# Medicare Monthly Review

**February 2015**

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National Government Services Articles for Part B Providers

2015 Medicare Participating Provider Resources

We encourage you to visit the Medicare Learning Network—the place for official CMS Medicare fee-for-service provider educational information. There you can find one of our most popular products, MLN Matters national provider education articles. These articles help you understand new or changed Medicare policy and how those changes affect you. A full array of other educational products (including web-based training courses, hard copy and downloadable publications, and CD-ROMs) are also available and can be accessed at http://www.cms.gov/MLNProducts/. You can also find other important physician websites by visiting the Physician Center web page at http://www.cms.gov/center/physician.asp.

In addition to educational products, the MLN also offers providers and suppliers opportunities to learn more about the Medicare program through MLN National Provider Calls. These national conference calls, held by CMS for the Medicare Fee-For-Service provider and supplier community, educate and inform participants about new policies and/or changes to the Medicare program. Offered free of charge, continuing education credits may be awarded for participation in certain National Provider Calls. To learn more about MLN National Provider Calls including upcoming calls, registration information, and links to previous call materials, visit http://www.cms.gov/Outreach-and-Education/Outreach/NPC/index.htm.

Medicare Participating Physicians Directory

The Medicare Participating Physicians Directory (MEDPARD) listing includes all providers in Part B Jurisdiction 6 and Jurisdiction K who have agreed to accept assignment on all Medicare-covered services.

The current list is located on our website under the Enrollment tab, select the link for MEDPARD.
Centers for Medicare & Medicaid Services
Articles for Part A&B Providers
Recognizing Lung Cancer Awareness Month and the Great American Smokeout

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

MLN Matters® Number: MM8583 Revised
Related Change Request (CR) #: CR 8583
Related CR Release Date: January 7, 2015
Effective Date: April 1, 2015
Related CR Transmittal #: R566PI
Implementation Date: April 6, 2015

New Timeframe for Response to Additional Documentation Requests

Note: This article was revised on January 8, 2015, to reflect the revised CR8583 issued on January 7. The article was revised to include a statement that reviewers should not grant providers additional time to respond to additional documentation requests. Also, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

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 You Need to Know

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

Background

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

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

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

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

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
Centers for Medicare & Medicaid Services

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REVISED products from the Medicare Learning Network® (MLN)

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

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<table>
<thead>
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<th>MLN Matters® Number: MM8667 Revised</th>
<th>Related Change Request (CR) #: CR 8667</th>
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<tr>
<td>Related CR Release Date: May 16, 2014</td>
<td>Effective Date: January 1, 2015</td>
</tr>
<tr>
<td>Related CR Transmittal #: R1384OTN</td>
<td>Implementation Date: October 6, 2014</td>
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### Posting the Limiting Charge after Applying the Electronic Health Record (EHR) and Physician Quality Reporting System (PQRS) Negative Adjustments

**Note:** This article was revised on January 15, 2015, to correct a typo on page 4. The reference should have stated “2% EHR negative adjustment $1.90 (95 x.02).” It incorrectly stated “2% PQRS.” All other information remains the same.

### Provider Types Affected

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

### Provider Action Needed

This article is based on Change Request (CR) 8667, whose purpose is to place the Electronic Health Record (EHR) and Physician Quality Reporting System (PQRS) Negative Adjustment Limiting Charge amounts on MAC websites and hard copy disclosure reports. EPs under the Medicare EHR Incentive Program include: Doctor of medicine or osteopathy, Doctor of oral surgery or dental medicine, Doctor of podiatry, Doctor of optometry, and Chiropractor. Be sure your billing staffs are aware of these changes.

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Background

**Electronic Health Record (EHR)**

Beginning January 1, 2015, Section 1848(a)(7) of the Social Security Act as amended by Section 4101(b) of the HITECH Act, requires that EPs that are not meaningful EHR users are subject to the EHR negative adjustment.

Specifically, Section 1848(a)(7) of the Act states that: “If the eligible professional is not a meaningful EHR user (as determined under Subsection (o)(2)) for an EHR reporting period for the year, the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3) but without regard to this paragraph).”

**Physician Quality Reporting System (PQRS)**

Beginning on January 1, 2015, Section 1848(a)(8) of the Social Security Act, as added by Section 3002(b) of the Affordable Care Act, requires that EPs who do not satisfactorily report data on quality measures for covered professional services for the quality reporting period of the year are subject to the PQRS negative adjustment.

Specifically, Section 1848(a)(8) of the Act states that: “If the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under Subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).”

The negative payment adjustment applies to all EPs, regardless of whether the EP elects to be “participating” or “non-participating” for purposes of Medicare payments.

Non-participating (Non-Par) EPs in the Medicare program may choose either to accept or not accept assignment on Medicare claims on a claim-by-claim basis. If EPs choose not to accept assignment, they may not charge the beneficiary more than the Medicare limiting charge for unassigned claims for Medicare services. The limiting charge is 115 percent of the MPFS amount. The beneficiary is not responsible for billed amounts in excess of the limiting charge for a covered service.

Non-participating EPs that do not accept assignment on a claim may choose to collect the entire limiting charge amount up front from the beneficiary at the time of service.

Submission of a non-par, non-assigned Medicare Physician Fee Schedule (MPFS) service with a charge in excess of the Medicare limiting charge amount constitutes a violation of the limiting charge. A physician or supplier who violates the limiting charge is subject to a civil
monetary penalty of not more than $10,000, an assessment of not more than 3 times the amount claimed for each item or service, and possible exclusion from the Medicare program. Therefore, it is crucial that EPs are provided with the correct limiting charge they may bill for a MPFS service.

Your MAC will list and display the limiting charge amount after applying the EHR and PQRS negative adjustment on their website. Specifically, they will add the following to their website:

- EHR Limiting Charge;
- PQRS Limiting Charge;
- EHR/2014 eRx Limiting Charge;
- EHR + PQRS Limiting Charge; and
- EHR/2014 eRx + PQRS Limiting Charge.

**Examples**

**Non-Par Non-Assigned Claim No EHR/PQRS Adjustment:**

Original Fee Schedule Amount: $100  
5% non-PAR status: $5 (100 x .05)  
Adjustment Total $5.00  
MPFS Allowed Amount $100-$5.00= $95.00  
Limiting Charge Allowed= $95.00 x 115%= $109.25

**Non-Par Non-Assigned Claim with EHR Adjustment:**

Original Fee Schedule Amount: $100  
5% non-PAR status: $5 (100 x .05)  
1% EHR negative adjustment $.95 (95 x.01)  
Adjustment Total $5.95  
MPFS Allowed Amount $100-$5.95= $94.05  
Limiting Charge Allowed= $94.05 x 115%= $108.16

**Non-Par Non-Assigned Claim with PQRS Adjustment:**

Original Fee Schedule Amount: $100  
5% non-PAR status: $5 (100 x .05)  
1.5% PQRS negative adjustment $1.43 (95 x.015)  
Adjustment Total $ 6.43  
MPFS Allowed Amount $100-$6.43= $93.57

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Limiting Charge Allowed= $93.57 x 115% = $107.61

**Non-Par Non-Assigned Claim with EHR + e-prescribing:**

Original Fee Schedule Amount: $100  
5% non-PAR status: $5 (100 x .05)  
2% EHR negative adjustment $1.90 (95 x .02)  
Adjustment Total $ 6.90  
MPFS Allowed Amount $100-$6.90= $93.10  
Limiting Charge Allowed= $93.10 x 115% = $107.07

**Non-Par Non-Assigned Claim with EHR without 2014 e-Prescribing Adjustment + PQRS:**

Original Fee Schedule Amount: $100  
5% non-PAR status: $5 (100 x .05)  
1% EHR negative adjustment $.95 (95 x .01)  
EHR Adjustment Total $5.95  
MPFS Allowed Amount $100-$5.95= $94.05  
1.5% PQRS negative adjustment $1.41 ($94.05 x .015)  
PQRS Adjustment Total $94.05-$1.41=$92.64  
MPFS Allowed Amount $92.64  
Limiting Charge Allowed= $92.64 x 115% = $106.54

**Non-Par Non-Assigned Claim with EHR with 2014 e-Prescribing Adjustment + PQRS:**

Original Fee Schedule Amount: $100  
5% non-PAR status: $5 (100 x .05)  
2% EHR negative adjustment $1.90 (95 x .02)  
EHR Adjustment Total $6.90  
MPFS Allowed Amount $100-$6.90= $93.10  
1.5% PQRS negative adjustment $1.40 (93.10 x .015)  
PQRS Adjustment Total $93.10-$1.40=$91.70  
MPFS Allowed Amount $91.70  
Limiting Charge Allowed= $91.70 x 115% = $105.46

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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. You can also find a link to your MAC's website at this page.

