http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html](http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html) on the CMS website.

**Telehealth Origination Site Facility Fee Payment Amount Update**

The Social Security Act (Section 1834(m)(2)(B) (see [http://www.ssa.gov/OP_Home/ssact/title18/1834.htm](http://www.ssa.gov/OP_Home/ssact/title18/1834.htm)) establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31 2002, at $20.

For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in the Social Security Act (Section 1842(i)(3) (see [http://www.ssa.gov/OP_Home/ssact/title18/1842.htm](http://www.ssa.gov/OP_Home/ssact/title18/1842.htm) on the Internet).

The MEI increase for 2015 is 0.8 percent. Therefore, for CY 2015, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $24.83. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

**Revisions to Malpractice Relative Value Units (RVUs)**

As required by the Medicare law, CMS conducted a five-year review and updated the resource-based malpractice RVUs based on updated professional liability insurance premiums, largely paralleling the methodology used in the CY 2010 update. The final rule indicated that anesthesia RVUs will be updated in CY 2016.

**Revisions to Geographic Practice Cost Indices (GPCIs)**

As required by the Medicare law, CMS adjusts payments under the PFS to reflect local differences in the cost of operating a medical practice. For CY 2015, CMS is using territory-level wage data to calculate the work GPCI and employee wage component of the PE GPCI for the Virgin Islands.
The CY 2015 GPCIs also reflect the application of the statutorily mandated of 1.5 work GPCI floor in Alaska, and 1.0 work GPCI floor for all other physician fee schedule areas, and the 1.0 PE GPCI floor for frontier states (Montana, Nevada, North Dakota, South Dakota, and Wyoming).

However, given that the statutory 1.0 work GPCI floor is scheduled to expire under current law on March 31, 2015, the GPCIs reflect the elimination of the 1.0 work GPCI floor from April 1, 2015, through December 31, 2015.

**Services Performed in Off-campus Provider-Based Departments**

CMS will collect data on services furnished in off-campus provider-based departments by requiring hospitals to report a modifier for those services furnished in an off-campus provider-based department of the hospital and by requiring physicians and other billing practitioners to report these services using a new place of service code on professional claims.

Data collection will be voluntary for hospitals in 2015 and required beginning on January 1, 2016. The new place of service codes will be used for professional claims as soon as it is available, but not before January 1, 2016.

**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) on the CMS website.

---

**Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach

Note: This article was revised on December 8, 2014, to include the dates and some additional details for the three end-to-end testing periods.

Provider Types Affected

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

Provider Action Needed

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

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

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

The four-pronged approach includes:

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

Each approach is discussed in more detail below.

CMS Internal Testing of Its Claims Processing Systems

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

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

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

Provider-Initiated Beta Testing Tools

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

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


Acknowledgement Testing

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

All MACs and the DME MAC Common Electronic Data Interchange (CEDI) contractor will promote this ICD-10 acknowledgement testing with trading partners. This testing allows all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A or a 999) that confirms whether the submitted test claims were accepted or rejected.

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

End-to-End Testing

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

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

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. To facilitate this testing, CMS requires MACs to do the following:

- Conduct limited end-to-end testing with submitters in three testing periods; January 2015, April 2015 and July 2015. Test claims will be submitted January 26 – 30, 2015, April 27 – May 1, 2015, and July 20 – 24, 2015.
- Each MAC (and CEDI with assistance from DME MACs) will select 50 submitters for each MAC Jurisdiction supported to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will also select 50 submitters. Testers will be selected randomly from a list of volunteers to represent a broad cross-section of provider types, claims types, and submitter types. At least five, but not more than fifteen, of the testers will be a clearinghouse.
- MACs and CEDI will post a volunteer form to their website during the enrollment periods to collect volunteer information with which to select volunteers. Those interested in testing should review the minimum testing requirements on the form to ensure they qualify before volunteering.

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

**Claims Submission Alternatives**

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

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work. In addition to showing the toll-free numbers, you will find your MAC’s website address at this site in the event you want more information on the free billing software or the MAC’s provider internet portals mentioned above.
MLN Matters® Number: SE1435  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

FAQs - International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing

Note: This article was revised on December 24, 2014, to add FAQs 6-8 on page 3 and the former FAQ 6 is now FAQ 9. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition article is intended for all physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing.

Provider Action Needed

Physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 end-to-end testing to gain an understanding of the guidelines and requirements for successful testing.

Disclaimer

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

1. **How is ICD-10 end-to-end testing different from acknowledgement testing?**

   The goal of acknowledgement testing is for testers to submit claims with ICD-10 codes to the Medicare Fee-For-Service claims systems and receive acknowledgements to confirm that their claims were accepted or rejected.

   End-to-end testing takes that a step further, processing claims through all Medicare system edits to produce and return an accurate Electronic Remittance Advice (ERA). While acknowledgement testing is open to all electronic submitters, end-to-end testing is limited to a smaller sample of submitters who volunteer and are selected for testing.

2. **What constitutes a testing slot for this testing?**

   A testing slot is the ability to submit 50 claims to a particular Medicare Administrative Contractor (MAC) who selected you for testing.

3. **What data must I provide to the MAC before testing?**

   For each testing slot, you must provide the MAC: up to 2 submitter identifiers (IDs), up to 5 National Provider Identifiers (NPIs)/Provider Transaction Access Numbers (PTANs), and up to 10 Health Insurance Claim Numbers (HICNs). You may use these in any combination on the 50 claims. You will need to use the same HICN on multiple claims. Therefore, you will need to consider this when designing a test plan, since claims will be subject to standard utilization edits.

   If you were selected to test with only one submitter ID but would like to choose a second one, you must contact the MAC to add the second submitter ID. If the MAC is not aware of your preference to use a second submitter ID, claims submitted with that ID may not be processed.

4. **What should I consider when choosing HICNs for testing?**

   The MAC will copy production information into the test region for the HICNs that you provide. This includes eligibility information, claims history, and other documentation such as Certificates of Medical Necessity (CMNs). The HICNs you provide must be real beneficiaries and may not have a Date of Death on file. If you previously submitted HICNs for beneficiaries who are deceased, contact the MAC as soon as possible with replacement HICNs.
5. If I was selected for the January 2015 end-to-end testing, do I need to reapply for later testing rounds?

   No, once you are selected for testing, you are automatically registered for the later rounds of testing.

6. Does this mean that no new submitters will be accepted for the April and July 2015 end-to-end testing periods or will a new group of 850 testers be selected for both April and July?

   A new group will be selected for each of the April and July 2015 testing periods, and these groups will be able to test in addition to the already chosen testers. Therefore, the total number of potential testers will be 1,700 for April 2015 and 2,550 for July 2015.

7. Do you have information on who has been selected for the January 2015 end-to-end testing?

   We will release this information as part of the public release of our January test results.

8. When do you expect to publically release results of the first round of end-to-end testing?

   We expect to publically release results of the first round of end-to-end testing around the end of February 2015.

9. Can I submit additional NPIs, PTANs, and HICNs for the later rounds of testing?

   Yes, while you do not need to re-apply for the later rounds of testing, you may choose to submit up to 2 additional submitter IDs, up to 5 additional NPIs/PTANs, and up to 10 additional HICNs. You may also still use the information you submitted for the previous testing round. The MAC will provide the form you must use to submit this new information, and the information must be received by the due date on the form to be considered for the next round of testing.

What to Know During Testing

1. Is it safe to submit test claims with Protected Health Information (PHI)?

   The test claims you submit are accepted into the system using the same secure method used for production claims on a daily basis. They will be processed by the same MACs who process production claims, and all the same security protocols will be followed. Therefore, using real data for this test does not cause any additional risk of release of PHI.
2. What Dates of Service can be used on test claims?

Professional claims with an ICD-10 code must have a date of service on or after October 1, 2015.

Inpatient claims with an ICD-10 code must have a discharge date on or after October 1, 2015.

Supplier claims with an ICD-10 code must have a date of service between October 1, 2015, and October 15, 2015.

For professional and institutional claims, you may use dates up to December 31, 2015. You cannot use dates in 2016 or beyond.

3. Can both ICD-9 and ICD-10 codes be submitted on the same claim?

ICD-9 and ICD-10 codes cannot be submitted on the same claim. For additional information on how to submit claims that span the ICD-10 implementation date (when ICD-9 codes are effective for that portion of the services rendered on September 30, 2015, and earlier, and when ICD-10 codes are effective for that portion of the services rendered on October 1, 2015, and later), please refer to MLN Matters® Article SE1325, “Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims that span the ICD-10 Implementation Date” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf on the Centers for Medicare & Medicaid Services website.

4. Do Returned to Provider (RTP) claims count toward the 50 claims submitted? Can RTP’d claims be re-submitted for testing?

Institutional claims that fail Return to Provider (RTP) editing count toward the 50 claim submission limit. Claims that are RTP’d will not appear on the electronic remittance advice, and will not be available through DDE. If claims accepted by the front end edits do not appear on the remittance advice, please contact the Medicare Administrative Contractor (MAC) for further information.

Claims that are rejected by front end editing do not count toward the 50 claim submission limit; therefore, they should be corrected and resubmitted.

5. If a Certificate of Medical Necessity (CMN) or DME Information Form (DIF) is required for a supplier claim, do I need to submit a CMN during testing?

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
If the beneficiary has a valid CMN or DIF on file for that equipment/supply covered by the dates of service on your test claim (after 10/1/2015), you do not need to submit a new CMN/DIF.

If the beneficiary’s CMN/DIF has expired for the dates of service on your test claim (after 10/1/2015), you must submit a revised CMN/DIF to extend the end date for that CMN/DIF.

If the beneficiary does not have a CMN or DIF for that equipment/supply, you must submit a new CMN/DIF.

6. **For Home Health claims, how should I submit the Request for Anticipated Payment (RAP) and final claim for testing?**

   Submit the RAP and final claim in the same file and the system will allow them to process. The final claim will be held and recycle (as in normal processing) until the RAP finalizes. It will then be released to the Common Working File (CWF). The RAP processing time will be short since the test beneficiaries are set up in advance.

   To get your results more quickly, you may also want to consider billing Low Utilization Payment Adjustment claims with four visits or less that do not require a RAP.

7. **For Hospice claims, should I submit the Notice of Election (NOE) prior to testing?**

   You will not need to provide NOEs to the MAC prior to the start of testing. The MACs will set up NOEs for any hospice claims received during testing.

8. **For an Inpatient Rehabilitation Facility (IRF) or Skilled Nursing Facility (SNF) stay, can the Case-Mix Group (CMG) or Resource Utilization Group (RUG) code be submitted on the claim even though the date of service is in the future?**

   Yes, you can send the IRF claim with a valid CMG code on the claim and a SNF claim with a valid RUG code on the claim, even though the date is in the future. For testing purposes, only a claim with a valid Health Insurance Prospective Payment System (HIPPS) code will be required. You do not need to submit the supporting data sheets.

**Additional Information**

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

**Disclaimer**

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

**Note:** This article was revised on December 31, 2014, to add clarifying language. All other information remains unchanged.

**Provider Types Affected**

This MLN Matters® Special Edition (SE) 1436 is intended for Medicare-enrolled physicians who certify patient eligibility for home health care services and submit claims to Medicare Administrative Contractors (MACs) for those services provided to Medicare beneficiaries.

**What You Need to Know**

This MLN Matters® SE1436 article gives Medicare-enrolled providers an overview of the Medicare home health services benefit, including patient eligibility requirements and certification/recertification requirements of covered Medicare home health services.
## Key Points

To be eligible for Medicare home health services a patient must have Medicare Part A and/or Part B per Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Social Security Act (the Act):

- Be confined to the home;
- Need skilled services;
- Be under the care of a physician;
- Receive services under a plan of care established and reviewed by a physician; and
- Have had a face-to-face encounter with a physician or allowed Non-Physician Practitioner (NPP).

Care must be furnished by or under arrangements made by a Medicare-participating Home Health Agency (HHA).

### Patient Eligibility—Confined to Home

Section 1814(a) and Section 1835(a) of the Act specify that an individual is considered “confined to the home” (homebound) if the following two criteria are met:

<table>
<thead>
<tr>
<th>First Criteria</th>
<th>Second Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>One of the Following must be met:</td>
<td>Both of the following must be met:</td>
</tr>
<tr>
<td>1. Because of illness or injury, the individual needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence.</td>
<td>1. There must exist a normal inability to leave home.</td>
</tr>
<tr>
<td>2. Have a condition such that leaving his or her home is medically contraindicated.</td>
<td>2. Leaving home must require a considerable and taxing effort.</td>
</tr>
</tbody>
</table>

The patient may be considered homebound (that is, confined to the home) if absences from the home are:

- Infrequent;
- For periods of relatively short duration;
- For the need to receive health care treatment;
- For religious services;
- To attend adult daycare programs; or
- For other unique or infrequent events (for example, funeral, graduation, trip to the barber).
Some examples of persons confined to home are:

- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence;
- A patient who has just returned from a hospital stay involving surgery, who may be suffering from resultant weakness and pain and therefore their actions may be restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time or walking stairs only once a day; and
- A patient with a psychiatric illness that is manifested, in part, by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

**Patient Eligibility—Need Skilled Services**

According to Section 1814(a)(2)(C) and Section1835(a)(2)(A) of the Act, the patient must be in need of one of the following services:

- Skilled nursing care on an intermittent basis (furnished or needed on fewer than 7 days each week or less than 8 hours each day for periods of 21 days or less, with extensions in exceptional circumstances when the need for additional care is finite and predictable per Section 1861(m) of the Act);
- Physical Therapy (PT);
- Speech-Language Pathology (SLP) services; or
- Continuing Occupational Therapy (OT).

**Patient Eligibility—Under the Care of a Physician and Receiving Services Under a Plan of Care**

Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act require that the patient must be under the care of a Medicare-enrolled physician, defined at 42 CFR 424.22(a)(1)(iii) as follows:

- Doctor of Medicine;
- Doctor of Osteopathy; or
- Doctor of Podiatric Medicine (may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law).

According to Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act, the patient must receive home health services under a plan of care established and periodically reviewed by a physician. Based on 42 CFR 424.22(d)(1) a plan of care may not be established and reviewed by any physician who has a financial relationship with the HHA.

**Certification Requirements, Including the Required Face-to-Face Encounter are as follows:**

As a condition for payment, according to the regulations at 42 CFR 424.22(a)(1):

- A physician must certify that a patient is eligible for Medicare home health services according to 42 CFR 424.22(a)(1)(i)-(v); and

---

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

The Centers for Medicare & Medicaid Services (CMS) does not require a specific form or format for the certification as long as a physician certifies that the following five requirements, outlined in 42 CFR Section 424.22(a)(1), are met:

1. The patient needs intermittent SN care, PT, and/or SLP services;
2. The patient is confined to the home (that is, homebound);
3. A plan of care has been established and will be periodically reviewed by a physician;
4. Services will be furnished while the individual was or is under the care of a physician; and
5. A face-to-face encounter:
   a. Occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care;
   b. Was related to the primary reason the patient requires home health services; and
   c. Was performed by a physician or allowed Non-Physician Practitioner.

According to the regulations at 42 CFR 424.22(a)(2) physicians should complete the certification when the plan of care is established or as soon as possible thereafter. The certification must be complete prior to when an HHA bills Medicare for reimbursement.