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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 on a keyword(s) and you will find articles that contained 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:** MM8739 Revised  
**Related Change Request (CR) #:** CR 8739  
**Related CR Release Date:** January 8, 2015  
**Effective Date:** June 11, 2013  
**Related CR Transmittal #:** R3162CP, R168NCD  

**Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) for Solid Tumors (This Change Request (CR) rescinds and fully replaces MM 8468, dated February 6, 2014.)**

**Note:** This article was revised on January 12, 2015, to reflect the revised CR8739 issued on January 8. In the article, reference to an attachment at the bottom of page 2 has been replaced with a Web link to the list of appropriate diagnosis codes. Note that 793.11 has been added to that list. Also, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

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

Provider Action Needed

This article is based on Change Request (CR) 8739, which advises MACs, effective for dates of service on or after June 11, 2013, to cover three FDG PET scans when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same cancer diagnosis. Coverage of any additional FDG PET scans (that is, beyond three) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same diagnosis will be determined by your MAC. Make sure your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) has reconsidered Section 220.6, of the “National Coverage Determinations (NCD) Manual” to end the prospective data collection requirements across all oncologic indications of FDG PET in the context of CR8739. The term FDG PET includes PET/computed tomography (CT) and PET/magnetic resonance (MRI).

CMS is revising the “NCD Manual”, Section 220.6, to reflect that CMS has ended the coverage with evidence development (CED) requirement for (2-[F18] fluoro-2-deoxy-D-glucose) FDG PET, PET/CT, and PET/MRI for all oncologic indications contained in Section 220.6.17 of the “NCD Manual”. This removes the current requirement for prospective data collection by the National Oncologic PET Registry (NOPR) for oncologic indications for FDG (Healthcare Common Procedure Coding System (HCPCS) Code A9552) only.

NOTE: For clarification purposes, as an example, each different cancer diagnosis is allowed one (1) initial treatment strategy (-PI modifier) FDG PET Scan and three (3) subsequent treatment strategy (-PS modifier) FDG PET Scans without the -KX modifier. The fourth FDG PET Scan and beyond for subsequent treatment strategy for the same cancer diagnosis will always require the -KX modifier. If a different cancer diagnosis is reported, whether reported with a -PI modifier or a -PS modifier, that cancer diagnosis will begin a new count for subsequent treatment strategy for that beneficiary. A beneficiary's file may or may not contain a claim for initial treatment strategy with a -PI modifier. The existence or non-existence of an initial treatment strategy claim has no bearing on the frequency count of the subsequent treatment strategy (-PS) claims.


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Effective for claims with dates of service on or after June 11, 2013, Medicare will accept and pay for FDG PET oncologic claims billed to inform initial treatment strategy or subsequent treatment strategy for suspected or biopsy proven solid tumors for all oncologic conditions without requiring the following:

- Q0 modifier: Investigational clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);

- Q1 modifier: routine clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);

- V70.7: Examination of participant in clinical research; or

- Condition code 30 (institutional claims only).

Effective for dates of service on or after June 11, 2013, MACs will use the following messages when denying claims in excess of three for PET FDG scans for subsequent treatment strategy when the –KX modifier is not included, identified by CPT codes 78608, 78811, 78812, 78813, 78814, 78815, or 78816, modifier –PS, HCPCS A9552, and the same cancer diagnosis code:

- Claim Adjustment Reason Code (CARC) 96: “Non-Covered Charge(s). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

- Remittance Advice Remarks Code (RARC) N435: “Exceeds number/frequency approved/allowed within time period without support documentation.”

- Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

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

MACs will not search their files to adjust claims processed prior to implementation of CR8739. However, if you have such claims and bring them to the attention of your MAC, the MAC will adjust such claims if appropriate.

**Synopsis of Coverage of FDG PET for Oncologic Conditions**

Effective for claims with dates of service on and after June 11, 2013, the chart below summarizes national FDG PET coverage for oncologic conditions:
<table>
<thead>
<tr>
<th>FDG PET for Cancers Tumor Type</th>
<th>Initial Treatment Strategy (formerly “diagnosis” &amp; “staging”)</th>
<th>Subsequent Treatment Strategy (formerly “restaging” &amp; “monitoring response to treatment”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Esophagus</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Head and Neck (not thyroid, CNS)</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Non-small cell lung</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Ovary</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Brain</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Cervix</td>
<td>Cover with exceptions *</td>
<td>Cover</td>
</tr>
<tr>
<td>Small cell lung</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>Soft tissue sarcoma</td>
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<tr>
<td>Pancreas</td>
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<td>Cover</td>
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<tr>
<td>Testes</td>
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<td>Prostate</td>
<td>Non-cover</td>
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<td>Thyroid</td>
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<td>Cover</td>
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<tr>
<td>Breast (male and female)</td>
<td>Cover with exceptions *</td>
<td>Cover</td>
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<tr>
<td>Melanoma</td>
<td>Cover with exceptions *</td>
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<td>All other solid tumors</td>
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<td>Myeloma</td>
<td>Cover</td>
<td>Cover</td>
</tr>
<tr>
<td>All other cancers not listed</td>
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*Cervix: Nationally non-covered for the initial diagnosis of cervical cancer related to initial anti-tumor treatment strategy. All other indications for initial anti-tumor treatment strategy for cervical cancer are nationally covered.

*Breast: Nationally non-covered for initial diagnosis and/or staging of axillary lymph nodes. Nationally covered for initial staging of metastatic disease. All other indications for initial anti-tumor treatment strategy for breast cancer are nationally covered.

*Melanoma: Nationally non-covered for initial staging of regional lymph nodes. All other indications for initial anti-tumor treatment strategy for melanoma are nationally covered.

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Additional Information


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Cervical Health Awareness Month - January is Cervical Health Awareness Month - a time to draw attention to cervical cancer, cervical cancer screening, prevention, and treatment. Read more about Medicare coverage of cervical cancer screening.

MLN Matters® Number: MM8867 Related Change Request (CR) #: CR 8867

Related CR Release Date: January 20, 2015

Related CR Transmittal #: R1451OTN

EFFECTIVE DATES: September 12, 2014 - for MACs and CEDI (non-systems change requirements) (Note: This is the due date of the first MAC and CEDI requirement); January 26, 2015 - for FISS and CEDI coding for January Testing Week; April 27, 2015 - for FISS and CEDI coding for April Testing Week; July 20, 2015 - for FISS and CEDI coding for July Testing Week.