**Certification Requirements: Face-to-Face Encounter**

According to 42 CFR 424.22(a)(1)(v)(A), the face-to-face encounter can be performed by:

• The certifying physician;
• The physician who cared for the patient in an acute or post-acute care facility (from which the patient was directly admitted to home health);
• A nurse practitioner or a clinical nurse specialist who is working in collaboration with the certifying physician or the acute/post-acute care physician; or
• A certified nurse midwife or physician assistant under the supervision of the certifying physician or the acute/post-acute care physician.

According to 42 CFR 424.22(d)(2), the face-to-face encounter cannot be performed by any physician or allowed NPP (listed above) who has a financial relationship with the HHA.

**Certification Requirements: Management and Evaluation Narrative**

According to 42 CFR 424.22(a)(1)(i) if a patient's underlying condition or complication requires a Registered Nurse (RN) to ensure that essential non-skilled care is achieving its purpose and a RN needs to be involved in the development, management and evaluation of a patient's care plan, the physician will include a brief narrative describing the clinical justification of this need.

If the narrative is part of the certification form then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the certification form in addition to the physician's signature on the certification form, the physician must sign immediately following the narrative in the addendum.
For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of a registered nurse to promote the patient's recovery and medical safety in view of the patient's overall condition.


Certification Requirements: Supporting Documentation

- Documentation in the certifying physician’s medical records and/or the acute/post-acute care facility’s medical records (if the patient was directly admitted to home health) shall be used as the basis for certification of home health eligibility. If the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment will not be rendered for home health services provided.

- According to the regulations at 42 CFR 424.22(c), Certifying physicians and acute/post-acute care facilities must provide, upon request, the medical record documentation that supports the certification of patient eligibility for the Medicare home health benefit to the home health agency, review entities, and/or CMS. Certifying physicians who show patterns of non-compliance with this requirement, including those physicians whose records are inadequate or incomplete for this purpose, may be subject to increased reviews, such as provider-specific probe reviews.

- Information from the HHA, such as the patient’s comprehensive assessment, can be incorporated into the certifying physician’s and/or the acute/post-acute care facility’s medical record for the patient.
  - Information from the HHA must be corroborated by other medical record entries and align with the time period in which services were rendered.

  - The certifying physician must review and sign off on anything incorporated into the patient’s medical record that is used to support the certification of patient eligibility (that is, agree with the material by signing and dating the entry).

  - The certifying physician’s and/or the acute/post-acute care facility’s medical record for the patient must contain information that justifies the referral for Medicare home health services. This includes documentation that substantiates the patient’s:
    1. Need for the skilled services; and
    2. Homebound status.
• The certifying physician’s and/or the acute/post-acute care facility’s medical record for the patient must contain the **actual clinical note for the face-to-face encounter visit** that demonstrates that the encounter:
  1. Occurred within the required timeframe;
  2. Was related to the primary reason the patient requires home health services; and
  3. Was performed by an allowed provider type.

This information can be found most often in, but is not limited to, clinical and progress notes and discharge summaries.

Please review the following examples included at the end of this article:

1. Discharge Summary;
2. Progress Note;
3. Progress Note and Problem List; or
4. Discharge Summary and Comprehensive Assessment.

**Recertification**

At the end of the initial 60-day episode, a decision must be made as to whether or not to recertify the patient for a subsequent 60-day episode. According to the regulations at 424.22(b)(1) recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode and unless there is a:

• Patient-elected transfer; or
• Discharge with goals met and/or no expectation of a return to home health care.

(These situations trigger a new certification, rather than a recertification)

Medicare does not limit the number of continuous episodes of recertification for patients who continue to be eligible for the home health benefit.

**Recertification Requirements:**

1. Must be signed and dated by the physician who reviews the plan of care;
2. Indicate the continuing need for skilled services (the need for OT may be the basis for continuing services that were initiated because the individual needed SN, PT or SLP services); and

3. Estimate how much longer the skilled services will be required.

**Physician Billing for /Certification/Recertification**

Certifying/recertifying patient eligibility can include contacting the home health agency and reviewing of reports of patient status required by physicians to affirm the implementation of the plan of care that meets patient’s needs.

2. HCPCS code G0179 − Physician recertification home health patient for Medicare-covered home health services under a home health plan of care (patient not present).

Physician claims for certification/recertification of eligibility for home health services (G0180 and G0179 respectively) are not considered to be for “Medicare-covered” home health services if the HHA claim itself was non-covered because the certification/recertification of eligibility was not complete or because there was insufficient documentation to support that the patient was eligible for the Medicare home health benefit.

Additional Information

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

More information is available at the Medicare Home Health Agency website at [http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html](http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html) on the CMS website.

Attached are a number of examples that illustrate some of the key points of this article.

### Seasonal Flu Vaccinations

- Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit MLN Matters® Article #MM8890, “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season” and MLN Matters® Article #SE1431, “2014-2015 Influenza (Flu) Resources for Health Care Professionals.”

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

Disclaimer

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

CPT only copyright 2013 American Medical Association.
Example 1

AAA HOSPITAL DISCHARGE SUMMARY
-DEPARTMENT OF SURGERY-

DOE, JANE 00000123 02-13-2014
Patient Name Med Rec No. Admit Date
Physician: John A. Doe, M.D.
Dictated By: John A. Doe, M.D.

ADMISSION DIAGNOSIS:
Right knee osteoarthritis.

DISCHARGE DIAGNOSIS:
Right knee osteoarthritis.

CONSULTATIONS:
1. Physical Therapy
2. Occupational Therapy

PROCEDURES:
02/14/2014: Total Right knee arthroplasty.

HISTORY OF PRESENT ILLNESS:
Mrs. Doe is a pleasant 60-year old female who has had a longstanding history of right knee arthritis. She has complained of right sided knee pain since January 2013. Since then, her ambulation has been limited by pain and she has pain at night that interrupts sleep. Pain medication, ibuprofen and hydrocodone, have been unsuccessful in relieving her pain for the last 6 months. Workup did show reduction in the right knee joint space. She initially failed conservation treatment and has elected to proceed with surgical treatment.

PAST MEDICAL HISTORY:
Hypertension, Gout.

PAST SURGICAL HISTORY:
Hysterectomy.

DISCHARGE MEDICATIONS:
Colace 100 mg daily, Percocet 5/325 every 4 hours as needed for pain, Lisinopril 10 mg daily, Coumadin 4 mg daily; blood draw for INR ordered for 2/20/2014.

DISCHARGE CONDITION:
Upon discharge Mrs. Doe is stable status post right total knee replacement and has made good progress with her therapies and rehabilitation. Mrs. Doe is to be discharged to home with home health services, physical therapy and nursing visits, ordered. The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition or adverse events from the new Coumadin medical regimen.

PATIENT INSTRUCTION:
The patient is discharged to home in the care of her son. Diet is regular. Activity, weight bear as tolerated right lower extremity. The patient prescribed Coumadin 4 mg a day as the INR was 1.9 on discharge with twice weekly lab checks. Resume home medications. Call the office or return to the emergency room for any concerns including increased redness, swelling, drainage, fever, or any concerns regarding operation or site of incision. The patient is to follow up with Dr. Doe in two weeks.

Transcribed by: A.M 02/17/2014
Electronically signed by: John A. Doe, M.D. 02/17/2014 17:52
Subjective:
CC:
   1. Wound on left heel.
HPI:
   Pt is here for evaluation of wound on left heel. Patient reports her daughter noticed the wound on patient’s heel when she was washing her feet. Patient states she has difficulty with reaching her feet and her daughter will sometimes clean them for her. She reports she uses a shoe horn to put on her shoes.
ROS:
   General:
   No weight change, no fever, no weakness, no fatigue.
   Cardiology:
   No chest pain, no palpitations, no dizziness, no shortness of breath.
   Skin:
   Wound on left lower heel, no pain.

Medical History: HTN, hyperlipidemia, hypothyroidism, DJD.

Medications: zolpidem 10 mg tablet 1 tab(s) once a day (at bedtime), Diovan HCl 12.5 mg-320 mg tablet 1 tab(s) once a day, Lipitor 10 mg tablet 1 tab(s) once a day.

Allergies: NKDA

Objective:
Vitals: Temp 96.8, BP 156/86, HR 81, RR 19, Wt 225, Ht 5’4”
Examination: General appearance pleasant. HEENT normal. Heart rate regular rate and rhythm, lungs clear, BS present, pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees. Left heel wound measures 3 cm by 2 cm and 0.4 cm deep. Wound bed is red, without slough. Minimal amount of yellow drainage noted on removed bandage.

Assessment:
1. Open wound left heel

Plan:
1. OPEN WOUND Begin hydrocolloid with silver dressing changes. Minimal weight bear on left leg with a surgical boot on left foot. Begin home health for wound care, family teaching on wound care, and patient education on signs and symptoms of infection. The patient is now homebound due to minimal weight bearing on left foot and restrictions on walking to promote wound healing, she is currently using a wheelchair. Short-term nursing is needed for wound care, monitor for signs of infection, and education on wound care for family to perform dressing changes.

Follow Up: Return office visit in 2 weeks.

Provider: John Doe, M.D.
Patient: Smith, Jane  DOB: 04/13/1941  Date: 05/03/2013
Electronically signed by John Doe, M.D. on 05/03/2013 at 10:15 AM
Sign off status: Completed

Meets the requirements for documenting: (1) the need for skilled services; (2) why the patient was/is confined to the home (homebound); and (3) that the encounter was related to the primary reason the patient requires home health services.
Progress Notes

Patient: Rogers, Buck
DOB: 08/13/1925
Address: 234 Happy Lane, Teamwork, MD 12345

Subjective:
CC:
Weakness

HPI:
Pt was hospitalized 2 weeks ago for pneumonia. He was treated with IV antibiotics for 5 days and discharged on oral antibiotics for 10 days. His caregiver is present with him for the visit. The patient reports that his appetite has been decreased since the hospitalization and he has noticed increasing weakness and difficulty walking. The patient has lost 2 lbs. since his last visit. He has stayed in bed for most of the time since his hospitalization. He used a wheelchair to move from the front of the office building to the exam room. The patient has not needed a wheel chair previously. The patient denies any fever, chills, cough, rhinorrhea, sore throat, ear pain, difficulty drinking liquids, nausea, vomiting or diarrhea.

ROS:
General:
2 lb weight change, positive for weakness, positive for fatigue.

Pulmonary: As per the HPI

Cardiology:
No chest pain, no palpitations, no dizziness, no shortness of breath.

Medical History: HTN; hyperlipidemia; Diabetes Mellitus

Medications: ASA 325 mg once a day, Diovan HCl 12.5 mg-320 mg tablet 1 tab(s) once a day, Lipitor 10 mg tablet 1 tab(s) once a day. Metformin 1000 mg once a day.

Allergies: NKDA

Objective:
Vitals: Temp 98.6, BP 120/80, HR 71, RR 12, Wt 200, Ht 5’9” pulse ox 99% on room air
Examination: The patient is awake and alert and in no acute distress. He is in a wheelchair. HEENT: Pupils do not react to light. Heart rate regular rate and rhythm, lungs clear, BS present, Extremities: pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees ; Muscle Strength 3/5 in all 4 extremities(normal 5/5). The patient’s get up and to test was 35 seconds(normal <10)

Assessment:
1. Muscle Weakness secondary to deconditioning due to pneumonia

Plan:
1. Prior to the patient’s hospitalization for pneumonia, the patient could ambulate in his residence with assistance and was able to rise from a chair without difficulty. The patient requires a home health PT program for gait training and increasing muscle strength to restore the patient’s ability to walk in his residence.

Follow Up: Return office visit in 6 weeks.

Provider: Jane Doe, M.D.
Electronically signed by Jane Doe, M.D. on 09/02/2014 at 10:15 AM
Sign off status: Completed

Meets the requirements for documenting: (1) the need for skilled services; and (2) that the encounter was related to the primary reason the patient requires home health services.

Please see problem list (Part 2 of 2) for homebound status.
Example 3 – Part 2 of 2

Problem List*

**Patient:** Rogers, Buck  
**DOB:** 08/13/1925  
**Address:** 234 Happy Lane, Teamwork, MD 12345

401.1  HTN - 1999  
272.2  Hyperlipidemia -1999  
250.5  Diabetes Mellitus with ophthalmic manifestations -2000  
369.22  Blindness - 2002 (requires a caregiver assistance in order to leave the home)  
482.31  Pneumonia- Streptococcus- 2014

*In conjunction with the progress note, this meets the requirements for documenting why the patient was/is confined to the home (homebound).*

*A problem list would not be acceptable by itself to demonstrate skilled need and/or homebound status.*
Example 4 – Part 1 of 2

AAA HOSPITAL DISCHARGE SUMMARY
-DEPARTMENT OF SURGERY-

Smith, John 00000124
Patient Name Med Rec No. 04-14-2014 Discharge Date
Physician: Sam Bone, M.D. 04-18-2014 Admit Date
Dictated By: Sam Bone, M.D.

ADMISSION DIAGNOSIS:
Left knee osteoarthritis.

DISCHARGE DIAGNOSIS:
Left knee osteoarthritis.

CONSULTATIONS:
1. Physical Therapy
2. Occupational Therapy

PROCEDURES:
04/14/2014: Left knee arthroplasty.

HISTORY OF PRESENT ILLNESS:
Mr. Smith is 70 y.o. male who presents with left knee osteoarthritis for 10 years. Over the past three years the pain has steadily increased. It was initially controlled by ibuprofen and steroid injections. In the last year he has required ibuprofen and Percocet to ambulate and this treatment has been unsuccessful in relieving pain for the last 6 months. His ambulation has been limited by pain and he has pain at night that interrupts sleep. Workup did show reduction in the left knee joint space. He has failed conservative treatment and has elected to proceed with surgical treatment.

PAST MEDICAL HISTORY:
Hypertension

PAST SURGICAL HISTORY:
Inguinal hernia repair

DISCHARGE MEDICATIONS:
Colace 100 mg daily, Percocet 5/325 every 4 hours as needed for pain, Lisinopril 10 mg daily, Lovenox 30mg sq every 12hours for 6 more days.

DISCHARGE CONDITION:
Upon discharge Mr. Smith is stable status post left total knee replacement and has made good progress with his therapies and rehabilitation. Mr. Smith is to be discharged to home with home health services, physical therapy and nursing visits, ordered. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition and teaching of Lovenox injections.

PATIENT INSTRUCTION:
The patient is discharged to home in the care of his wife. Diet is regular. Activity, weight bear as tolerated left lower extremity. Call the office or return to the emergency room for any concerns including increased redness, swelling, drainage, fever, or any concerns regarding operation or site of incision. The patient is to follow up with Dr. Bone in two weeks.

Transcribed by: A.M 04/18/2014
Electronically signed by: Sam Bone, M.D. 04/18/2014 18:31

Meets the requirements for documenting: (1) the need for skilled services; and (2) that the encounter was related to the primary reason the patient requires home health services.

Please see OASIS (Part 2 of 2) for homebound status.
Patient Name: John Smith
HH Record Number: 4433225

ADL/IADLs continued

(M1845) Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

0 - Able to manage toileting hygiene and clothing management without assistance.
X 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
0 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
0 - Patient depends entirely upon another person to maintain toileting hygiene.