IMPLEMENTATION DATES: January 5, 2015 - for FISS and CEDI coding for January Testing Week; February 16, 2015 - for MAC requirements for the January 15 testing. This is the due date of the last MAC deliverable.; April 6, 2015 - for FISS and CEDI coding for April Testing Week; May 18, 2015 - for MAC requirements for the April 15 testing. This is the due date of the last MAC deliverable.; July 6, 2015 - for FISS and CEDI coding for July Testing Week; August 10, 2015 - for MAC requirements for the July 15 testing. This is the due date of the last MAC deliverable.

International Classification of Diseases, Tenth Revision (ICD-10) Limited End to End Testing with Submitters for 2015

Provider Types Affected

This MLN Matters® Article is intended for providers and clearinghouses wishing to submit test claims with ICD-10 codes to Medicare Administrative Contractors (MACs).

What You Need to Know

Change Request (CR) 8867 directs MACs to test with a limited number of providers and clearinghouses to ensure claims with ICD-10 codes can be processed from submission to remittance. This additional testing effort will help ensure a successful transition to ICD-10.

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The Centers for Medicare & Medicaid Services (CMS) defines successful end-to-end testing as being able to demonstrate that:

- Testing entities are able to successfully submit ICD-10 claims to the shared systems,
- Software changes made to support ICD-10 result in appropriately adjudicated claims based on the pricing data employed for testing purposes; and
- Remittance advices are produced.

Make sure your billing staffs are aware of this update.

**Background**

The International Classification of Disease, Tenth Revision, (ICD-10) must be implemented by October 1, 2015. While system changes to implement this project have been completed and tested in previous releases, the industry has requested the opportunity to test with CMS. CR8867 will allow a small subset of submitters to test with MACs and the Common Electronic Data Interchanges (CEDIs) in three testing periods to demonstrate to the industry that CMS systems are ready for the ICD-10 implementation. MACs and CEDI shall conduct three limited End-to-End testing weeks with a small subset of submitters.

To facilitate this testing, CR8867 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. At least five, but not more than fifteen of the testers will be a clearinghouse, and submitters should be a mix of provider types.
- MACs and CEDIs will post a volunteer form to their website to collect volunteer information with which to select volunteers.
  - Form verifies testers are ready to test, meet the requirements to test, and collect data about the tester. (How they submit claims, what types of claims they will submit, and so forth.)
  - MACs and CEDIs will post the form to their website by March 13, 2015, for the July 2015 testing.
  - Volunteers must submit completed forms to the MACs and CEDIs by April 17, 2015, for the July 2015 testing.
- By May 8, 2015, for the July 2015 testing, the MACs and CEDIs (for the DME MACs) will notify the volunteers that they have been selected to test and provide them with the information needed for the testing, such as:
  - How to submit test claims (for example, what test indicators should be set);
  - What dates of service may be used for testing;
o How many claims may be submitted for testing (Test claims volume is limited to a total of 50 claims for the entire testing week, submitted in no more than three files);

o Request for National Provider Identifiers (NPIs) and Health Insurance Claim Numbers (HICNs) that will be used in testing (no more than five NPIs and 10 HICNs per submitter);

o Notice that if more than 50 claims are submitted, they may not be processed;

o Notice that claims submitted with NPIs or HICNs not previously submitted for testing, likely will not be completed; and

o Notice of potential Protected Health Information (PHI) on test remittances not submitted (and instructions to report PHI found to the MAC).

- MACs and CEDI will collect information from the testers after they have been notified of their selection, using a form provided by CMS. This form will specifically request the Health Insurance Claim Numbers (HICNs), Provider Transaction Access Number (PTANs), and National Provider Identifiers (NPIs) the tester will use during testing. Testers shall submit these forms back to the MAC/CEDI by February 20, 2015, for the April 2015 testing, and by May 29, 2015, for the July 2015 testing. Notification will warn testers that if forms are not received timely, they may lose their opportunity to test.

- Testers selected in the January 2015 Testing may participate in the April 2015 testing, and may submit an additional 50 test claims using the same HICNs and NPIs provided previously. MACs shall send a reminder to the January 2015 testers of this option 30 days prior to the start of the April 2015 testing, using language provided by CMS.

- Testers selected in the January 2015 and April 2015 Testing may participate in the July 2015 testing, and may submit an additional 50 test claims using the same HICNs and NPIs provided previously. MACs shall send a reminder to the January 2015 and April 2015 testers of this option 30 days prior to the start of the July 2015 testing, using language provided by CMS.

- MACs and CEDI will work with the testers selected to ensure they are prepared to test, and understand the requirements for testing.

- MACs will instruct testers to submit up to a total of 50 test claims during the testing period. This may be submitted in one to three files, but the total number of test claims cannot exceed 50.

- CEDI will instruct suppliers to submit claims with ICD-10 code with Dates of Service October 1, 2015, through October 15, 2015. They may also submit claims with ICD-9 codes with Dates of Service before October 1, 2015.

- MACs will instruct testers to submit test claims with ICD-10 code with Dates of Service on or after October 1, 2015. They may also submit test claims with ICD-9 codes with Dates of Service before October 1, 2015.

- MACs and CEDI will be prepared to support increased call volume from testers during the testing window, and up to 2 weeks following the receipt of the ERAs from testing.
• MACs and CEDIs will provide information to the testers on who to contact for testing questions. This may be separate contacts for front end questions and remittance questions.

• MACs and CEDIs will post an announcement about the testing to their websites. The announcement will be provided by CMS.

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number, as well as your MAC’s website address, 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)

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

MLN Matters® Number: MM8874 Revised Related Change Request (CR) #: CR 8874
Related CR Release Date: January 7, 2015 Effective Date: January 1, 2015
Related CR Transmittal #: R3160CP 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

Note: This article was revised on January 8, 2015, to reflect the revised CR8874 issued on January 7. In the article, the CR release date, transmittal number, and the Web address for accessing CR8874 are revised. All other information remains the same.

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

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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.

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

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

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• 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:

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• 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.

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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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html), “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.

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Get Your Patients Off to a Healthy Start in 2015 with the Medicare Annual Wellness Visit – a yearly office visit that focuses on preventive health, and the Initial Preventive Physical Examination, commonly known as the "Welcome to Medicare" Preventive Visit – a one-time service for newly-enrolled beneficiaries. Read more.

MLN Matters® Number: MM9004 Related Change Request (CR) #: CR 9004
Related CR Release Date: January 9, 2015 Effective Date: April 1, 2015
Related CR Transmittal #: R3161CP Implementation Date: April 6, 2015

Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9004 updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists that are effective April 1, 2015. The CR instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes for 2015 and that they obtain the updated MREP or PC Print software if they use that software.

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Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and appropriate RARCs that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice and coordination of benefits transactions.

The CARC and RARC changes that affect Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. Medicare contractors and Shared System Maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

SSMs have the responsibility to implement code deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the on Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR9004, MACs will implement on the date specified on the WPC website. The WPC website is available at http://www.wpc-edi.com/Reference on the Internet.

CR9004 lists only the changes that have been approved since the last code update CR (CR8855, Transmittal 2996, issued on July 25, 2014, with a related MLN Matters® article available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8855.pdf), and does not provide a complete list of codes for these two code sets.

The complete list for both CARC and RARC from the WPC website is updated three times a year – around March 1, July 1, and November 1. The WPC website, which has four listings available for both CARC and RARC, is available at http://www.wpc-edi.com/Reference on the Internet.

Changes in CARC List since CR8855

These are changes in the CARC database since the last code update in CR8855.
**New Codes – CARC:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>262</td>
<td>Adjustment for delivery cost. Note: To be used for pharmaceuticals only.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>263</td>
<td>Adjustment for shipping cost. Note: To be used for pharmaceuticals only.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>264</td>
<td>Adjustment for postage cost. Note: To be used for pharmaceuticals only.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>265</td>
<td>Adjustment for administrative cost. Note: To be used for pharmaceuticals only.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>266</td>
<td>Adjustment for compound preparation cost. Note: To be used for pharmaceuticals only.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>267</td>
<td>Claim spans multiple months. Rebill separate claim/service.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>268</td>
<td>Claim spans 2 calendar years. Please resubmit one claim per calendar year.</td>
<td>11/1/2014</td>
</tr>
</tbody>
</table>

**Modified Codes – CARC:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Modified Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>133</td>
<td>The disposition of the claim/service is pending further review. (Use only with Group Code OA). This change effective 11/01/2014: The disposition of this service line is pending further review. (Use only with Group Code OA). NOTE: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>201</td>
<td>Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR) At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)</td>
<td>11/1/2014</td>
</tr>
</tbody>
</table>

**Deactivated Codes – CARC – None**

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Changes in RARC List since CR8855

These are changes in the RARC database since the last code update CR 8855.

New Codes – RARC:

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N729</td>
<td>Missing patient medical/dental record for this service.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>N730</td>
<td>Incomplete/invalid patient medical/dental record for this service.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>N731</td>
<td>Incomplete/Invalid mental health assessment.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>N732</td>
<td>Services performed at an unlicensed facility are not reimbursable.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>N733</td>
<td>Regulatory surcharges are paid directly to the state.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>N734</td>
<td>The patient is eligible for these medical services only when unable to work or perform normal activities due to an illness or injury.</td>
<td>11/1/2014</td>
</tr>
</tbody>
</table>

Modified Codes – RARC:

<table>
<thead>
<tr>
<th>Code</th>
<th>Modified Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N42</td>
<td>Missing mental health assessment.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>MA118</td>
<td>Alert: No Medicare payment issued for this claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. Coinsurance and/or deductible are applicable.</td>
<td>11/1/2014</td>
</tr>
<tr>
<td>MA09</td>
<td>Claim submitted as unassigned but processed as assigned in accordance with our current assignment/participation agreement.</td>
<td>11/1/2014</td>
</tr>
</tbody>
</table>

Deactivated Codes – RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N483</td>
<td>Missing Periodontal Charts</td>
<td>05/01/2015</td>
</tr>
<tr>
<td>N484</td>
<td>Incomplete/invalid Periodontal Charts.</td>
<td>5/1/2015</td>
</tr>
</tbody>
</table>

NOTE: In case of any discrepancy in the code text as posted on WPC website and as reported in any CR, the WPC version should be implemented.

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Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

REVISED product from the Medicare Learning Network® (MLN)
- “Medicare Enrollment and Claim Submission Guidelines” Booklet (ICN 906764), Hard copy

MLN Matters® Number: MM9051 Related Change Request (CR) #: CR 9051
Related CR Release Date: December 31, 2014 Effective Date: September 19, 2014
Related CR Transmittal #: R202BP and R3159CP Implementation Date: February 2, 2015

Modifications to Medicare Part B Coverage of Pneumococcal Vaccinations

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

Provider Action Needed
Change Request (CR) 9051 provides an update to the Medicare pneumococcal vaccine coverage requirements, to align with new Advisory Committee on Immunization Practices (ACIP) recommendations. Make sure your billing staffs are aware of these updates.

Background
Medicare Part B covers certain vaccinations including pneumococcal vaccines. Specifically, Section 1861(s)(10)(A) of the Social Security Act, which is available at http://www.ssa.gov/OP_Home/ssact/title18/1861.htm, and regulations at 42 CFR 410.57 (http://www.ecfr.gov/cgi-bin/text-

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idx?SID=85dbd4eb66820b751f8e58a6c58988df&node=se42.2.410_157&rgn=div8) authorize Medicare coverage under Part B for pneumococcal vaccine and its administration. For services furnished on or after May 1, 1981, through September 18, 2014, the Medicare Part B program covered pneumococcal pneumonia vaccine and its administration when furnished in compliance with any applicable State law by any provider of services or any entity or individual with a supplier number. Coverage included an initial vaccine administered only to persons at high risk of serious pneumococcal disease (including all people 65 and older; immunocompetent adults at increased risk of pneumococcal disease or its complications because of chronic illness; and individuals with compromised immune systems), with revaccination administered only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least 5 years had passed since the previous dose of pneumococcal vaccine.

However, ACIP updated its guidelines regarding pneumococcal vaccines; now recommending the administration of two different pneumococcal vaccinations. The Centers for Medicare & Medicaid Services (CMS) is updating the Medicare coverage requirements to align with the updated ACIP recommendations. Effective for dates of service on or after September 19, 2014, (and upon implementation of CR9051), Medicare will cover:

- An initial pneumococcal vaccine to all Medicare beneficiaries who have never received the vaccine under Medicare Part B; and
- A different, second pneumococcal vaccine one year after the first vaccine was administered (that is, 11 full months have passed following the month in which the last pneumococcal vaccine was administered).

Since the updated ACIP recommendations are specific to vaccine type and sequence of vaccination, prior pneumococcal vaccination history should be taken into consideration. For example, if a beneficiary who is 65 years or older received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) a year or more ago, then the 13-valent pneumococcal conjugate vaccine (PCV13) should be administered next as the second in the series of the two recommended pneumococcal vaccinations. Receiving multiple vaccinations of the same vaccine type is not generally recommended. Ideally, providers should readily have access to vaccination history, such as with electronic health records, to ensure reasonable and necessary pneumococcal vaccinations.

Medicare does not require that a doctor of medicine or osteopathy order the vaccine; therefore, the beneficiary may receive the vaccine upon request without a physician’s order and without physician supervision.

Note that MACs will not search for and adjust any claims for pneumococcal vaccines and their administration, with dates of service on and after September 19, 2014. However, they may adjust such claims that you bring to their attention.
Additional Information


The Centers for Disease Control and Prevention (CDC) recommends that providers use two pneumococcal vaccines for adults aged ≥65. These vaccinations are 13-Valent Pneumococcal Conjugate Vaccine (PCV13) and 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23). For more information on these recommendations, visit [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6337a4.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6337a4.htm) on the CDC website.

If you have questions, please contact your DME 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](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html), “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season” and [MLN Matters® Article SE1431](https://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 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](https://www.healthmap.org) for an account to submit your information in the database. Also, visit the CDC [Influenza (Flu)](https://www.cdc.gov/flu) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza.

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NEW product from the Medicare Learning Network® (MLN)

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

MLN Matters® Number: MM9081
Related Change Request (CR) #: CR 9081
Related CR Release Date: January 16, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R3166CP
Implementation Date: January 5, 2015

Emergency Update to the Calendar Year (CY) 2015 Medicare Physician Fee Schedule Database (MPFSDB)

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 9081, to announce an emergency update to payment files issued to contractors based on the CY 2015 MPFS Final Rule. CR9081 amends those payment files, including an updated conversion factor of $35.7547 for services furnished between January 1, 2015, and March 31, 2015, consistent with the Protecting Access to Medicare Act of 2014 that provides for a zero percent update from CY 2014 rates. Make sure that your billing staffs are aware of these changes.
Background

Payment files were issued to contractors based upon the CY 2015 MPFS Final Rule, displayed on October 31, 2014 (and published in the Federal Register on November 13, 2014). CR9081 amends those payment files in order to correct technical errors to the MPFS update files, including an updated conversion factor of $35.7547 for services furnished between January 1, 2015, and March 31, 2015, consistent with the Protecting Access to Medicare Act of 2014 that provides for a zero percent update from the CY 2014 rate.

In preparing the CY 2015 final rates, errors were made in work, practice expense and malpractice RVUs. In correcting these errors and making adjustments to reflect the policies in the CY 2015 final rule with comment period, relativity adjustments were required across the fee schedule, and the conversion factor was adjusted from that published in the final rule. The amended payment files reflect all these changes and a conversion factor of $35.7547 for services furnished on or after January 1, 2015, and on or before March 31, 2015.