Comments: Patient requires clothes to be laid out on bed. He is able to dress himself from a seated position at foot of bed.

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

0 - Able to independently transfer.
X 1 - Able to transfer with minimal human assistance or with use of an assistive device.
0 - Able to bear weight and pivot during the transfer process but unable to transfer self.
0 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
0 - Bedfast, unable to transfer but is able to turn and position self in bed.
0 - Bedfast, unable to transfer and is unable to turn and position self.

Comments: Patient requires one-arm assistance to transfer from bed to chair.

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
0 - With the use of a one-handed device (e.g., cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
X 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
0 - Able to walk only with the supervision or assistance of another person at all times.
0 - Chairfast, unable to ambulate but is able to wheel self independently.
5 - Chairfast, unable to ambulate and is unable to wheel self.

6 - Bedfast, unable to ambulate or be up in a chair.

Comments: Pt. with a shuffling gait and frequently trips while ambulating. Pt. requires a wheeled walker and requires frequent cueing to remind him to not shuffle when he walks and to look up to avoid environmental hazards. Unable to go up and down stairs without his daughter assisting him. Daughter states that patient needs 24/7 supervision and is only able to leave his home for doctor appointments and only when she and her husband assist him. Patient is an increased fall risk because of inability to safely navigate stairs, uneven sidewalks and curbs.

In conjunction with the discharge summary, this meets the requirements for documenting why the patient was/is confined to the home (homebound).

Signed and dated by certifying physician indicating review and incorporation into the patient’s medical record.
Centers for Medicare & Medicaid Services
Articles for Part A Providers
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

REVISED products from the Medicare Learning Network® (MLN)

- “The DMEPOS Competitive Bidding Program: Non-Contract Supplier”, Fact Sheet, ICN 900925, downloadable

MLN Matters® Number: MM8566 Revised  Related Change Request (CR) #: CR 8566
Related CR Release Date: December 5, 2014  Effective Date: April 1, 2014
Related CR Transmittal #: R1445OTN  Implementation: April 7, 2014

Rescind/ Replace Reclassification of Certain Durable Medical Equipment from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category

Note: This article was revised on December 9, 2014, to reflect the revised CR8566 issued on December 5. The CR was revised to add a caret (^) to code E2378 in the table in Attachment A of the CR denoting this is an item which can be billable with complex rehabilitative wheelchair codes K0835-K0864. In the article, the CR release date, transmittal number, and the Web address for accessing CR8566 are revised also. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Home Health & Hospice MACs for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provided to Medicare beneficiaries. **In addition, this MLN Matters® Article is intended to clarify the interaction between these Part B coding changes and the bundled Part A payment that SNFs receive for a resident’s Medicare-covered stay.**
Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8566 as a one-time notification that provides instructions regarding the reclassification of certain DME from the inexpensive and routinely purchased (IN) DME payment category to the capped rental (CR) DME payment category for the Healthcare Common Procedure Coding System (HCPCS) codes listed in ‘Attachment A’ of CR8566. Be sure your billing personnel are aware of these changes.

Background

DME and accessories used in conjunction with DME are paid for under the DME benefit and in accordance with the rules at section 1834(a) of the Social Security Act (the Act). The Medicare definition of routinely purchased durable medical equipment (DME) set forth at 42 CFR 414.220(a)(2) specifies that routinely purchased equipment means equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987. A review of expensive items that have been classified as routinely purchased equipment since 1989, that is, new codes added to the HCPCS after 1989 for items costing more than $150, showed inconsistencies in applying the definition. As a result, a review of the definition of routinely purchased DME was published in the Federal Register (CMS-1526-F) along with notice of DME items (codes) requiring a revised payment category. CMS-1526-F is available at [http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28451.pdf](http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28451.pdf) on the Internet.

Also in the rule, CMS established that DME wheelchair accessories that are capped rental items furnished for use as part of a complex rehabilitative power wheelchair (wheelchair base codes K0835 – K0864) are payable under the lump sum purchase method. The complex rehabilitative power wheelchair base codes and options/accessories are payable under the lump sum purchase method set forth at 42 CFR 414.229(a)(5) and section 1834(a)(7)(A)(iii) of the Act.

In order to align the payment category with the required regulatory definition, certain HCPCS codes listed in Attachment A will reclassify from the inexpensive and routinely purchased (IN) DME payment category to the capped rental (CR) DME payment category. Instructions for billing capped rental items can be found at “Medicare Claims Processing Manual” (Pub. 100-04), Chapter 20, Section 130.9 at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf) along with other sources listed on the CMS and contractor websites.

Be aware the effective date is April 1, 2014 for HCPCS codes not included in a Competitive Bidding Program (CBP) as shown in Attachment A of CR8566. A forthcoming CR will address the codes that are reclassifying to the capped rental payment category effective July 1, 2016, and January 1, 2017.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2012 American Medical Association.
As shown in the table below, HCPCS codes for items included under the Round 2 and/or Round 1 Recompete DMEPOS CBPs will transition to the capped rental payment category in stages.

<table>
<thead>
<tr>
<th>Payment Category Transition Effective Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1, 2014</td>
</tr>
<tr>
<td>July 1, 2016</td>
</tr>
<tr>
<td>January 1, 2017</td>
</tr>
</tbody>
</table>

When the HCPCS codes listed below are furnished in CBAs in accordance with contracts entered into as part of the Round 1 Recompete CBP, the payment category transition from inexpensive and routinely purchased to capped rental DME is effective January 1, 2017.

<table>
<thead>
<tr>
<th>HCPCS for Items Reclassified to Capped Rental DME Category Effective July 1, 2016*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support Surfaces</td>
</tr>
<tr>
<td>Walkers</td>
</tr>
<tr>
<td>Wheelchairs Options/Accessories</td>
</tr>
<tr>
<td>Wheelchair Seating</td>
</tr>
</tbody>
</table>

* Items furnished in accordance with Round 1 Recompete contracts reclassify effective January 1, 2017

**Complex Rehabilitative Power Wheelchair Accessories**

Effective April 1, 2014, for wheelchair accessory codes classified under the capped rental DME payment category and furnished for use with a complex rehabilitative power wheelchair (that is, furnished to be used as part of the complex rehabilitative power wheelchair), the supplier must give the beneficiary the option of purchasing these accessories at the time they are furnished. These accessory items would be considered as part of the complex rehabilitative power wheelchair (codes K0835 – K0864) and associated lump sum purchase option set forth at 42 CFR 414.229(a)(5).

If the beneficiary declines the purchase option, the supplier must furnish the items on a rental basis and payment will be made on a monthly rental basis in accordance with the capped rental payment rules.

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

CPT only copyright 2012 American Medical Association.
Note: Items Needed During a Covered Part A Stay in a SNF

For an SNF resident whose stay is covered by Part A of Medicare, the extended care benefit provides comprehensive coverage for the overall package of institutional care that the SNF furnishes. This coverage includes any medically necessary durable medical equipment (DME) under the heading of “. . . drugs, biologicals, supplies, appliances, and equipment . . .” (section 1861(h)(5) of the Social Security Act (the Act)).

Accordingly, in cases where such a resident has a medical need for DME during the course of the Part A stay, the SNF is obligated to furnish it, since the SNF’s global per diem payment for the covered stay itself already includes any medically necessary DME.

Prior to April 1, 2014, and the change in Medicare Part B payment rules addressed in this article, Medicare beneficiaries may have brought this equipment purchased under Part B with them for use during a covered Part A stay in a SNF. This may still be the case for beneficiaries who take over ownership of the equipment after 13 months of continuous Part B rental payments.

However, in those cases where the beneficiary enters a SNF under a covered Part A stay and is in the middle of the 13-month capped rental period under Part B for the item, it is the responsibility of the SNF to ensure that the beneficiary has access to this equipment if it is medically necessary while the beneficiary is in the SNF during the Part A stay.

Additional Information


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

#### Inexpensive & Routinely Purchased (IN) Items Reclassified to Capped Rental (CR)

<table>
<thead>
<tr>
<th>Group Category</th>
<th>HCPCS</th>
<th>Descriptor</th>
<th>Effective</th>
<th>Effective</th>
<th>Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>4/1/14</td>
<td>7/1/16 at end of DMEPOS Competitive Bidding</td>
<td>1/1/17* at end of DMEPOS Competitive Bidding</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Program Round 2</td>
<td>Program Round 1 Recompete</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Automatic External Defibrillator</td>
<td>K0607</td>
<td>Repl battery for AED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canes/Crutches</td>
<td>E0117</td>
<td>Underarm spring assist crutch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucose Monitor</td>
<td>E0620</td>
<td>Capillary blood skin piercing device laser</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Frequency Chest Wall Oscillation Device (HFCWO)</td>
<td>A7025</td>
<td>Replace chest compress vest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Beds/Accessories</td>
<td>E0300</td>
<td>Enclosed ped crib hosp grade</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misc. DMEPOS</td>
<td>A4639</td>
<td>Infrared ht sys replacement pad</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E0762</td>
<td>Trans elec jt stim dev sys</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1700</td>
<td>Jaw motion rehab system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nebulizers &amp; Related Drugs</td>
<td>K0730</td>
<td>Ctrl dose inh drug deliv system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Neuromuscular Stimulators</td>
<td>E0740</td>
<td>Incontinence treatment system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E0764</td>
<td>Functional neuromuscular stimulation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumatic Compression Device</td>
<td>E0656</td>
<td>Segmental pneumatic trunk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E0657</td>
<td>Segmental pneumatic chest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power Operated Vehicles</td>
<td>E0984</td>
<td>Add pwr tiller</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Generating Devices</td>
<td>E2500</td>
<td>SGD digitized pre-rec &lt;=8min</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2502</td>
<td>SGD prerec msg &gt;8min &lt;=20min</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2012 American Medical Association.
<table>
<thead>
<tr>
<th>Group Category</th>
<th>HCPCS</th>
<th>Descriptor</th>
<th>Effective 4/1/14</th>
<th>Effective 7/1/16 at end of DMEPOS Competitive Bidding Program Round 2</th>
<th>Effective 1/1/17* at end of DMEPOS Competitive Bidding Program Round 1 Recompete</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E2504</td>
<td>SGD prerec msg&gt;20min &lt;=40min</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2506</td>
<td>SGD prerec msg &gt; 40 min</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2508</td>
<td>SGD spelling phys contact</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2510</td>
<td>SGD w multi methods msg/access</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support Surfaces</td>
<td>E0197</td>
<td>Air pressure pad for mattress</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E0198</td>
<td>Water pressure pad for mattress</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traction Equipment</td>
<td>E0849</td>
<td>Cervical pneum traction equip</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E0855</td>
<td>Cervical traction equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E0856</td>
<td>Cervical collar w air bladder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walkers</td>
<td>E0140</td>
<td>Walker w trunk support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E0144</td>
<td>Enclosed walker w rear seat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E0149</td>
<td>Heavy duty wheeled walker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchairs Manual</td>
<td>E1161</td>
<td>Manual adult wc w tiltinspac</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1232</td>
<td>Folding ped wc tilt-in-space</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1233</td>
<td>Rig ped wc tiltinspc w/o seat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1234</td>
<td>Fld ped wc tiltinspc w/o seat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1235</td>
<td>Rigid ped wc adjustable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1236</td>
<td>Folding ped wc adjustable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1237</td>
<td>Rgd ped wc adjstabl w/o seat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1238</td>
<td>Fld ped wc adjstabl w/o seat</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2012 American Medical Association.
<table>
<thead>
<tr>
<th>Group Category</th>
<th>HCPCS</th>
<th>Descriptor</th>
<th>Effective 4/1/14</th>
<th>Effective 7/1/16 at end of DMEPOS Competitive Bidding Program Round 2</th>
<th>Effective 1/1/17* at end of DMEPOS Competitive Bidding Program Round 1 Recompete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheelchair Options/Accessories</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E0985 *</td>
<td>W/c seat lift mechanism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E0986</td>
<td>Man w/c push-rim pow assist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1002 ^</td>
<td>Pwr seat tilt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1003 ^</td>
<td>Pwr seat recline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1004 ^</td>
<td>Pwr seat recline mech</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1005 ^</td>
<td>Pwr seat recline pwr</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1006 ^</td>
<td>Pwr seat combo w/o shear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1007 ^</td>
<td>Pwr seat combo w/shear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1008 ^</td>
<td>Pwr seat combo pwr shear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1010 ^</td>
<td>Add pwr leg elevation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1014</td>
<td>Reclining back add ped w/c</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1020 *</td>
<td>Residual limb support system</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1028 *</td>
<td>W/c manual swingaway</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1029</td>
<td>W/c vent tray fixed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E1030 ^</td>
<td>W/c vent tray gimbaled</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2227</td>
<td>Gear reduction drive wheel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2228 *</td>
<td>Mwc acc, wheelchair brake</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2310 ^</td>
<td>Electro connect btw control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2311 ^</td>
<td>Electro connect btw 2 sys</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2312 ^</td>
<td>Mini-prop remote joystick</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2313 ^</td>
<td>PWC harness, expand control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>E2321 ^</td>
<td>Hand interface joystick</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Category</td>
<td>HCPCS</td>
<td>Descriptor</td>
<td>Effective 4/1/14</td>
<td>Effective 7/1/16 at end of DMEPOS Competitive Bidding Program Round 2</td>
<td>Effective 1/1/17* at end of DMEPOS Competitive Bidding Program Round 1 Recompete</td>
</tr>
<tr>
<td>----------------</td>
<td>-------</td>
<td>------------</td>
<td>------------------</td>
<td>-------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>E2322</td>
<td>Mult mech switches</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2325</td>
<td>Sip and puff interface</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2326</td>
<td>Breath tube kit</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2327</td>
<td>Head control interface mech</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2328</td>
<td>Head/extremity control interface</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2329</td>
<td>Head control interface nonproportional</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2330</td>
<td>Head control proximity switch</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2351</td>
<td>Electronic SGD interface</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2368</td>
<td>Pwr wc drivewheel motor replace</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2369</td>
<td>Pwr wc drivewheel gear box replace</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2370</td>
<td>Pwr wc dr wh motor/gear comb</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2373</td>
<td>Hand/chin ctrl spec joystick</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2374</td>
<td>Hand/chin ctrl std joystick</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2375</td>
<td>Non-expandable controller</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2376</td>
<td>Expandable controller, replace</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2377</td>
<td>Expandable controller, initial</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>E2378</td>
<td>Pw actuator replacement</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>K0015</td>
<td>Detach non-adjus hght armrest</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td></td>
<td>K0070</td>
<td>Rear whl complete pneum tire</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
</tbody>
</table>

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2012 American Medical Association.
<table>
<thead>
<tr>
<th>Group Category</th>
<th>HCPCS</th>
<th>Descriptor</th>
<th>Effective</th>
<th>Effective</th>
<th>Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>4/1/14</td>
<td>7/1/16 at end of DMEPOS Competitive Bidding Program Round 2</td>
<td>1/1/17* at end of DMEPOS Competitive Bidding Program Round 1 Recompete</td>
</tr>
<tr>
<td>Wheelchairs Seating</td>
<td>E0955 *</td>
<td>Cushioned headrest</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Effective January 1, 2017 if the item is furnished in CBAs in accordance with contracts entered into as part of the Round 1 Recompete of DMEPOS CBP

^ Item billable with Complex Rehabilitative Power Wheelchair codes K0835 – K0864

**Disclaimer**

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

CPT only copyright 2012 American Medical Association.
Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - April 2015

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8918 to provide the DMEPOS Competitive Bidding Program (CBP) April 2015 quarterly update. CR 8918 provides specific instructions to your DME MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Background

The DMEPOS Competitive Bidding Program was mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).
statute requires that Medicare replace the current fee schedule payment methodology for selected DMEPOS items with a competitive bid process. The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality items and services.