Under current law, a new conversion factor will be required for services furnished on or after April 1, 2015. These files will be provided with the April quarterly update.

Additional Information


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

| 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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html), “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/vaccinefinder) 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/vaccinefinder) for an account to submit your information in the database. Also, visit the CDC [Influenza (Flu)](http://www.cdc.gov/flu) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza.

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NEW product from the Medicare Learning Network® (MLN)

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

MLN Matters® Number: SE1501  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


Provider Types Affected

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

Provider Action Needed

Physicians, providers, suppliers, clearinghouses, and billing agencies who participate in acknowledgement testing and who are selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 acknowledgement testing and end-to-end testing to gain an understanding of the guidelines and requirements for successful testing. When “you” is used in this publication, we are referring to ICD-10 acknowledgement testers or end-to-end testers.

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<table>
<thead>
<tr>
<th>Question</th>
<th>Acknowledgement Testing</th>
<th>End-to-End Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do I need to register for testing?</td>
<td>No, you do not need to register for acknowledgement testing.</td>
<td>Yes, end-to-end testing volunteers must register on their Medicare Administrative Contractor (MAC) website during specific time periods.</td>
</tr>
</tbody>
</table>
| Who can participate in testing? | Acknowledgement testing is open to all Medicare Fee-For-Service (FFS) electronic submitters. | End-to-end testing is open to:  
- Medicare FFS direct submitters;  
- Direct Data Entry (DDE) submitters who receive an Electronic Remittance Advice (ERA);  
- Clearinghouses; and  
- Billing agencies. |
| How many testers will be selected? | All Medicare FFS electronic submitters can acknowledgement test. | 50 end-to-end testers will be selected per MAC jurisdiction for each testing round. You must be selected by the MAC for this testing. |
| What will the testing show? | The goal of acknowledgement testing is to demonstrate that:  
- Providers and submitters can submit claims with valid ICD-10 codes and ICD-10 companion qualifier codes;  
- Providers submitted claims with valid National Provider Identifiers (NPIs)  
- The claims are accepted by the Medicare FFS claims systems; and  
- Claims receive 277CA or 999 acknowledgement, as appropriate, to confirm that the claim was accepted or rejected by Medicare. | The goal of end-to-end testing is to demonstrate that:  
- Providers and submitters can successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems;  
- Software changes the Centers for Medicare & Medicaid Services (CMS) made to support ICD-10 result in appropriately adjudicated claims; and  
- Accurate Remittance Advices are produced. |
<p>| Will the testing test National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)? | No, acknowledgement testing will not test NCDs and LCDs. | Yes, end-to-end test claims will be subject to all NCDs and LCDs. |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Acknowledgement Testing</th>
<th>End-to-End Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will the testing confirm payment and return an ERA to the tester?</td>
<td>No, acknowledgement testing will not confirm payment. Test claims will receive 277CA or 999 acknowledgement, as appropriate, to confirm that the claim was accepted or rejected by Medicare.</td>
<td>Yes, end-to-end testing will provide an ERA based on current year pricing.</td>
</tr>
<tr>
<td>How many claims can testers submit?</td>
<td>There is no limit on the number of acknowledgement test claims you can submit.</td>
<td>You may submit 50 end-to-end test claims per test week.</td>
</tr>
<tr>
<td>How do testers submit claims for testing?</td>
<td>You submit acknowledgement test claims directly or through a clearinghouse or billing agency with test indicator “T” in the Interchange Control Structure (ISA) 15 field.</td>
<td>You submit end-to-end test claims directly with test indicator “T” in the ISA15 field or through DDE.</td>
</tr>
</tbody>
</table>
| When should testers submit test claims?                                 | You may submit acknowledgement test claims anytime. We encourage you to test during the highlighted testing weeks:  
  - March 2 – 6, 2015; and  
  - June 1 – 5, 2015.                                                                 | You must submit end-to-end test claims during the following testing weeks:  
  - January 26 – 30, 2015;  
  - April 27 – May 1, 2015; and  
| What dates of service do testers use during testing?                    | You must use current dates of service during acknowledgement testing.                     | You must use the following future dates of service during end-to-end testing:  
  - Professional claims – Dates of service on or after October 1, 2015;  
  - Inpatient claims – Discharge dates on or after October 1, 2015;  
  - Supplier claims – Dates of service between October 1, 2015, and October 15, 2015; and  
  - Professional and institutional claims – Dates up to December 31, 2015. You cannot use dates in 2016 or beyond. |
**Important Note:** Remember that you must be selected by the MAC in order to participate in end-to-end testing.

**RESOURCES**

The chart below provides ICD-10 resource information.

<table>
<thead>
<tr>
<th>For More Information About…</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10 Information for Medicare Fee-For-Service Providers</td>
<td><a href="http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html">http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html</a> on the CMS website</td>
</tr>
<tr>
<td>All Available Medicare Learning Network® (MLN) Products</td>
<td>“Medicare Learning Network® Catalog of Products” located on the CMS website or scan the Quick Response (QR) code on the right</td>
</tr>
<tr>
<td>Medicare Information for Patients</td>
<td><a href="http://www.medicare.gov">http://www.medicare.gov</a> on the CMS website</td>
</tr>
</tbody>
</table>

**Additional Information**

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

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Get Your Patients Off to a Healthy Start in 2015 with the Medicare Annual Wellness Visit – a yearly office visit that focuses on preventive health, and the Initial Preventive Physical Examination, commonly known as the "Welcome to Medicare" Preventive Visit – a one-time service for newly-enrolled beneficiaries. Read more.

MLN Matters® Number: SE1503
Related Change Request (CR) #: CR 8863
Related CR Release Date: N/A
Effective Date: January 1, 2015
Related CR Transmittal #: N/A
Implementation Date: January 5, 2015

Continued Use of Modifier 59 after January 1, 2015

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) implemented Change Request (CR) 8863 on January 5, 2015, effective January 1, 2015. This CR established four (4) new HCPCS modifiers (XE, XP, XS, XU) to define specific subsets of the -59 modifier, a modifier used to define a “Distinct Procedural Service”. These modifiers are collectively referred to as –X {EPSU} modifiers. Please note that providers may continue to use the -59 modifier after January 1, 2015, in any instance in which it was correctly used prior to January 1, 2015. The initial CR establishing the modifiers was designed to inform system developers that healthcare systems would need to accommodate the new modifiers. Additional guidance and education as to the appropriate use of the new –X {EPSU} modifiers will be forthcoming as CMS continues to introduce the modifiers in a gradual and controlled fashion. That guidance will include additional descriptive information about the

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new modifiers. CMS will identify situations in which a specific –X {EPSU} modifier will be required and will publish specific guidance before implementing edits or audits.

CR 8863 states that providers who wish to use the new modifiers may use them in accordance with their published definitions, and the X modifiers will function within CMS systems in the same manner as the 59 modifier, bypassing Procedure-to-Procedure (PTP) edits with a modifier indicator of “1,” for example. A modifier indicator of “1” indicates that NCCI-associated modifiers may be used to bypass an edit under appropriate circumstances.

**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.

Inquiries about CR 8863 (Specific Modifiers for Distinct Procedural Services) and any MLN Matters® article associated with the new X Modifiers, should be sent to the following email address: NCCIPTPMUE@cms.hhs.gov.

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Centers for Medicare & Medicaid Services
Articles for Part A Providers
SUBJECT: Moratorium on Classification of Long-Term Care Hospitals (LTCH) or Satellites/Increase in Certified LTCH Beds

I. SUMMARY OF CHANGES: This Change Request provides details on how to apply the exceptions to the moratorium on the establishment of new LTCH and LTCH satellites under Section 1206 of the Pathways to SGR Reform Act (Pub. L.113-67).