Under the program, a competition among suppliers who operate in a particular competitive bidding area is conducted. Suppliers are required to submit a bid for selected products. Not all products or items are subject to competitive bidding. Bids are submitted electronically through a web-based application process and required documents are mailed. Bids are evaluated based on the supplier’s eligibility, its financial stability and the bid price. Contracts are awarded to the Medicare suppliers who offer the best price and meet applicable quality and financial standards. Contract suppliers must agree to accept assignment on all claims for bid items and will be paid the bid price amount. The amount is derived from the median of all winning bids for an item.

You can find additional information on the DMEPOS CBP at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html) on the CMS website.

More information is available at [http://www.dmecompetitivebid.com/palmetto/cbic.nsf](http://www.dmecompetitivebid.com/palmetto/cbic.nsf) on the Internet. The information at this site includes information on all rounds of the CBP, including product categories single payment amounts for the Round 1 Recompete, Round 2, and the national mail-order program for diabetic testing supplies; and the ZIP codes of areas included in the CBP.

### Additional Information


There are 14 separate products on pages four through six in the MLN Catalogue of Products at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/mlncatalog.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/mlncatalog.pdf) that describe the various aspects of the DMEPOS program. These fact sheets and booklets provide information for pharmacies, ways to pay for medical equipment, billing procedures for upgrades, repairs and replacements of equipment, and more.

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

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
Want to stay connected about the latest new and revised Medicare Learning Network® (MLN) products and services? Subscribe to the MLN Educational Products electronic mailing list! For more information about the MLN and how to register for this service, visit [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MLNProducts_listserv.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MLNProducts_listserv.pdf) and start receiving updates immediately!

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

*Note: This article was revised on December 19, 2014, to reflect the revised CR8950 issued on December 17. In the article, all references to CARC 169 have been replaced with CARC 186. In addition, the CR release date, transmittal number, and the Web address for accessing CR8950 are revised. All other information remains the same.*

**Provider Types Affected**

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

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

CR 8950:
1. Provides approved remittance advice code pairs to apply to claims in which only a Remittance Advice Remark Code (RARC) is currently used. This correction is required for compliance with operating rules of the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules, for Information Exchange (CORE).
2. Reflects changes to the Home Health (HH) Pricer logic that were implemented as part of the 2015 Home Health Prospective Payment System (HH PPS) payment update.

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

Background

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

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

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

2. In 2012, Change Request (CR) 7760 began the implementation of a process to validate HIPPS codes against the assessment records submitted to the Quality Improvement Evaluation System (QIES). This process currently applies to inpatient rehabilitation facility claims and will be expanded to HH and skilled nursing facility claims in the future. CR 7760 only required Medicare systems to apply RARC N69 to claims recoded based on QIES data, also without a corresponding Claim Adjustment Reason Code (CARC). You can find the associated MLN Matters® Article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7760.pdf on the CMS website.
CR8950 seeks to correct these oversights. However, CAQH CORE has not yet assigned approved code pairs for RARC N69. Medicare will request the approval of RARC N69 to be paired with CARC 186, Medicare systems will apply CARC 186 with RARC N69 in both situations described above.

Your MAC will:

1. Apply the following remittance advice codes on claims with Type of Bill (TOB) 032x (Home Health Services under a Plan of Treatment) when the output HIPPS code returned by the HH Pricer is different from the input HIPPS code:
   - Group code: CO
   - CARC: 186
   - RARC: N69

2. Apply the following remittance advice codes on claims with TOBs 011x (Hospital Inpatient (Part A)) with CMS Certification Numbers (CCNs) XX3025 - XX3099, XXTXXX, or XXRXXX, or TOBs 018x (Hospital Swing Bed), 021x (SNF Inpatient) or 032x (Home Health) when a HIPPS code is changed due to response file information received from QIES:
   - Group code: CO
   - CARC: 186
   - RARC: N69

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

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

**Additional Information**


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

**Disclaimer**

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

CPT only copyright 2013 American Medical Association.
NEW product from the Medicare Learning Network® (MLN)

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

**Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2015**

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 8969 informs MACs about the changes and updates to the 60-day national episode rates, the national per-visit amounts, Low-Utilization Payment Adjustment (LUPA) add-on amounts, and the non-routine medical supply payment amounts under the HH PPS for Calendar Year (CY) 2015. Make sure that your billing staffs are aware of these changes.

**Background**

The Affordable Care Act of 2010 mandated several changes to Section 1895(b) of the Social Security Act (or the Act) and hence the HH PPS Update for CY 2014.
Section 3131(a) of the Affordable Care Act mandates that, starting in CY 2014, the Secretary must apply an adjustment to the national, standardized 60-day episode payment rate and other amounts applicable under Section 1895(b)(3)(A)(i)(III) of the Act to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. In addition, Section 3131(a) of the Affordable Care Act mandates that this rebasing must be phased in over a 4-year period in equal increments, not to exceed 3.5 percent of the amount (or amounts), as of the date of enactment, applicable under Section 1895(b)(3)(A)(i)(III) of the Act, and be fully implemented by CY 2017.

Also, Section 3131(c) of the Affordable Care Act amended Section 421(a) of the Medicare Modernization Act (MMA), which was amended by Section 5201(b) of the Deficit Reduction Act (DRA). The amended Section 421(a) of the MMA provides an increase of 3 percent of the payment amount otherwise made under Section 1895 of the Act for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2016. The statute waives budget neutrality related to this provision, as the statute specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under Section 1895 of the Act applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

**Market Basket Update**

The Multi-Factor Productivity (MFP) adjusted Home Health (HH) market basket update for CY 2015 is 2.1 percent. HHAs that do not report the required quality data will receive a 2-percentage point reduction to the MFP adjusted HH market basket update of 2.1 percent for CY 2015.

**National, Standardized 60-Day Episode Payment**

As described in the CY 2015 final rule, to determine the CY 2015 national, standardized 60-day episode payment rate, the Centers for Medicare & Medicaid Services (CMS) starts with the CY 2014 national, standardized 60-day episode rate ($2,869.27). CMS applies a wage index budget neutrality factor of 0.9974 and a case-mix weight budget neutrality factor of 1.0366. CMS then applies an $80.95 reduction (which is 3.5 percent of the CY 2010 national, standardized 60-day episode rate of $2,312.94). Lastly, the national, standardized 60-day episode payment rate is updated by the CY 2015 MFP adjusted HH market basket update of 2.1 percent for HHAs that do submit the required quality data and by 0.1 percent for HHAs that do not submit quality data. The updated CY 2015 national standardized 60-day episode payment rate for HHAs that do submit the required quality data is shown in Table 1 below and for HHAs that do not submit the required quality data are shown in Table 2 below. These payments are further adjusted by the individual episode’s case-mix weight and wage index.
Table 1: For HHAs that DO Submit Quality Data -- National 60-Day Episode Amounts Updated by the MFP adjusted Home Health Market Basket Update for CY 2015 Before Case-Mix Adjustment, Wage Index Adjustment Based on the Site of Service for the Beneficiary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,869.27 X 1.0024 X 1.0366 -$80.95 X 1.021 =$2,961.38</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2: For HHAs that DO NOT Submit Quality Data -- National 60-Day Episode Amounts Updated by the MFP adjusted Home Health Market Basket Update for CY 2015 Before Case-Mix Adjustment, Wage Index Adjustment Based on the Site of Service for the Beneficiary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,869.27 X 1.0024 X 1.0366 -$80.95 X 1.001 =$2,903.37</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**National Per-Visit Rates**

To calculate the CY 2015 national per-visit payment rates, CMS starts with the CY 2014 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0012 to ensure budget neutrality for LUPA per-visit payments after applying the CY 2014 wage index, and then applies the maximum rebasing adjustments to the 2014 per-visit rates. The per-visit rates for each discipline are then updated by the MFP adjusted CY 2015 HH market basket update of 2.1 percent for HHAs that do submit the required quality data and by 0.1 percent for HHAs that do not submit quality data. The CY 2015 national per-visit rates per discipline for HHAs that do submit the required quality data are shown in Table 3 below and for HHAs that do not submit the required quality data are shown in Table 4 below.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
### Table 3: For HHAs that DO Submit Quality Data – CY 2015 National Per-Visit Amounts for LUPAs and Outlier Calculations Updated by the MFP adjusted HH Market Basket Update, Before Wage Index Adjustment

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2014 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2015 Rebasing Adjustment</th>
<th>CY 2015 HH Payment Update Percentage</th>
<th>CY 2015 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$54.84</td>
<td>X 1.0012</td>
<td>+$1.79</td>
<td>X 1.021</td>
<td>$57.89</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$194.12</td>
<td>X 1.0012</td>
<td>+$6.34</td>
<td>X 1.021</td>
<td>$204.91</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$133.30</td>
<td>X 1.0012</td>
<td>+$4.35</td>
<td>X 1.021</td>
<td>$140.70</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$132.40</td>
<td>X 1.0012</td>
<td>+$4.32</td>
<td>X 1.021</td>
<td>$139.75</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$121.10</td>
<td>X 1.0012</td>
<td>+$3.96</td>
<td>X 1.021</td>
<td>$127.83</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$143.88</td>
<td>X 1.0012</td>
<td>+$4.70</td>
<td>X 1.021</td>
<td>$151.88</td>
</tr>
</tbody>
</table>

### Table 4: For HHAs that DO NOT Submit Quality Data – CY 2015 National Per-Visit Amounts for LUPAs and Outlier Calculations Updated by the MFP adjusted HH Market Basket Update, Before Wage Index Adjustment

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2014 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2015 Rebasing Adjustment</th>
<th>CY 2015 HH Payment Update Percentage Minus 2 Percentage Points</th>
<th>CY 2015 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$54.84</td>
<td>X 1.0012</td>
<td>+$1.79</td>
<td>X 1.001</td>
<td>$56.75</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$194.12</td>
<td>X 1.0012</td>
<td>+$6.34</td>
<td>X 1.001</td>
<td>$200.89</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$133.30</td>
<td>X 1.0012</td>
<td>+$4.35</td>
<td>X 1.001</td>
<td>$137.95</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$132.40</td>
<td>X 1.0012</td>
<td>+$4.32</td>
<td>X 1.001</td>
<td>$137.02</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$121.10</td>
<td>X 1.0012</td>
<td>+$3.96</td>
<td>X 1.001</td>
<td>$125.33</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$143.88</td>
<td>X 1.0012</td>
<td>+$4.70</td>
<td>X 1.001</td>
<td>$148.90</td>
</tr>
</tbody>
</table>

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

Low-Utilization Payment Adjustment (LUPA) episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. Beginning in CY 2014, CMS calculates the payment for the first visit in a LUPA episode by multiplying the per-visit rate by a LUPA add-on factor specific to the type of visit (skilled nursing, physical therapy, or speech-language pathology). The specific requirements for the new LUPA add-on calculation are described in Transmittal 2796 dated September 27, 2013. The CY 2015 LUPA add-on adjustment factors are displayed in Table 5.

Table 5: CY 2015 LUPA Add-On factors

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>Add-On Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td>1.8451</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>1.6700</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>1.6266</td>
</tr>
</tbody>
</table>

Non-Routine Supply Payments

Payments for Non-Routine Supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by the NRS conversion factor. To determine the CY 2015 NRS conversion factor, CMS starts with the CY 2014 NRS conversion factor ($53.65) and applies a 2.82 percent rebasing adjustment calculated in the CY 2015 final rule (1 - 0.0282 = 0.9718). CMS then updates the conversion factor by the MFP adjusted HH market basket update of 2.1 percent for HHAs that do submit the required quality data and by 0.1 percent for HHAs that do not submit quality data. CMS does not apply a standardization factor as the NRS payment amount calculated from the conversion factor is not wage or case-mix adjusted when the final claim payment amount is computed. The NRS conversion factor for CY 2015 payments for HHAs that do submit the required quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b. The NRS conversion factor for CY 2015 payments for HHAs that do not submit quality data is shown in Table 7a and the payment amounts for the various NRS severity levels are shown in Table 7b.

Table 6a: CY 2015 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2014 NRS Conversion Factor</th>
<th>2015 Rebasing Adjustment</th>
<th>CY 2015 HH Payment Update Percentage</th>
<th>CY 2015 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$53.65</td>
<td>X 0.9718</td>
<td>X 1.021</td>
<td>$53.23</td>
</tr>
</tbody>
</table>

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
Table 6b: CY 2015 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2015 NRS Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.36</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$51.86</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$142.19</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$211.25</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$325.76</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$560.27</td>
</tr>
</tbody>
</table>

Table 7a: CY 2015 NRS Conversion Factor for HHAs that DO NOT Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2014 NRS Conversion Factor</th>
<th>2015 Rebasing Adjustment</th>
<th>CY 2015 HH Payment Update Percentage minus 2 Percentage Points</th>
<th>CY 2015 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$53.65</td>
<td>X 0.9718</td>
<td>X 1.001</td>
<td>$52.19</td>
</tr>
</tbody>
</table>

Table 7b: CY 2015 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2015 NRS Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.08</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$50.84</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$139.41</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$207.12</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$319.39</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$549.32</td>
</tr>
</tbody>
</table>

**Rural Add-on**

Section 3131(c) of the Affordable Care Act applies a 3 percent rural add-on to the national standardized 60-day episode rate, national per-visit payment rates, LUPA add-on payments, and the NRS conversion factor when home health services are provided in rural (non-urban) areas.

Disclaimer

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

CPT only copyright 2013 American Medical Association.
CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2016. The following tables show the CY 2015 rural payment rates.

**Table 8a: CY 2015 Payment Amounts for 60-Day Episodes for Services Provided in a Rural Area before Case-Mix and Wage Index Adjustment for HHAs that DO Submit Quality Data**

<table>
<thead>
<tr>
<th>CY 2015 National, Standardized 60-Day Episode Payment Rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural National, Standardized 60-Day Episode Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,961.38</td>
<td>X 1.03</td>
<td>$3,050.22</td>
</tr>
</tbody>
</table>

**Table 8b: CY 2015 Payment Amounts for 60-Day Episodes for Services Provided in a Rural Area before Case-Mix and Wage Index Adjustment for HHAs that DO NOT Submit Quality Data**

<table>
<thead>
<tr>
<th>CY 2015 National Standardized 60-Day Episode Payment Rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural National, Standardized 60-Day Episode Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,903.37</td>
<td>X 1.03</td>
<td>$2,990.47</td>
</tr>
</tbody>
</table>

**Table 9a: CY 2015 Per-Visit Amounts for Services Provided in a Rural Area, Before Wage Index Adjustment for HHAs that DO Submit Quality Data**

<table>
<thead>
<tr>
<th>Home Health Discipline Type</th>
<th>CY 2015 Per-visit rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural per-visit rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH Aide</td>
<td>$57.89</td>
<td>X 1.03</td>
<td>$59.63</td>
</tr>
<tr>
<td>MSS</td>
<td>$204.91</td>
<td>X 1.03</td>
<td>$211.06</td>
</tr>
<tr>
<td>OT</td>
<td>$140.70</td>
<td>X 1.03</td>
<td>$144.92</td>
</tr>
<tr>
<td>PT</td>
<td>$139.75</td>
<td>X 1.03</td>
<td>$143.94</td>
</tr>
<tr>
<td>SN</td>
<td>$127.83</td>
<td>X 1.03</td>
<td>$131.66</td>
</tr>
<tr>
<td>SLP</td>
<td>$151.88</td>
<td>X 1.03</td>
<td>$156.44</td>
</tr>
</tbody>
</table>

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.
Table 9b: CY 2015 Per-Visit Amounts for Services Provided in a Rural Area, Before Wage Index Adjustment for HHAs that DO NOT submit quality data

<table>
<thead>
<tr>
<th>Home Health Discipline Type</th>
<th>CY 2015 Per-visit rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural per-visit rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH Aide</td>
<td>$56.75</td>
<td>X 1.03</td>
<td>$58.45</td>
</tr>
<tr>
<td>MSS</td>
<td>$200.89</td>
<td>X 1.03</td>
<td>$206.92</td>
</tr>
<tr>
<td>OT</td>
<td>$137.95</td>
<td>X 1.03</td>
<td>$142.09</td>
</tr>
<tr>
<td>PT</td>
<td>$137.02</td>
<td>X 1.03</td>
<td>$141.13</td>
</tr>
<tr>
<td>SN</td>
<td>$125.33</td>
<td>X 1.03</td>
<td>$129.09</td>
</tr>
<tr>
<td>SLP</td>
<td>$148.90</td>
<td>X 1.03</td>
<td>$153.37</td>
</tr>
</tbody>
</table>

Table 10a: CY 2015 Conversion Factor for Services Provided in Rural Areas for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>CY 2015 Conversion Factor</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$53.23</td>
<td>X 1.03</td>
<td>$54.83</td>
</tr>
</tbody>
</table>

Table 10b: CY 2015 Conversion Factor for Services Provided in Rural Areas for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>CY 2015 Conversion Factor</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2015 Rural Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$52.19</td>
<td>X 1.03</td>
<td>$53.76</td>
</tr>
</tbody>
</table>
Table 10c: CY 2015 Relative Weights and Payment Amounts for the 6-Severity NRS System for Services Provided in Rural Areas for HHAs that DO submit quality data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>Total CY 2015 NRS Payment Amount for Rural Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.79</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$53.42</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$146.46</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$217.60</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$335.55</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$577.11</td>
</tr>
</tbody>
</table>

Table 10d: CY 2015 Relative Weights and Payment Amounts for the 6-Severity NRS System for Services Provided in Rural Areas for HHAs that DO NOT submit quality data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>Total CY 2015 NRS Payment Amount for Rural Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.50</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$52.37</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$143.60</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$213.35</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$329.00</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$565.85</td>
</tr>
</tbody>
</table>

These changes are to be implemented through the Home Health Pricer software found in Medicare contractor standard systems.

HHAs should remember to:

- Submit the Core Based Statistical Area (CBSA) code or special wage index code corresponding to the state and county of the beneficiary’s place of residence in value code 61 on home health Requests for Anticipated Payments (RAPs) and claims;

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

CPT only copyright 2013 American Medical Association.
Use the wage index table attached to CR8969, which associates states and counties to CBSA codes (codes in the range 10020 – 49780 and 999xx rural state codes) to determine the code to report in value code 61;

Use the codes in the range 50xxx in the wage index table attached to CR8969 to determine the code to report in value code 61 if the provider serves beneficiaries in areas where there is more than one unique CBSA due to the wage index transition.

Additional Information

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

Note: This article was revised on December 8, 2014, to reflect the revised CR8978 issued on December 2. In the article, the CR release date, transmittal numbers, and the Web addresses for accessing CR8978 are revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

Disclaimer

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


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

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

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

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

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

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

CPT only copyright 2013 American Medical Association.
The consolidated billing requirements for drugs and biologicals included in the ESRD PPS will be updated to include Health Care Procedure Coding System (HCPCS) code J3480 (Injection, potassium chloride, per 2 meq). It is a composite rate drug and therefore, is not eligible for outlier consideration.

Regarding the calculation for outlier payments, there is a correction to the mean unit cost associated with the oral equivalent drug, Hectorol (doxercalciferol) 0.5 mcg capsule and 1 mcg capsule, applicable to claims with dates of service in 2014. Facilities that believe the mean unit cost corrections may impact their outlier payments for claims in 2014, should submit adjustments to their claims within 6 months from the effective date of CR8978. MACs will be instructed to override timely filing if necessary.

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

**Calendar year (CY) 2015 ESRD PPS Updates:**

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

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

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

**Outlier Policy:**
CMS will make the following updates to the adjusted average outlier service Medicare Allowable Payment (MAP) amount per treatment:
1. For adult patients, the adjusted average outlier service MAP amount per treatment is $51.29.
2. For pediatric patients, the adjusted average outlier service MAP amount per treatment is $43.57.

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

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

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

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

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

Additional Information


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

- “Heart-Wise: AHRQ and Million Hearts Share Evidence and Outcomes for Cardiovascular Disease (CVD)” Web-Based Training (WBT). See course description for continuing education credit.

MLN Matters® Number: MM8981 Related Change Request (CR) #: CR 8981
Related CR Release Date: December 12, 2014 Effective Date: January 1, 2015
Related CR Transmittal #: R201BP Implementation Date: January 5, 2015

2015 Update of the Medicare Benefit Policy Manual, Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services

Provider Types Affected

This MLN Matters® Article is intended for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8981 advises MACs of updates to Chapter 13 of the "Medicare Benefit Policy Manual.” These updates include new and clarifying information on the FQHC Prospective Payment System (PPS) rate, adjustments, payment codes, and qualifying visits; RHC employment requirements; RHC and FQHC preventive health services; and other issues related to RHC and FQHC billing and services.

Disclaimer

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

The Centers for Medicare & Medicaid Services (CMS) has released an update to the “Medicare Benefit Policy Manual,” Chapter 13, Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services.” Some of the key section updates as a result of CR8981 are as follows:

- **Section 10.1 - RHC General Information**  
  **Clarification** - A provider-based CMS Certification Number is not an indication that the RHC has a provider-based determination for purposes of an exception to the payment limit.

- **Section 10.2 - FQHC General Information**  
  **New** - On or after October 1, 2014, FQHCs began to transition to the FQHC PPS as required by Section 10501(i)(3)(B) of the Affordable Care Act.

- **Section 30.1.1 – RHC Requirements**  
  **Clarification** - An Advanced Practice Registered Nurse who is not a Nurse Practitioner (NP), or Physician Assistant (PA), or a NP or PA who is working as a substitute in an arrangement similar to a locum tenens physician, would not satisfy the RHC employment requirements.

  **New** - As of July 1, 2014, RHCs may contract with NPs, PAs, certified nurse midwives, clinical psychologists, or clinical social workers as long as at least one NP or PA is employed by the RHC (subject to the waiver provision for existing RHCs set forth at Section 1861(aa)(7) of the Social Security Act).

- **Section 40 - RHC and FQHC Visits**  
  **New** - A list of qualifying visits for FQHCs paid under the PPS is located on the FQHC PPS webpage at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html) on the CMS website.

- **Section 40.3 - Multiple Visits on Same Day and Exceptions**  
  **Clarification** - Except as noted below, encounters with more than one RHC or FQHC practitioner on the same day, or multiple encounters with the same RHC or FQHC practitioner on the same day, constitute a single RHC or FQHC visit and is payable as one visit. This policy applies regardless of the length or complexity of the visit, the number or type of practitioners seen, whether the second visit is a scheduled or unscheduled appointment, or whether the first visit is related or unrelated to the subsequent visit. This would include situations where a RHC or FQHC patient has a medically-necessary face-to-face visit with a RHC or FQHC practitioner, and is then seen by another RHC or FQHC practitioner, including a specialist, for further evaluation of the same condition on the same day, or is then seen by another RHC or FQHC practitioner (including a specialist) for evaluation of a different condition on the same day.

  **New** - Exceptions for FQHCs that are authorized to bill under the PPS

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC or FQHC) (2 visits can be billed), or
- The patient has a medical visit and a mental health visit on the same day (2 visits can be billed).

- **50.1 - RHC Services**  
  **New** – RHC services includes Hepatitis C screenings.

  **Clarification** - Except for influenza and pneumococcal vaccines and their administration, which are paid through the cost report, RHCs are paid for the professional component of these services based on their AIR.

- **50.2 – FQHC Services**  
  **New** – FQHC services includes Hepatitis C screenings.

  **Clarification/New** - Except for influenza and pneumococcal vaccines and their administration which are paid through the cost report, FQHCs are paid for the professional component of these services based on their AIR, or, for FQHCs that are authorized to bill under the PPS, based on the lesser of the FQHC’s charge or the PPS rate for the specific payment code.

- **Section 70.1.2 – FQHC Per-Visit Payment Limit**  
  **New** – FQHCs that bill under the AIR and are located within a Metropolitan Statistical Area are considered urban FQHCs. MSAs are Core-Based Statistical Areas that are associated with at least one urbanized area that has a population of at least 50,000 people.

- **Section 70.2 – FQHCs Billing Under the PPS Payment Rate and Adjustments**  
  **New** - For FQHCs that are authorized to bill under the PPS, Medicare pays 80 percent of the lesser of the FQHC’s charge or the PPS payment rate for the specific payment code, unless otherwise noted. The PPS payment rate reflects a base rate that is the same for all FQHCs, a geographic adjustment, and other applicable adjustments as described below. The PPS base rate will be updated annually by the Medicare Economic Index (MEI) or by a FQHC market basket.

  **Geographic Adjustment:** The PPS base rate will be adjusted for each FQHC based on its location by the FQHC Geographic Adjustment Factor (FQHC GAF). The PPS payment rate is the PPS base rate multiplied by the FQHC GAF for the location where the service is furnished. Since the FQHC GAF is based on where the services are furnished, the FQHC payment rate may differ among FQHC sites within the same organization. FQHC GAFs are available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html) on the CMS website.

  **New Patient Adjustment:** The PPS payment rate will be adjusted by a factor of 1.3416 when a FQHC furnishes care to a patient who is new to the FQHC. A new patient is someone who has not received any professional health services (medical or mental health) from any site.
within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service.

**IPPE and AWV Adjustment:** The PPS payment rate will be adjusted by a factor of 1.3416 when a FQHC furnishes an IPPE or an Annual Wellness Visit (AWV) to a Medicare beneficiary.

- **Section 70.2.1 – Payment Codes for FQHCs Billing Under the PPS**
  - **New** - FQHCs that are authorized to bill under the PPS must include a FQHC payment code on their claim for payment. FQHCs set their own charges for services they provide and determine which services are included in the bundle of services associated with each FQHC G-code. The five specific payment codes to be used by FQHCs submitting claims under the PPS are:
    - G0466 – FQHC visit, new patient
    - G0467 – FQHC visit, established patient
    - G0468 – FQHC visit, Initial Preventative Physical Exam (IPPE) or AWV
    - G0469 – FQHC visit, mental health, new patient
    - G0470 – FQHC visit, mental health, established patient

- **Section 70.3 - Cost Reports**
  - **New** - FQHCs that are authorized to bill under the FQHC PPS are required to file a cost report annually and are paid for the costs of GME, bad debt, and influenza and pneumococcal vaccines and their administration through the cost report.

- **Section 70.4 – Productivity Standards**
  - **New** - FQHCs that are authorized to bill under the FQHC PPS are not subject to the productivity standards.

- **Section 80 - RHC and FQHC Patient Charges, Coinsurance, Deductible, and Waivers**
  - **New** - For FQHCs billing under the PPS, the coinsurance is 20 percent of the lesser of the FQHC’s charge for the specific payment code or the PPS rate.

- **Section 100.4 – Transitional Care Management (TCM) Services**
  - **Clarification** - TCM services can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC or FQHC practitioner and it meets the TCM billing requirements. If it is furnished on the same day as another visit, only one visit can be billed.

- **Section 110.3 - Payment for Incident to Services and Supplies**
  - **Clarification** - If a Medicare-covered Part B drug is furnished by a RHC or FQHC practitioner to a Medicare patient as part of a billable visit, the cost of the drug and its administration is included in the RHC or FQHC’s AIR or the FQHC’s PPS payment. RHCs and FQHCs cannot bill separately for Part B drugs or other incident to services or supplies.

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

CPT only copyright 2013 American Medical Association.
• **Section 170 - Physical and Occupational Therapy**
  New - PT and OT therapists who provide services incident to a physician, NP, or PA visit may be an employee of the RHC or FQHC or contracted to the RHC or FQHC.

• **Section 190 - Telehealth Services**
  Clarification - RHCs and FQHCs are not authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner at the time the telehealth service is furnished, and may not bill or include the cost of a visit on the cost report. This includes telehealth services that are furnished by a RHC or FQHC practitioner who is employed by or under contract with the RHC or FQHC, or a non-RHC or FQHC practitioner furnishing services through a direct or indirect contract.

• **Section 210 - Preventive Health Services**
  Clarification - RHCs and FQHCs are paid for the professional component of allowable preventive services when all of the program requirements are met. The beneficiary copayment and deductible (where applicable) is waived by the Affordable Care Act for the IPPE and AWV, and for Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. Healthcare Common Procedure Coding System (HCPCS) coding is required on all claims to allow for the coinsurance and deductible to be waived.

• **Section 210.1 - Preventive Health Services in RHCs**
  Clarification – HCPCS codes, payment and billing, and coinsurance and deductible information is provided for Influenza (G0008) and Pneumococcal Vaccines (G0009), Hepatitis B Vaccine (G0010), Initial Preventive Physical Exam (G0402), Annual Wellness Visit (G0438 and G0439), Screening Pelvic and Clinical Breast Examination (G0101), Screening Papanicolaou Smear (Q0091); Prostate Cancer Screening (G0102), and Glaucoma Screening (G0117 and G0118).

  New - **Hepatitis C Screening (GO472)**
  Hepatitis C screening is included in a RHC visit and is not separately billable. The cost of the professional component of the screening can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if this is the only service the RHC provides. Effective for claims with dates of service on or after June 2, 2014, the beneficiary coinsurance and deductible are waived.

• **210.3 - Preventive Health Services in FQHCs**
  Clarification - HCPCS codes, payment and billing, and coinsurance information is provided for Influenza and Pneumococcal Vaccines G0009), Hepatitis B Vaccine (G0010), Initial Preventive Physical Exam (G0402), Annual Wellness Visit (G0438 and G0439), Diabetes Counseling and Medical Nutrition Services, Screening Pelvic and Clinical Breast Examination (G0101), Screening Papanicolaou Smear (Q0091), Prostate Cancer Screening (G0102), Glaucoma Screening (G0117 and G0118).
New - Hepatitis C Screening (GO472)
Hepatitis C screening is included in a FQHC visit and is not separately billable. The cost of the professional component of the screening can be included in the line item for the otherwise qualifying visit. A visit cannot be billed if this is the only service the FQHC provides. Effective for claims with dates of service on or after June 2, 2014, the beneficiary coinsurance is waived.