EFFECTIVE DATE: April 1, 2014
*Unless otherwise specified, the effective date is the date of service.
IMPLEMENTATION DATE: February 10, 2015

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-Only One Per Row.

<table>
<thead>
<tr>
<th>R/N/D</th>
<th>CHAPTER / SECTION / SUBSECTION / TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One Time Notification
SUBJECT: Moratorium on Classification of Long-Term Care Hospitals (LTCH) or Satellites/Increase in Certified LTCH Beds

EFFECTIVE DATE: April 1, 2014
*Unless otherwise specified, the effective date is the date of service.

IMPLEMENTATION DATE: February 10, 2015

I. GENERAL INFORMATION

A. Background: Section 1206 of the Pathways to SGR Reform Act (Pub. L. 113-67), enacted December 26, 2013, later amended by section 112(b) of the Protecting Access to Medicare Act of 2014 (Pub. L. 113-93), enacted April 1, 2014 establishes a moratorium on the designation of new LTCHs or LTCH satellites, and on an increase of beds in an LTCH. The moratorium began on April 1, 2014, and ends on September 30, 2017.

The statute also provides for certain exceptions to the moratorium on new LTCHs and additional LTCH satellite facilities. A prior moratorium was in effect from December 29, 2007 through December 28, 2012. The primary difference between the “expired” moratoria and the “new” moratorium is that, while the “expired moratoria” provided for specific exceptions to both the moratorium on the establishment of new LTCHs and LTCH satellite facilities and on increases in the number of beds in existing LTCHs and LTCH satellite facilities, the “new” moratorium only provides exceptions to the moratorium on the establishment of new LTCHs and LTCH satellite facilities. However, no exceptions are provided for increases in the number of certified beds in existing LTCHs and LTCH satellites. (For a detailed description of the “expired” moratoria provisions (including the applicable exceptions) that were in effect from December 29, 2007 through December 28, 2012, see the May 22, 2008 Interim Final Rule with Comment Period (73 FR 29705 through 29708) as well as S&C-8-26, June 13, 2008; S&C-9-32, April 17, 2009; S&C 10-25, July 27, 2010; and S&C 13-08, January 25, 2013).

B. Policy: 1206 of the Pathways to SGR Reform Act (Pub. L. 113-67)

For hospitals that are seeking to be excluded from the Inpatient Prospective Payment System for the first time as a LTCH, under the existing regulations at §412.23(e)(1) and (e)(2)(i), which implement Section 1886(d)(1)(B)(iv)(I) of the Social Security Act, such hospitals must have a provider agreement with Medicare and must have an average Medicare inpatient length of stay (LOS) greater than 25 days. The MAC (Medicare Administrative Contractor) will verify whether the hospital meets the average LOS requirement.

Section 1206(b)(2) of the Pathways to SGR Reform Act provides for limited exceptions to the moratorium on the establishment of new LTCH or LTCH Satellites. As is generally noted in the preamble to our FY 2015 final rule, these are separate exceptions(one of which has two potential prongs) which were establish by the statute, but it has come to our attention that the regulatory text (using periods) does not make this clear. Therefore, in this CR, we are clarifying that a new LTCH or LTCH Satellite only needs to meet one of the three exceptions described below (one of which has two prongs). There is no exception to the moratorium on the increase of the number of beds in existing LTCH or LTCH Satellites.

1. Establishment and Classification of a LTCH or LTCH Satellite

To qualify for an exception under the moratorium to establish a new LTCH or LTCH satellite facility between April 1, 2014, and September 30, 2017, a hospital must meet one of the following three exceptions:

I. For a new LTCH, an existing hospital (that is, one that was certified for Medicare participation as a hospital prior to April 1, 2014) must have begun “its qualifying period for payment as a long-term care hospital under 42 CFR 412.23(e) . . . prior to the date of enactment of this Act” (Section 112(b) of Pub. L. 113-93). This exception applies to a hospital that already participates in Medicare and which began its qualifying period for LTCH status prior to April 1, 2014. To qualify for this exception to the moratorium,
the LOS data used to demonstrate that the hospital has met the average LOS requirement at 42 CFR 412.23 must be from the hospital’s cost reporting period that began prior to April 1, 2014. Note that an LTCH satellite may not qualify for this exception, since there is no “qualifying period” for the establishment of a satellite facility for payment as an LTCH under §412.23(e).

or

II. Prior to April 1, 2014 the LTCH has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for an LTCH or LTCH satellite, as applicable, and has expended, prior to April 1, 2014, at least 10 percent of the estimated cost of the project or, $2,500,000, whichever amount is less. (Section 114(d)(2)(B) of Pub. L. 113-93) This exception applies in any one of the following three circumstances:

1. Prior to April 1, 2014, an existing hospital (that is, one that was certified for Medicare participation as a hospital prior to April 1, 2014) seeking to become an LTCH has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for converting the hospital to an LTCH and has expended, before that date, at least 10 percent of the estimated cost of the project or $2,500,000, whichever amount is less; or

2. Prior to April 1, 2014, an entity that is developing a hospital that will ultimately seek to become an LTCH has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition of a hospital and that entity has expended, before that date, at least 10 percent of the estimated cost of the project or $2,500,000, whichever amount is less; or

3. An existing LTCH, prior to April 1, 2014, has a binding written agreement with an outside unrelated party for the actual construction, renovation, lease or demolition of a new LTCH satellite facility and the LTCH has expended prior to April 1, 2014 at least 10 percent of the estimated cost of the project or $2,500,000, whichever amount is less.

or

III. An entity has obtained prior to April 1, 2014 an approved certificate of need (CON) in a State where one is required. This exception applies to a hospital or entity that was actively engaged in developing an LTCH, as evidenced by the fact that either:

1. An entity that is seeking to create an LTCH, but which was not an existing hospital (that is, one that was certified for Medicare participation as a hospital prior to April 1, 2014), had obtained an approved CON for a hospital or LTCH, as applicable, prior to April 1, 2014. Depending on the State’s CON law, there may or may not be a CON that is specifically for a long-term acute care hospital, as opposed to one for a general or short-term acute care hospital. If the State’s CON law provides for a CON that is specifically for an LTCH, then the entity must have obtained an approved CON that is specifically for creation of an LTCH. If the State’s CON law does not provide for a specific LTCH CON, then it is sufficient for the entity to have obtained an approved hospital CON prior to April 1, 2014, so long as it was not on that date an existing hospital (that is, one that was certified for Medicare participation as a hospital prior to April 1, 2014); or

2. An existing hospital (that is, one that was certified for Medicare participation as a hospital prior to April 1, 2014) had obtained an approved CON prior to April 1, 2014 to convert the hospital into a new LTCH, or an existing LTCH had obtained an approved CON by that date to create a satellite. This exception does not apply to an existing hospital that obtained an approved CON for a hospital type other than an LTCH prior to April 1, 2014. The fact that an existing hospital may have also had a CON issued to it prior to April 1, 2014 to operate a hospital would not be a reason to grant it an exception, unless that CON was specifically for an LTCH. This exception is not available to any existing hospital in a State that does not provide for a specific CON for an LTCH type of hospital.
The applicable MAC has the responsibility for recommending to the RO whether a provider qualifies for an exception, based either on having begun its qualifying period prior to April 1, 2014, or on having requisite binding agreements and evidence of expenditures prior to that date. With respect to the CON exception, the State Survey Agency is expected to verify to the RO whether the State issued the applicant hospital a CON that meets the criteria described above. The RO will share this information with the MAC expeditiously.