- Section 210.4 - Copayment for FQHC Preventive Health Services
  Clarification - When one or more qualified preventive service is provided as part of a FQHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary copayment. For example, if the total charge for the visit is $150, and $50 of that is for a qualified preventive service, the beneficiary copayment is based on $100 of the total charge, and Medicare would pay 80 percent of the $100, and 100 percent of the $50. If no other FQHC service took place along with the preventive service, there would be no copayment applied, and Medicare would pay 100 percent of the payment amount.

New - FQHCs that are authorized to bill under the FQHC PPS would follow the same process, but would deduct the total charges for the preventive services from the lesser of the FQHC’s charge or the PPS rate.

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

CPT only copyright 2013 American Medical Association.
MLN Matters® Articles Index: Have you ever tried to search MLN Matters® articles for information regarding a certain issue, but you did not know what year it was published? To assist you next time in your search, try the CMS article indexes that are published at [http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/MLNMattersArticles](http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/MLNMattersArticles) on the CMS website. These indexes resemble the index in the back of a book and contain keywords found in the articles, including HCPCS codes and modifiers. These are published every month. Just search for a keyword(s) and you will find articles that contain those word(s). Then just click on one of the related article numbers and it will open that document. Give it a try.

MLN Matters® Number: MM9014 Related Change Request (CR) #: CR 9014
Related CR Release Date: December 22, 2014 Effective Date: January 1, 2015
Related CR Transmittal #: R3156CP Implementation Date: January 5, 2015

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

Note: This article was revised on December 23, 2014, based on a revised Change Request (CR) that corrected some values in Table 8, which addressed changes to the Outpatient Provider Specific File. That Table is in Attachment A of the CR, but was not included in this article. The CR Release Date, transmittal number and link to the CR was also changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS).
Provider Action Needed

Change Request (CR) 9014 describes changes to and billing instructions for various payment policies implemented in the January 2015 OPPS update. Make sure your billing staffs are aware of these changes.

Background

CR9014 describes changes to and billing instructions for various payment policies implemented in the January 2015 Outpatient Prospective Payment System (OPPS) update. The January 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, Status Indicators (SIs) and Revenue Code additions, changes, and deletions identified in CR 9014.


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

**New Service**

The new service listed in Table 1 is assigned for payment under the OPPS, effective January 1, 2015.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Effective Date</th>
<th>SI</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>Payment</th>
<th>Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9742</td>
<td>01/01/2015</td>
<td>T</td>
<td>0073</td>
<td>Laryngoscopy with injection</td>
<td>Laryngoscopy, flexible fiberoptic, with injection into vocal cord(s), therapeutic, including diagnostic laryngoscopy, if performed</td>
<td>$1259.06</td>
<td>$251.82</td>
</tr>
</tbody>
</table>

**New Device Pass-Through Categories**

The Social Security Act (Section 1833(t)(6)(B); see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) requires that, under the OPPS,
categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Social Security Act (the Act) requires that CMS create additional categories for transitional pass-through payment of new medical devices not described by existing or previously existing categories of devices.

CMS is establishing one new device pass-through category as of January 1, 2015. Table 2 provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment.

**Table 2 – New Device Pass-Through Code**

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Effective Date</th>
<th>SI</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>Device Offset from Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2624</td>
<td>01/01/15</td>
<td>H</td>
<td>2624</td>
<td>Wireless pressure sensor</td>
<td>Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components</td>
<td>$310.33</td>
</tr>
</tbody>
</table>

**a. Device Offset from Payment:** Section 1833(t)(6)(D)(ii) of the Act requires that CMS deduct from pass-through payments for devices an amount that reflects the portion of the APC payment amount that CMS determines is associated with the cost of the device (70 FR 68627-8).

CMS has determined that a portion of the APC payment amount associated with the cost of C2624 is reflected in APC 0080, Diagnostic Cardiac Catheterization. The C2624 device should always be billed with procedure code C9741 (Right heart catheterization with implantation of wireless pressure sensor in the pulmonary artery, including any type of measurement, angiography, imaging supervision, interpretation, and report), which is assigned to APC 0080 for CY 2015. The device offset from payment represents a deduction from pass-through payments for the device in category C2624. Therefore, CMS is establishing the offset amount for C2624 to be that of APC 0080, $310.33, which will be deducted from pass-through payment.

**Comprehensive APCs**

For CY 2015, CMS is creating a new category of codes, called “Comprehensive APCs,” for which CMS provides a **single claim payment**. Through OCE logic, the PRICER will automatically assign payment for a “Comprehensive APC” service reported on a claim. Both the OCE and the PRICER will implement these new policies without any coding change required on the part of hospitals.
Effective January 1, 2015, comprehensive APCs (Identified by a new Status Indicator, J1) provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service.

CMS is updating the “Medicare Claims Processing Manual,” (Chapter 4,, by adding Section 10.2.3 and revising Section 10.4 to reflect comprehensive APC payment policies. The added Section 10.2.3 (Comprehensive APCs) and revised Section 10.4 (Packaging) are included in CR9014. The added Section 10.2.3 states the following:

HCPCS codes assigned to comprehensive APCs are designated with status indicator J1, See Addendum B at www.cms.hhs.gov/HospitalOutpatientPPS/ for the list of HCPCS codes designated with status indicator J1.

Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:

- Major OPPS procedure codes (status indicators P, S, T, V);
- Lower ranked comprehensive procedure codes (status indicator J1);
- Non-pass-through drugs and biologicals (status indicator K);
- Blood products (status indicator R);
- DME (status indicator Y); and
- Therapy services (HCPCS codes with status indicator A reported on therapy revenue centers).

The following services are excluded from comprehensive APC packaging:

- Brachytherapy sources (status indicator U);
- Pass-through drugs, biologicals and devices (status indicators G or H);
- Corneal tissue, CRNA services, and Hepatitis B vaccinations (status indicator F);
- Influenza and pneumococcal pneumonia vaccine services (status indicator L);
- Ambulance services;
- Mammography; and
- Certain preventive services

The single payment for a comprehensive claim is based on the rate associated with the J1 service. When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service. When certain pairs of J1 services (or in certain cases a J1 service and an add-on code) are reported on the same claim, the claim is eligible for a complexity adjustment, which provides a single payment for the claim based on the rate of the next higher comprehensive APC within the same clinical family. Note that complexity adjustments will not be applied to discontinued services (reported with modifier -73 or -74).
Billing for Corneal Tissue

CMS reminds hospitals that according to the “Medicare Claims Processing Manual” (Chapter 4, Section 200.1 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf), the corneal tissue is paid on a cost basis and not under the OPPS. To receive cost based reimbursement for corneal tissue, hospitals must bill charges for corneal tissue using HCPCS code V2785.

Billing for Mobile Cardiac Telemetry Monitoring Services

Current Procedural Terminology (CPT) code 93229 describes wearable mobile cardiovascular telemetry services. As instructed in the CY 2015 OPPS/ASC final rule, CPT code 93229 should be used to report continuous outpatient cardiovascular monitoring that includes up to 30 consecutive days of real-time cardiac monitoring. In particular, the 2015 CPT Code Book defines CPT code 93229 as:

“Mobile Cardiovascular Telemetry (MCT): continuously records the electrocardiographic rhythm from external electrodes placed on the patient's body. Segments of the ECG data are automatically (without patient intervention) transmitted to a remote surveillance location by cellular or landline telephone signal. The segments of the rhythm, selected for transmission, are triggered automatically (MCT device algorithm) by rapid and slow heart rates or by the patient during a symptomatic episode. There is continuous real time data analysis by preprogrammed algorithms in the device and attended surveillance of the transmitted rhythm segments by a surveillance center technician to evaluate any arrhythmias and to determine signal quality. The surveillance center technician reviews the data and notifies the physician or other qualified health care professional depending on the prescribed criteria” (2015 CPT Professional Edition; page 578).

CMS expects that hospitals will report CPT code 93229 on hospital claims only when they have provided the mobile telemetry service as described above.

For information on the APC assignment, OPPS status indicator, and payment rate for CPT code 93229 effective January 1, 2015, refer to Addendum B of the January 2015 OPPS Update that is posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html on the CMS website.

Billing for “Sometimes Therapy” Services that May be Paid as Non-Therapy Services for Hospital Outpatients

The Social Security Act (Section 1834(k); see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm, as added by Section 4541 of the Balanced Budget Act (BBA), allows payment at 80 percent of the lesser of the actual charge for the services or the applicable fee schedule amount for all outpatient therapy services; that is, physical therapy services, speech-language pathology services, and occupational therapy services. As provided under Section 1834(k)(5) of the Act, a therapy code list was created based on a uniform coding system

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

CPT only copyright 2013 American Medical Association.
(that is, the HCPCS) to identify and track these outpatient therapy services paid under the Medicare Physician Fee Schedule (MPFS).

The list of therapy codes, along with their respective designation, can be found at http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage on the CMS website. Two of the designations that are used for therapy services are: “always therapy” and “sometimes therapy.” An “always therapy” service must be performed by a qualified therapist under a certified therapy plan of care, and a “sometimes therapy” service may be performed by physician or a non-physician practitioner outside of a certified therapy plan of care.

Under the OPPS, separate payment is provided for certain services designated as “sometimes therapy” services if these services are furnished to hospital outpatients as a non-therapy service, that is, without a certified therapy plan of care. Specifically, to be paid under the OPPS for a non-therapy service, hospitals SHOULD NOT append the therapy modifier GP (physical therapy), GO (occupational therapy), or GN (speech language pathology), or report a therapy revenue code 042x, 043x, or 044x in association with the “sometimes therapy” codes listed in Table 3 below.

To receive payment under the MPFS, when “sometimes therapy” services are performed by a qualified therapist under a certified therapy plan of care, providers should append the appropriate therapy modifier GP, GO, or GN, and report the charges under an appropriate therapy revenue code, specifically 042x, 043x, or 044x. This instruction does not apply to claims for “sometimes therapy” codes furnished as non-therapy services in the hospital outpatient department and paid under the OPPS.

Effective January 1, 2015, two HCPCS codes designated as “Sometimes Therapy” services, G0456 (Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters) and G0457 (Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters) would be terminated and replaced with two new CPT codes 97607 (Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters) and 97608 (Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters).

The list of HCPCS codes designated as “sometimes therapy” services that may be paid as non-therapy services when furnished to hospital outpatients is displayed in Table 3.
Table 3 – Services Designated as “Sometimes Therapy” that May be Paid as Non-Therapy Services for Hospital Outpatients

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>92520</td>
<td>Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)</td>
</tr>
<tr>
<td>97597</td>
<td>Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (for example, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters</td>
</tr>
<tr>
<td>97598</td>
<td>Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (for example, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters</td>
</tr>
<tr>
<td>97602</td>
<td>Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (for example, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session</td>
</tr>
<tr>
<td>97605</td>
<td>Negative pressure wound therapy (for example, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters</td>
</tr>
<tr>
<td>97606</td>
<td>Negative pressure wound therapy (for example, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters</td>
</tr>
<tr>
<td>97607</td>
<td>Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters</td>
</tr>
<tr>
<td>97608</td>
<td>Negative pressure wound therapy, (for example, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters</td>
</tr>
<tr>
<td>97610</td>
<td>Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day</td>
</tr>
</tbody>
</table>

**New Laboratory HCPCS G-codes Effective January 1, 2015**

For the CY 2015 update, the CPT Editorial Panel deleted several laboratory services on December 31, 2014 and replaced them with new CPT codes effective January 1, 2015. Because the laboratory services described by the 2014 CPT codes (which are being deleted) will continue to be paid under the Clinical Lab Fee Schedule (CLFS) in 2015, Medicare has established the following HCPCS G-
codes to replace the deleted CPT codes for these laboratory services. Under the hospital OPPS, the HCPCS G-codes are assigned to status indicator “N” (packaged) effective January 1, 2015. In addition, the new laboratory CY 2015 CPT codes that replaced the deleted laboratory CY 2014 CPT codes have been assigned to status indicator “B” to indicate that another code should be reported under the hospital OPPS. The list of the new HCPCS G-codes and their predecessor CPT codes are in Table 4.

### Table 4—New HCPCS G-codes and their Predecessor CPT codes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>80102</td>
<td>Drug confirmation, each procedure</td>
<td>G6058</td>
<td>Drug confirmation, each procedure</td>
<td>N</td>
</tr>
<tr>
<td>80152</td>
<td>Amitriptyline</td>
<td>G6030</td>
<td>Amitriptyline</td>
<td>N</td>
</tr>
<tr>
<td>80154</td>
<td>Benzodiazepines</td>
<td>G6031</td>
<td>Benzodiazepines</td>
<td>N</td>
</tr>
<tr>
<td>80160</td>
<td>Desipramine</td>
<td>G6032</td>
<td>Desipramine</td>
<td>N</td>
</tr>
<tr>
<td>80166</td>
<td>Doxepin</td>
<td>G6034</td>
<td>Doxepin</td>
<td>N</td>
</tr>
<tr>
<td>80172</td>
<td>Gold</td>
<td>G6035</td>
<td>Gold</td>
<td>N</td>
</tr>
<tr>
<td>80174</td>
<td>Imipramine</td>
<td>G6036</td>
<td>Imipramine</td>
<td>N</td>
</tr>
<tr>
<td>80182</td>
<td>Nortriptyline</td>
<td>G6037</td>
<td>Nortriptyline</td>
<td>N</td>
</tr>
<tr>
<td>80196</td>
<td>Salicylate</td>
<td>G6038</td>
<td>Salicylate</td>
<td>N</td>
</tr>
<tr>
<td>82003</td>
<td>Acetaminophen</td>
<td>G6039</td>
<td>Acetaminophen</td>
<td>N</td>
</tr>
<tr>
<td>82055</td>
<td>Alcohol (ethanol); any specimen except breath</td>
<td>G6040</td>
<td>Alcohol (ethanol); any specimen except breath</td>
<td>N</td>
</tr>
<tr>
<td>82101</td>
<td>Alkaloids, urine, quantitative</td>
<td>G6041</td>
<td>Alkaloids, urine, quantitative</td>
<td>N</td>
</tr>
<tr>
<td>82145</td>
<td>Amphetamine or methamphetamine</td>
<td>G6042</td>
<td>Amphetamine or methamphetamine</td>
<td>N</td>
</tr>
<tr>
<td>82205</td>
<td>Barbiturates, not elsewhere specified</td>
<td>G6043</td>
<td>Barbiturates, not elsewhere specified</td>
<td>N</td>
</tr>
<tr>
<td>82520</td>
<td>Cocaine or metabolite</td>
<td>G6044</td>
<td>Cocaine or metabolite</td>
<td>N</td>
</tr>
<tr>
<td>82646</td>
<td>Dihydrocodeinone</td>
<td>G6045</td>
<td>Dihydrocodeinone</td>
<td>N</td>
</tr>
</tbody>
</table>
### 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.”

As stated in Chapter VIII, Section D, Item 20 of the CY 2015 “National Correct Coding Initiative (NCCI) Policy Manual,” 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.