If the new LTCH will be co-located with another hospital or part of another hospital, it must notify the MAC of that fact in accordance with 42 CFR Section 412.22(e)(3) regardless of which exception is met. Furthermore, new LTCH Satellites are, by definition, co-located with another hospital or part of another hospital and must notify the MAC as described above.

The current moratorium does not preclude an LTCH from establishing a new remote location, subject to the moratorium on an increase in the number of the LTCH’s beds. An LTCH remote location is provider-based to the LTCH, provides inpatient services at a site that is not on the LTCH’s main campus, and is not co-located with another hospital.

2. Increase in the Number of LTCH Beds

The statute prohibits, with no exceptions, an increase in the number of an LTCH’s Medicare-certified beds during the moratorium period. Therefore, a LTCH that establishes a new satellite, based upon meeting the criteria for an exception to the moratorium, must reduce beds elsewhere in the LTCH in order to have beds in the new satellite location. Overall, the LTCH and all satellites must have no more Medicare-certified beds than it did on March 31, 2014.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

<table>
<thead>
<tr>
<th>Number</th>
<th>Requirement</th>
<th>Responsibility</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>9025.1</td>
<td>MAC shall review and evaluate the documentation concerning binding agreements/actual expenditures for projects under development.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>9025.2</td>
<td>MAC shall recommend to the RO whether or not a provider qualifies for an exception, based either on having begun its qualifying period prior to April 1, 2014, or on having requisite binding agreements and evidence of expenditures prior to that date. For exceptions based on the qualifying period, the recommendation should include pertinent facts about the provider, including the provider’s date of participation in the Medicare program. Recommendations based on a provider having requisite binding agreements and evidence of expenditures prior to that date should include a description of the materials reviewed by the MAC which led to the particular recommendation.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
III. PROVIDER EDUCATION TABLE

<table>
<thead>
<tr>
<th>Number</th>
<th>Requirement</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>9025.3</td>
<td>When/if the provider eventually submits its complete application to CMS, MAC shall include the advance determination letter. It will not be necessary for the MAC to conduct a new review of its eligibility for an exception to the moratorium.</td>
<td>X</td>
</tr>
</tbody>
</table>

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
"Should" denotes a recommendation.

<table>
<thead>
<tr>
<th>X-Ref Requirement Number</th>
<th>Recommendations or other supporting information:</th>
</tr>
</thead>
</table>

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Emily Lipkin, 410-786-3633 or emily.lipkin@cms.hhs.gov, Daniel Schroder, 410-786-7452 or daniel.schroder@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR)

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized.
by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachment(s): 0
MLN Connects™ National Provider Call: National Partnership to Improve Dementia Care in Nursing Homes - Tuesday, December 9; 1:30-3pm ET - During this MLN Connects Call, speakers will discuss innovative efforts from State-based Alzheimer’s Association Chapters related to train-the-trainer programs, as well as the implementation of the Comfort First Approach in nursing homes. CMS subject matter experts will provide National Partnership updates and discuss next steps for the initiative. Register or visit the December 9 call web page for more information.

MLN Matters® Number: MM8384 Revised Related Change Request (CR) #: CR 8384
Related CR Release Date: January 14, 2015 Effective Date: April 1, 2015
Related CR Transmittal #: R3164CP Implementation Date: April 6, 2015

Medicare Shared Systems Modifications Necessary to Capture Various HI PAA Compliant Fields

Note: This article was revised on January 15, 2015, to reflect a revised Change Request (CR) on January 14, 2015. That CR removed bill types 81x and 82x from Business Requirement 8384.2.4 (ZIP code mapping). The transmittal number, CR date, and the link to the CR also changed. All other information remains the same.

Provider Types Affected

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

This article is based on CR8384 which informs MACs that the Centers for Medicare & Medicaid Services (CMS) needs to expand institutional claim processing fields and to update items on the version 5010 837I flat files. Specifically, CMS is:

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

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

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

Background

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

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


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

MLN Matters® Number: MM8900 Related Change Request (CR) #: CR 8900
Related CR Release Date: November 26, 2014 Effective Date: October 1, 2014
Related CR Transmittal #: R3138CP Implementation October 6, 2014

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

Note: This article was revised on January 6, 2015, to reflect a revised Change Request (CR). The CR was issued to correct information related to technical errors cited in the correction notice, CMS-1607-CN, published October 3, 2014. A list of the changes included in the CR may be found in the Additional Information Section of this article. The CR date, transmittal number and link to the CR also changed. All other information remains the same.

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

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

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

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

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

Key Points of CR8900

PPS Updates

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

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

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

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

CMS deleted:

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

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

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

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

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

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

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

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


**New Technology Add-On**

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

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

- Voraxaze- Cases involving Voraxaze that are eligible for the new technology add-on payment will be identified by ICD-9-CM procedure code 00.95. The corrected maximum add-on payment for a case involving the Voraxaze is $47,250. (For your information the ICD-10-CM procedure codes are: 3E033GQ - Introduction of Glucarpidase into Peripheral Vein, Percutaneous Approach or 3E043GQ - Introduction of Glucarpidase into Central Vein, Percutaneous Approach.)
- Argus- Cases involving the Argus ®II System that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 14.81. The maximum add-on payment for a case involving the Argus ®II System is $72,028.75. (For your information the ICD-10-CM procedure codes are: 08H005Z - Insertion of Epiretinal Visual Prosthesis into Right Eye, Open Approach or 08H105Z - Insertion of Epiretinal Visual Prosthesis into Left Eye, Open Approach.)

- Kcentra- Cases involving Kcentra that are eligible for new technology add-on payments will be identified by ICD-9-CM procedure code 00.96. The maximum add-on payment for a case of Kcentra™ is $1,587.50. DO NOT MAKE THIS NEW TECH PAYMENT IF ANY OF THE FOLLOWING DIAGNOSIS CODES ARE ON THE CLAIM: 286.0, 286.1, 286.2, 286.3, 286.4, 286.5, 286.6, 286.7, 286.52, 286.53, or 286.59. (For your information the ICD-10-CM procedure codes are: 30280B1 - Transfusion of Nonautologous 4-Factor Prothrombin Complex Concentrate into Vein, Open Approach or 30283B1 - Transfusion of Nonautologous 4-Factor Prothrombin Complex and the ICD-10-CM diagnosis codes are: D66, D67, D68.1, D68.2, D68.0, D68.311, D68.312, D68.318, D68.32, and D68.4.)

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

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

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

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

Cost of Living Adjustment (COLA) Update for IPPS PPS

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

**FY 2015 Cost-of-Living Adjustment Factors: Alaska Hospitals**

<table>
<thead>
<tr>
<th>Area</th>
<th>Cost of Living Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Anchorage and 80-kilometer (50-mile) radius by road</td>
<td>1.23</td>
</tr>
<tr>
<td>City of Fairbanks and 80-kilometer (50-mile) radius by road</td>
<td>1.23</td>
</tr>
<tr>
<td>City of Juneau and 80-kilometer (50-mile) radius by road</td>
<td>1.23</td>
</tr>
<tr>
<td>Rest of Alaska</td>
<td>1.25</td>
</tr>
</tbody>
</table>

**FY 2015 Cost-of-Living Adjustment Factors: Hawaii Hospitals**

<table>
<thead>
<tr>
<th>Area</th>
<th>Cost of Living Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>City and County of Honolulu</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Hawaii</td>
<td>1.19</td>
</tr>
<tr>
<td>County of Kauai</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Maui and County of Kalawao</td>
<td>1.25</td>
</tr>
</tbody>
</table>
FY 2015 Wage Index Changes and Issues

New Wage Index Labor Market Areas and Transitional Wage Indexes

Effective October 1, 2014, CMS is revising the labor market areas used for the wage index based on the most recent labor market area delineations issued by the Office of Management and Budget (OMB) using 2010 Census data.