### Disclaimer

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

CPT only copyright 2013 American Medical Association.
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 J3490 (Unclassified drugs), regardless of the site of service of the surgery, and are packaged as surgical supplies in both the HOPD and the 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; http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf on the CMS website) 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. **New CY 2015 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals**

For CY 2015, several new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. These new codes are listed in Table 5.

**Table 5 – New CY 2015 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A9606</td>
<td>Radium ra-223 dichloride, therapeutic, per microcurie</td>
<td>K</td>
<td>1745</td>
</tr>
<tr>
<td>C9027</td>
<td>Injection, pembrolizumab, 1 mg</td>
<td>G</td>
<td>1490</td>
</tr>
<tr>
<td>C9136</td>
<td>Injection, factor viii, fc fusion protein, (recombinant), per i.u.</td>
<td>G</td>
<td>1656</td>
</tr>
<tr>
<td>C9349</td>
<td>FortaDerm, and FortaDerm Antimicrobial, any type, per square centimeter</td>
<td>G</td>
<td>1657</td>
</tr>
<tr>
<td>C9442</td>
<td>Injection, belinostat, 10 mg</td>
<td>G</td>
<td>1658</td>
</tr>
<tr>
<td>C9443</td>
<td>Injection, dalbavancin, 10 mg</td>
<td>G</td>
<td>1659</td>
</tr>
<tr>
<td>C9444</td>
<td>Injection, oritavancin, 10 mg</td>
<td>G</td>
<td>1660</td>
</tr>
<tr>
<td>C9446</td>
<td>Injection, tedizolid phosphate, 1 mg</td>
<td>G</td>
<td>1662</td>
</tr>
<tr>
<td>C9447</td>
<td>Injection, phencylphrine and ketorolac, 4 ml vial</td>
<td>G</td>
<td>1663</td>
</tr>
<tr>
<td>J0571</td>
<td>Buprenorphine, oral, 1 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J0572</td>
<td>Buprenorphine/naloxone, oral, less than or equal to 3 mg</td>
<td>E</td>
<td></td>
</tr>
</tbody>
</table>

**Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
b. Other Changes to CY 2015 HCPCS and CPT Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Many HCPCS and CPT codes for drugs, biologicals, and radiopharmaceuticals have changes in their HCPCS and CPT code descriptors that will be effective in CY 2015. In addition, several temporary HCPCS C-codes have been deleted effective December 31, 2014, and replaced with permanent HCPCS codes in CY 2015. Hospitals should pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2015 HCPCS and CPT codes.

Table 6 below notes those drugs, biologicals, and radiopharmaceuticals that have changes in their HCPCS/CPT code, their long descriptor, or both. Each product’s CY 2014 HCPCS/CPT code and long descriptor are noted in the two left hand columns and the CY 2015 HCPCS/CPT code and long descriptor are noted in the adjacent right hand columns.

---

### Table 6: Changes to CY 2015 HCPCS and CPT Codes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>J0573</td>
<td>Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J0574</td>
<td>Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J0575</td>
<td>Buprenorphine/naloxone, oral, greater than 10 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J1826</td>
<td>Injection, interferon beta-1a, 30 mcg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J2704</td>
<td>Injection, Propofol, 10mg</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>J7182</td>
<td>Factor viii, (antihemophilic factor, recombinant), (novoeight), per iu</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J7301</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 13.5mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J7302</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>J7327</td>
<td>Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose</td>
<td>K</td>
<td>1747</td>
</tr>
<tr>
<td>J8565</td>
<td>Gefitinib, oral, 250 mg</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>Q4150</td>
<td>Allowrap dds or dry, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4151</td>
<td>Amnioband or guardian, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4152</td>
<td>Dermapure, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4153</td>
<td>Dermavest, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4154</td>
<td>Biovance, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4155</td>
<td>Neoxflo or Clarixflo, 1 mg</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4156</td>
<td>Neox 100, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4157</td>
<td>Revitalon, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4158</td>
<td>Marigen, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4159</td>
<td>Affinity, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Q4160</td>
<td>Nushield, per square centimeter</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

---

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
### Table 6 – Other CY 2015 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>J7195</td>
<td>Factor ix (antihemophilic factor, recombinant) per i.u.</td>
<td>J7195</td>
<td>Injection, Factor ix (antihemophilic factor, recombinant) per i.u., not otherwise specified</td>
</tr>
<tr>
<td>J7301</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5mg</td>
<td>J7301</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 13.5mg</td>
</tr>
<tr>
<td>Q4119</td>
<td>Matristem wound matrix, psmx, rs, or psm, per square centimeter</td>
<td>Q4119</td>
<td>Matristem wound matrix, per square centimeter</td>
</tr>
<tr>
<td>Q4147</td>
<td>Architect, extracellular matrix, per square centimeter</td>
<td>Q4147</td>
<td>Architect, architect px, or architect fx, extracellular matrix, per square centimeter</td>
</tr>
<tr>
<td>C9021</td>
<td>Injection, obinutuzumab, 10 mg</td>
<td>J9301</td>
<td>Injection, obinutuzumab, 10 mg</td>
</tr>
<tr>
<td>C9022</td>
<td>Injection, elosulfase alfa, 1mg</td>
<td>J1322</td>
<td>Injection, elosulfase alfa, 1mg</td>
</tr>
<tr>
<td>C9023</td>
<td>Injection, testosterone undecanoate, 1mg</td>
<td>J3145</td>
<td>Injection, testosterone undecanoate, 1mg</td>
</tr>
<tr>
<td>C9133</td>
<td>Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.</td>
<td>J7200</td>
<td>Factor ix (antihemophilic factor, recombinant), Rixubis, per i.u.</td>
</tr>
<tr>
<td>C9134</td>
<td>Factor XIII (antihemophilic factor, recombinant), Tretten, per i.u.</td>
<td>J7181</td>
<td>Factor XIII (antihemophilic factor, recombinant), Tretten, per i.u.</td>
</tr>
<tr>
<td>C9135</td>
<td>Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.</td>
<td>J7201</td>
<td>Factor ix (antihemophilic factor, recombinant), Alprolix, per i.u.</td>
</tr>
<tr>
<td>J0150</td>
<td>Injection, adenosine for therapeutic use, 6mg (not to be used to report any adenosine phosphate compounds, instead use a9270)</td>
<td>J0153</td>
<td>Injection, adenosine for therapeutic use, 6mg (not to be used to report any adenosine phosphate compounds, instead use a9270)</td>
</tr>
<tr>
<td>J0151</td>
<td>Injection, adenosine for diagnostic use, 1mg (not to be used to report any adenosine phosphate compounds, instead use a9270)</td>
<td>J0153</td>
<td>Injection, adenosine for diagnostic use, 1mg (not to be used to report any adenosine phosphate compounds, instead use a9270)</td>
</tr>
<tr>
<td>J1070</td>
<td>Injection, testosterone cypionate, up to 100mg</td>
<td>J1071</td>
<td>Injection, testosterone cypionate, 1mg</td>
</tr>
<tr>
<td>J1080</td>
<td>Injection, testosterone cypionate, 1cc, 200mg</td>
<td>J1071</td>
<td>Injection, testosterone cypionate, 1mg</td>
</tr>
<tr>
<td>J2271</td>
<td>Injection, morphine sulfate, 100mg</td>
<td>J2274</td>
<td>Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg</td>
</tr>
<tr>
<td>J2275</td>
<td>Injection, morphine sulfate (preservative-free sterile solution), per 10mg</td>
<td>J2274</td>
<td>Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg</td>
</tr>
</tbody>
</table>

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

CPT only copyright 2013 American Medical Association.
c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2015

For CY 2015, payment for nonpass-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.

Effective January 1, 2015, payment rates for many drugs and biologicals have changed from the values published in the CY 2015 OPPS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2014. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2015 release of the OPPS Pricer. CMS is not publishing the updated payment rates in this Change Request implementing the January 2015 update of the OPPS. However, the updated payment rates effective January 1, 2015, can be found in the January 2015 update of the OPPS Addendum A and Addendum B at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html) on the CMS website.

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

CPT only copyright 2013 American Medical Association.
d. Skin Substitute Procedure Edits

The payment for skin substitute products that do not qualify for pass-through status will be packaged into the payment for the associated skin substitute application procedure. The skin substitute products are divided into two groups: 1) high cost skin substitute products and 2) low cost skin substitute products for packaging purposes. Table 7 lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. CMS will implement an OPPS edit that requires hospitals to report all high-cost skin substitute products in combination with one of the skin application procedures described by CPT codes 15271-15278 and to report all low-cost skin substitute products in combination with one of the skin application procedures described by HCPCS codes C5271-C5278. All pass-through skin substitute products are to be reported in combination with one of the skin application procedures described by CPT codes 15271-15278.

Table 7 – Skin Substitute Product Assignment to High Cost/Low Cost Status for CY 2015

<table>
<thead>
<tr>
<th>CY 2015 HCPCS Code</th>
<th>CY 2015 Short Descriptor</th>
<th>CY 2015 SI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9349</td>
<td>Fortaderm, fortaderm antimic</td>
<td>G</td>
<td>High</td>
</tr>
<tr>
<td>C9358</td>
<td>SurgiMend, fetal</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>C9360</td>
<td>SurgiMend, neonatal</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>C9363</td>
<td>Integra Meshed Bil Wound Mat</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4100</td>
<td>Skin substitute, NOS</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4101</td>
<td>Apligraf</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4102</td>
<td>Oasis wound matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4103</td>
<td>Oasis burn matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4104</td>
<td>Integra BMWD</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4105</td>
<td>Integra DRT</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4106</td>
<td>Dermagraft</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4107</td>
<td>Graftjacket</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4108</td>
<td>Integra Matrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4110</td>
<td>Primatrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4111</td>
<td>Gammagraft</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4112</td>
<td>Cymetra injectable</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4113</td>
<td>GraftJacket Xpress</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4114</td>
<td>Integra Flowable Wound Matrix</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4115</td>
<td>Alloskin</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4116</td>
<td>Alloderm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>CY 2015 HCPCS Code</td>
<td>CY 2015 Short Descriptor</td>
<td>CY 2015 SI</td>
<td>Low/High Cost Skin Substitute</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------</td>
<td>-----------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Q4117</td>
<td>Hyalomatrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4118</td>
<td>Matristem Micromatrix</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4119</td>
<td>Matristem Wound Matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4120</td>
<td>Matristem Burn Matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4121</td>
<td>Theraskin</td>
<td>G</td>
<td>High</td>
</tr>
<tr>
<td>Q4122</td>
<td>Dermacell</td>
<td>G</td>
<td>High</td>
</tr>
<tr>
<td>Q4123</td>
<td>Alloskin</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4124</td>
<td>Oasis Tri-layer Wound Matrix</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4125</td>
<td>Arthroflex</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4126</td>
<td>Memoderm/derma/tranz/integup</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4127</td>
<td>Talymed</td>
<td>G</td>
<td>High</td>
</tr>
<tr>
<td>Q4128</td>
<td>Flexhd/Allopatchhd/matrixhd</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4129</td>
<td>Unite Biomatrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4131</td>
<td>Epifix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4132</td>
<td>Grafix core</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4133</td>
<td>Grafix prime</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4134</td>
<td>HMatrix</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4135</td>
<td>Mediskin</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4136</td>
<td>EZderm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4137</td>
<td>Amnioexcel or Biodexcel, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4138</td>
<td>BioDfence DryFlex, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4139</td>
<td>Amniomatrix or Biodmatrix, 1cc</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4140</td>
<td>Biodfence 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4141</td>
<td>Alloskin ac, 1 cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4142</td>
<td>Xcm biologic tiss matrix 1cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4143</td>
<td>Repriza, 1cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4145</td>
<td>Epifix, 1mg</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4146</td>
<td>Tensix, 1cm</td>
<td>N</td>
<td>Low</td>
</tr>
<tr>
<td>Q4147</td>
<td>Architect ecm px fx 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4148</td>
<td>NeoX 1k, 1cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4149</td>
<td>Excellagen, 0.1 cc</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4150</td>
<td>Allowrap DS or Dry 1 sq cm</td>
<td>N</td>
<td>Low</td>
</tr>
</tbody>
</table>

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2013 American Medical Association.
CY 2015 HCPCS Code | CY 2015 Short Descriptor | CY 2015 SI | Low/High Cost Skin Substitute
--- | --- | --- | ---
Q4151 | AmnioBand, Guardian 1 sq cm | N | Low
Q4152* | Dermapure 1 square cm | N | High
Q4153 | Dermavest 1 square cm | N | Low
Q4154 | Bovance 1 square cm | N | High
Q4155 | NeoxFlo or ClarixFlo 1 mg | N | N/A
Q4156 | Neox 100 1 square cm | N | High
Q4157 | Revitalon 1 square cm | N | Low
Q4158 | MariGen 1 square cm | N | Low
Q4159 | Affinity 1 square cm | N | High
Q4160 | NuShield 1 square cm | N | High

*HCPCS code Q4152 was assigned to the low cost group in the CY 2015 OPPS/ASC final rule with comment period. Upon submission of updated pricing information, Q4152 is assigned to the high cost group for CY 2015.

**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?redirect=/HospitalOutpatientPPS/01_overview.asp](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html?redirect=/HospitalOutpatientPPS/01_overview.asp) on the CMS website. Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

**Changes to OPPS Pricer Logic**

a) Rural sole community hospitals and Essential Access Community Hospitals (EACHs) will continue to receive a 7.1 percent payment increase for most services in CY 2015. The rural SCH and EACH payment adjustment excludes drugs, biologicals, items and services paid at charges reduced to cost, and items paid under the pass-through payment policy in accordance with Section 1833(t)(13)(B) of the Social Security Act, as added by Section 411 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

b) New OPPS payment rates and copayment amounts will be effective January 1, 2015. All copayment amounts will be limited to a maximum of 40 percent of the APC payment rate. Copayment amounts for each service cannot exceed the CY 2014 inpatient deductible.
c) For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2015. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments. This factor also is used to determine the outlier payment, which is 50 percent of estimated cost less 1.75 times the APC payment amount. The payment formula is \( \text{cost} - (\text{APC payment} \times 1.75) / 2 \).

d) The fixed-dollar threshold decreases in CY 2015 relative to CY 2014. The estimated cost of a service must be greater than the APC payment amount plus $2,775 in order to qualify for outlier payments.

e) For outliers for Community Mental Health Centers (bill type 76x), there will be no change in the multiple threshold of 3.4 for 2015. This threshold of 3.4 is multiplied by the total line-item APC payment for APC 0173 to determine eligibility for outlier payments. This multiple amount is also used to determine the outlier payment, which is 50 percent of estimated costs less 3.4 times the APC payment amount. The payment formula is \( \text{cost} - (\text{APC 0173 payment} \times 3.4) / 2 \).

f) Effective October 1, 2013, and continuing for CY 2015, one device is eligible for pass-through payment in the OPPS Pricer logic. Category C1841 (Retinal prosthesis, includes all internal and external components), has an offset amount of $0, because CMS is not able to identify portions of the APC payment amounts associated with the cost of the device in APC 0672, Level III, Posterior segment eye procedures. For outlier purposes, when C1841 is billed with CPT code 0100T, assigned to APC 0672, it will be eligible for outlier calculation and payment.

g) C2624 (Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components), is effective January 1, 2015, device offset is $310.33, assigned to APC 2624. The procedure this should be billed with is C9741 (Right heart catheterization with implantation of wireless pressure sensor in the pulmonary artery, including any type of measurement, angiography, imaging supervision, interpretation, and report), and the procedure maps to APC 0080 (which has the offset of $310.33).

h) Effective January 1, 2015, the OPPS Pricer will apply a reduced update ratio of 0.980 to the payment and copayment for hospitals that fail to meet their hospital outpatient quality data reporting requirements or that fail to meet CMS validation edits. The reduced payment amount will be used to calculate outlier payments.

i) Effective January 1, 2015, there will be two diagnostic radiopharmaceutical receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical
expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the “policy-packaged” portions of the CY 2014 APC payments for nuclear medicine procedures and may be found on the CMS website.

j) Effective January 1, 2015, there will be four skin substitute products receiving pass-through payment in the OPPS Pricer logic. For skin substitute application procedure codes that are assigned to APC 0328 (Level III Skin Repair) or APC 0329 (Level IV Skin Repair), Pricer will reduce the payment amount for the pass-through skin substitute product by the wage-adjusted offset for the APC when the pass-through skin substitute product appears on a claim with a skin substitute application procedure that maps to APC 0328 or APC 0329. The offset amounts for skin substitute products are the “policy-packaged” portions of the CY 2014 payments for APC 0328 and APC 0329.

k) Pricer will update the payment rates for drugs, biologicals, therapeutic radiopharmaceuticals, and diagnostic radiopharmaceuticals with pass-through status when those payment rates are based on ASP on a quarterly basis.

l) Effective January 1, 2015, CMS is adopting the FY 2015 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-Inpatient Prospective Payment System (IPPS) hospitals discussed below.

m) Effective January 1, 2015, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40%), a device offset cap will be applied based on the credit amount listed in the “FD” (Credit Received from the Manufacturer for a Replaced Medical Device) value code. The credit amount in value code “FD” which reduces the APC payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs are available on the CMS website.

n) Effective January 1, 2015, CMS is adopting the FY 2014 IPPS post-reclassification wage index values with application of out-commuting adjustment authorized by Section 505 of the MMA to non-IPPS hospitals discussed below.

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

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


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

Seasonal Flu Vaccinations - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit MLN Matters® Article #MM8890, “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season” and MLN Matters® Article #SE1431, “2014-2015 Influenza (Flu) Resources for Health Care Professionals.”

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

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

CPT only copyright 2013 American Medical Association.
Centers for Medicare & Medicaid Services
Articles for Part B Providers
MLN Connects™ National Provider Call: National Partnership to Improve Dementia Care in Nursing Homes - Tuesday, December 9; 1:30-3pm ET - During this MLN Connects Call, speakers will discuss innovative efforts from State-based Alzheimer’s Association Chapters related to train-the-trainer programs, as well as the implementation of the Comfort First Approach in nursing homes. CMS subject matter experts will provide National Partnership updates and discuss next steps for the initiative. Register or visit the December 9 call web page for more information.

MLN Matters® Number: MM8908  Related Change Request (CR) #: CR 8908
Related CR Release Date: November 26, 2014  Effective Date: April 1, 2015
Related CR Transmittal #: R3132CP  Implementation Date: April 6, 2015

Quarterly Update to the Correct Coding Initiative (CCI) Edits, Version 21.1, Effective April 1, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8908 informs MACs about the release of the latest package of CCI edits, Version 21.1, which will be effective April 1, 2015. Make sure that your billing staffs are aware of these changes.

Background

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

The latest package of NCCI edits, Version 21.1, effective April 1, 2015, will be available to the MACs via the CMS Data Center on or about January 31, 2015, and a final file will be available to them on or about February 14, 2015.

Version 21.1 will include all previous versions and updates from January 1, 1996, to the present. In the past, NCCI was organized in two tables: Column 1/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two Correct Coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for the Outpatient Code Editor (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.
Looking for the latest new and revised MLN Matters® articles? Subscribe to the MLN Matters® electronic mailing list! For more information about MLN Matters® and how to register for this service, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/What_Is_MLNMatters.pdf and start receiving updates immediately!

MLN Matters® Number: MM8951
Related Change Request (CR) #: CR 8951
Related CR Release Date: December 12, 2014
Effective Date: January 1, 2015
Related CR Transmittal #: R3149CP
Implementation Date: January 5, 2015

New Waived Tests

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8951 informs MACs about the new Clinical Laboratory Improvement Amendments of 1998 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests so that they can accurately process claims. There are four newly added waived complexity tests.

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The CPT codes that the CMS considers to be laboratory tests under CLIA (and thus requiring certification) change each year. If you do not have a valid, current, CLIA certificate and submit a claim to your MAC for a Current Procedural Terminology (CPT)
code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted. Make sure that your billing staffs are aware of these changes.

**Background**

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

Listed below are the latest tests approved by the FDA as waived tests under CLIA. CPT codes for the following new tests must have the modifier QW to be recognized as a waived test. Tests with CPT codes shown on the first page of the attachment to CR8951 (81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Effective Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>87807QW</td>
<td>March 18, 2014</td>
<td>BD Veritor System for Rapid Detection of RSV (For use with nasopharyngeal specimens) {Includes a reader}</td>
</tr>
<tr>
<td>G0434QW</td>
<td>May 12, 2014</td>
<td>Native Diagnostics International, DrugSmart Dip Single/Multi-Panel Drug Screen Dip Card Tests</td>
</tr>
<tr>
<td>87807QW</td>
<td>May 30, 2014</td>
<td>Sofia RSV</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen THC One Step Marijuana Test Strip</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen THC One Step Marijuana Test Cassette</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen THC One Step Marijuana Test Cup</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen THC One Step Marijuana Test Dip Card</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen mAMP One Step Methamphetamine Test Strip</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen mAMP One Step Methamphetamine Test Cassette</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen mAMP One Step Methamphetamine Test Cup</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 9, 2014</td>
<td>Healgen mAMP One Step Methamphetamine Test Dip Card</td>
</tr>
<tr>
<td>87880QW</td>
<td>June 11, 2014</td>
<td>Poly stat Strep A Strip Test {Specimen type (Throat Swab)}</td>
</tr>
</tbody>
</table>
MACs will not search their files to either retract payment or retroactively pay claims processed prior to implementation of CR8951; however, they should adjust claims if you bring such claims to your MAC's 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.

### CPT Code Table

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Effective Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>87880QW</td>
<td>June 25, 2014</td>
<td>StrepAim {Specimen type (Throat Swab)}</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 27, 2014</td>
<td>Wal-Mart Stores, Inc. ReliOn Home Drug Urine Cup Test</td>
</tr>
<tr>
<td>86308QW</td>
<td>July 7, 2014</td>
<td>Jant Pharmacal Corp. Accutest Rapid Mono Test {Whole Blood}</td>
</tr>
<tr>
<td>87880QW</td>
<td>July 9, 2014</td>
<td>Cardinal Health Strep A Dipstick – Rapid Test (Throat Swab Specimen)</td>
</tr>
<tr>
<td>G0434QW</td>
<td>July 18, 2014</td>
<td>Healgen COC One Step Cocaine Test Strip</td>
</tr>
<tr>
<td>G0434QW</td>
<td>July 18, 2014</td>
<td>Healgen COC One Step Cocaine Test Cassette</td>
</tr>
<tr>
<td>G0434QW</td>
<td>July 18, 2014</td>
<td>Healgen COC One Step Cocaine Test Cup</td>
</tr>
<tr>
<td>G0434QW</td>
<td>July 18, 2014</td>
<td>Healgen COC One Step Cocaine Test Dip Card</td>
</tr>
<tr>
<td>G0434QW</td>
<td>July 18, 2014</td>
<td>Healgen MOP One Step Morphine Test Strip</td>
</tr>
<tr>
<td>G0434QW</td>
<td>July 18, 2014</td>
<td>Healgen MOP One Step Morphine Test Cassette</td>
</tr>
<tr>
<td>G0434QW</td>
<td>July 18, 2014</td>
<td>Healgen MOP One Step Morphine Test Cup</td>
</tr>
<tr>
<td>G0434QW</td>
<td>July 18, 2014</td>
<td>Healgen MOP One Step Morphine Test Dip Card</td>
</tr>
<tr>
<td>81003QW</td>
<td>August 8, 2014</td>
<td>Medline 120 Urine Analyzer</td>
</tr>
</tbody>
</table>

Disclaimer

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

CPT only copyright 2013 American Medical Association.
**2015 Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List**

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 9018 notifies suppliers that the spreadsheet containing an updated list of Healthcare Common Procedure Coding System (HCPCS) codes for DME MAC or MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. Changes in Chapter 23, Section 20.3 of the “Medicare Claims Processing Manual” are reflected in the recurring update notification.

The spreadsheet for the 2015 DMEPOS Jurisdiction List is an Excel® spreadsheet and is available under the Coding Category at [http://www.cms.gov/Center/Provider-](http://www.cms.gov/Center/Provider-)
Additional Information


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

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

CPT only copyright 2013 American Medical Association.
Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs

Note: This article was revised on December 5, 2014, to add language to emphasize that form CMS-855O is appropriate for use by prescribers. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition is intended for physicians and other eligible professionals who write prescriptions for Medicare beneficiaries for Medicare Part D drugs. The article is also directed to Medicare Part D plan sponsors.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) finalized CMS-4159-F “Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs” on May 23, 2014. This rule requires physicians and, when applicable, other eligible professionals who write prescriptions for Part D drugs to be enrolled in an approved status or to have a valid opt-out affidavit on file for their prescriptions to be covered under Part D. The final regulation stated that the
effective date for this requirement would be June 1, 2015. However, CMS is announcing that it will delay enforcement of the requirements in 42 CFR 423.120(c)(6) until December 1, 2015. Nevertheless, prescribers of Part D drugs must submit their Medicare enrollment applications or opt-out affidavits to their Part B Medicare Administrative Contractors (MACs) by June 1, 2015, or earlier, to ensure that MACs have sufficient time to process the applications or opt out affidavits and avoid their patients’ prescription drug claims from being denied by their Part D plans, beginning December 1, 2015. Note that enrollment functions for physicians and other prescribers are handled by Part B MACs.

**Background**

If you write prescriptions for covered Part D drugs and you are not enrolled in Medicare in an approved status or have a valid record of opting out, you need to submit an enrollment application or an opt out affidavit to your Medicare Administrative Contractor (MAC) by June 1, 2015, or earlier. You may submit your enrollment application electronically using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) located at [https://pecos.cms.hhs.gov/pecos/login.do](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](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 your application submission.

If you wish to enroll to be reimbursed for the covered services furnished to Medicare beneficiaries, you must complete the CMS-855I application. The CMS-855O, which is a shorter, abbreviated form, should only be completed if you are seeking to enroll solely to order and refer and/or prescribe Part D drugs. (While the CMS-855O form states it is for physicians and non-physician practitioners who want to order and refer, it is appropriate for use by prescribers, who also want to enroll to prescribe Part D drugs.) If you do not see your specialty listed on either of the applications, select the Undefined Physician/Non-Physician Type option and identify your specialty in the space provided.

If you are a physician or eligible professional who wants to opt out of Medicare, you must submit an opt-out affidavit to the MAC within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every 2 years, and a National Provider Identifier (NPI) is required to be submitted on the affidavit). For more information on the opt-out process, refer to MLN Matters® article SE1311, titled “Opting out of Medicare and/or Electing to Order and Refer Services,” which 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) on the CMS website.

In an effort to prepare the prescribers and Part D sponsors for the December 1, 2015 enforcement date, CMS is making available an enrollment file that identifies physician and eligible professional who are enrolled in Medicare in an approved or opt out status. The first iteration of the enrollment file is now available at [https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx](https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx) on the CMS website. The file contains production data but is considered a test file since the Part D prescriber enrollment requirement is not yet
applicable. An updated enrollment file will be generated every two weeks and continue through the December 1, 2015 enforcement date.

The file displays physician and eligible professional eligibility as of and after November 1, 2014, (i.e., currently enrolled, new approvals, or changes from opt-out to enrolled as of November 1, 2014). Any periods, prior to November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will not be displayed on the enrollment file. However, any periods after November 1, 2014, for which a physician or eligible professional was not enrolled in an approved or opt-out status will be on the file with its respective end dates for that given provider. For opted out providers, the opt out flag will display a Y/N (Yes/No) value to indicate the periods the provider was opted out of Medicare. The file will include the provider’s:

- (NPI);
- First and Last Names;
- Effective and End Dates; and
- Opt Out Flag

**Example 1** – Dr. John Smith’s effective date of enrollment is January 1, 2014. Since he was enrolled prior to the generation of the test file, his effective date will display as November 1, 2014. Dr. Smith submits an enrollment application to voluntarily withdraw from Medicare effective December 15, 2014. Dr. Smith will appear on the applicable file as:

<table>
<thead>
<tr>
<th>NPI</th>
<th>First Name</th>
<th>Last Name</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Opt Out Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789</td>
<td>John</td>
<td>Smith</td>
<td>11/01/2014</td>
<td>12/15/2014</td>
<td>N</td>
</tr>
</tbody>
</table>

**Example 2** - Dr. Mary Jones submits an affidavit to opt out of Medicare, effective December 1, 2014. Since she has opted out after the generation of the test file, her effective date will display as December 1, 2014. After the 2 year opt out period expires, Dr. Jones decides she wants to enroll in Medicare to bill, order, and refer, or to write prescriptions. The enrollment application is received on January 31, 2017, and the effective date issued is January 1, 2017. Dr. Jones will display on the applicable file as:

<table>
<thead>
<tr>
<th>NPI</th>
<th>First Name</th>
<th>Last Name</th>
<th>Effective Date</th>
<th>End Date</th>
<th>Opt Out Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>987654321</td>
<td>Mary</td>
<td>Jones</td>
<td>12/01/2014</td>
<td>12/01/2016</td>
<td>Y</td>
</tr>
<tr>
<td>987654321</td>
<td>Mary</td>
<td>Jones</td>
<td>01/01/2017</td>
<td></td>
<td>N</td>
</tr>
</tbody>
</table>
After the enforcement date of December 1, 2015, the applicable effective dates on the file will be adjusted to December 1, 2015, and it will no longer be considered a test file. All inactive periods prior to December 1, 2015, will be removed from the file and it will only contain active and inactive enrollment or opt out periods as of December 1, 2015, and after. The file will continue to be generated every two weeks, with a purposeful goal toward more frequent updates on a set schedule. Part D sponsors may utilize the file to determine a prescriber’s Medicare enrollment or opt out status when processing Part D pharmacy claims. The file will not validate the provider’s ability to prescribe under applicable laws. Please submit questions or issues encountered in accessing the file to providerenrollment@cms.hhs.gov.

**Additional Information**

For more information on the enrollment requirements, visit [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Part-D-Enrollment-Information.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Part-D-Enrollment-Information.html) on the CMS website. If you have questions and need to speak with the Part B contractor that handles your enrollment, you may find their toll-free number 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. To identify your Medicare contractor, locate the state in which you provide services and refer to the contractor listed on the “Part B Contractor” line.

**Seasonal Flu Vaccinations** - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit **MLN Matters® Article #MM8890, “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season”** and **MLN Matters® Article #SE1431, “2014-2015 Influenza (Flu) Resources for Health Care Professionals.”**

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

**Disclaimer**

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