CMS is adopting a one-year transition for FY 2015 for hospitals that are experiencing a decrease in their wage index exclusively due to the implementation of the new OMB delineations. This mitigates potential negative payment impacts due to the adoption of the new OMB delineations.

Under the new OMB delineations for the few hospitals that have been located in an urban county prior to October 1, 2014, that are becoming rural effective October 1, 2014, CMS is assigning a hold-harmless urban wage index value of the labor market area in which they are physically located for FY 2014 for 3 years beginning in FY 2015. That is, for FYs 2015, 2016, and 2017, assuming no other form of wage index reclassification or redesignation is granted, these hospitals are assigned the area wage index value of the urban CBSA in which they were geographically located in FY 2014.

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

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

To ensure hospitals are paid correctly under the IPPS for the policies noted above, MACs followed the steps specified in CR 8900 titled, “Updating the PSF for Wage Index, Reclassifications and Redesignations” to update the PSF.

Treatment of Certain Providers Redesignated Under Section 1886(d)(8)(B) of the Act 42

CFR 412.64(b)(3)(ii) implements Section 1886(d)(8)(B) of the Social Security Act, which redesignates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as “Lugar counties”.) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are redesignated.
A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes.

**Section 505 Hospital (Out-Commuting Adjustment)**

Section 505 of the Medicare Modernization Act of 2003 (MMA), also known as the “outmigration adjustment, is an adjustment that is based primarily on commuting patterns and is available to hospitals that are not reclassified by the Medicare Geographic Classification Review Board (MGCRB).

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

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

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

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

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

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

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

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

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

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

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

For FY 2015 discharges occurring before April 1, 2015, qualifying low-volume hospitals and their payment adjustment are determined using Medicare discharge data from the March 2014 update of the FY 2013 MedPAR file. Table 14 of the FY 2015 IPPS/LTCH PPS final rule (which is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html) lists the “subsection (d)” hospitals with fewer than 1,600 Medicare discharges based on the March 2014 update of the FY 2013 MedPAR file and their low-volume payment adjustment for FY 2015 discharges occurring before April 1, 2015 (if eligible). CMS notes that the list of hospitals with fewer than 1,600 Medicare discharges in Table 14 does not reflect whether or not the hospital meets the mileage criterion (that is, the hospital is located more than 15 road miles from any other subsection (d) hospital, which, in general, is an IPPS hospital).

Effective April 1, 2015, in order to qualify as a low-volume hospital, a hospital must be located more than 25 road miles from another “subsection (d) hospital” and have less than 200 total discharges (including both Medicare and non-Medicare discharges) during the fiscal year. For FY 2015 discharges occurring on or after April 1, 2015, the low-volume hospital adjustment for all qualifying hospitals is 25 percent. For FY 2015 discharges occurring on or after April 1, 2015, the MAC will make the discharge determination based on the hospital’s number of total discharges, that is, Medicare and non-Medicare discharges as reported on the hospital’s most recently submitted cost report. To meet the mileage criterion to qualify for the low-volume hospital payment adjustment for FY 2015 discharges occurring on or after April 1, 2015, a hospital must be located more than 25 road miles (as defined at § 412.101(a)) from the nearest “ subsection (d) hospital” (that is, in general, an IPPS hospital).
A hospital must notify and provide documentation to its MAC that it meets the mileage criterion. The use of a Web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion for low-volume hospitals, is acceptable. The MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance (in road miles) from the hospital requesting low-volume hospital status, is sufficient to document that it meets the mileage criterion. If not, the MAC will follow up with the hospital to obtain additional necessary information to determine whether or not the hospital meets the low-volume hospital mileage criterion.

To receive a low-volume hospital payment adjustment under 412.101, a hospital must notify and provide documentation to its MAC that it meets the discharge and distance requirements under 412.101(b)(2)(ii) for FY 2015 discharges occurring before April 1, 2015, and 412.101(b)(2)(i) for FY 2015 discharges occurring on or after April 1, 2015, if also applicable. Specifically, for FY 2015, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2014, in order for the applicable low-volume hospital payment adjustment to be applied to payments for its discharges occurring on or after October 1, 2014, and through March 31, 2015, or through September 30, 2015, for hospitals that also meet the low-volume hospital payment adjustment qualifying criteria for discharges occurring during the second half of FY 2015.

A hospital that qualified for the low-volume payment adjustment in FY 2014 may continue to receive a low-volume payment adjustment for FY 2015 discharges occurring before April 1, 2015, without reapplying if it continues to meet the Medicare discharge criterion established for FY 2015 and the distance criterion. However, the hospital must send written verification that is received by its MAC no later than September 1, 2014, stating that it continues to be more than 15 miles from any other “subsection (d)” hospital. If a hospital’s written request for low-volume hospital status for FY 2015 is received after September 1, 2014, and if the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital’s FY 2015 discharges, effective prospectively within 30 days of the date of its low-volume hospital status determination.

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

**Hospital Quality Initiative**

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

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

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

A list of hospitals that will receive the EHR Incentive Payment reduction for FY 2015 is available in Attachment 1 in the Official Instruction to CR8900.

**Hospital Acquired Conditions (HAC)**

Section 3008 of the Affordable Care Act establishes a program, beginning in FY 2015, for IPPS hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain HACs. HACs are conditions that patients did not have when they were admitted to the hospital, but which developed during the hospital stay. Under the HAC Reduction Program, a 1 percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital's discharges for the specified fiscal year. The HAC Reduction Program adjustment amount (that is, the 1-percent payment reduction) is calculated after all other IPPS per discharge payments, which includes adjustments for DSH (including the uncompensated care payment), IME, outliers, new technology, readmissions, Value-Based Purchasing (VBP), low-volume hospital payments, and capital payments. This amount will be displayed in the PPS-FLX6- PAYMENT field in the IPPS PRICER output record. For SCHs and MDHs, the HAC Reduction Program adjustment amount applies to either the Federal rate payment amount or the hospital-specific rate payment amount, whichever results in a greater operating IPPS payment.

CMS did not make the list of providers subject to the HAC Reduction Program for FY 2015 public in the final rule because hospitals had until September 2014 to notify CMS of any errors in the calculation of their Total HAC Score under the Review and Correction period. Updated hospital level data for the Hospital-Acquired Condition (HAC) Reduction Program was made publicly available on December 18, 2014, in Table 17 at...
Hospital Value Based Purchasing

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

Under the Hospital VBP Program, CMS reduces base operating DRG payment amounts for subsection (d) hospitals by the applicable percent defined in statute. The applicable percent for payment reductions for FY 2015 is 1.50 percent. This percent is gradually increasing each fiscal year from 1.0 in FY 2013 to 2.0 percent in FY 2017. These payment reductions fund value-based incentive payment to hospitals that meet or exceed performance standards on the measures selected for the program. By law, CMS must base value-based incentive payments on hospitals’ performance under the Hospital VBP Program, and the total amount available for value-based incentive payments must be equal to the amount of payment reductions, as estimated by the Secretary.

CMS calculates a Total Performance Score (TPS) for each hospital eligible for the Hospital VBP Program. CMS then uses a linear exchange function to convert each hospital’s TPS into a value-based incentive payment. Based on that linear exchange function’s slope, as well as an individual hospital’s TPS, the hospitals’ own annual base operating DRG payment amount, and the applicable percent reduction to base operating DRG payment amounts, CMS calculates a value-based incentive payment adjustment factor that is applied to each discharge at a hospital, for a given fiscal year.

In the FY 2013 IPPS/LTCH PPS final rule, CMS established the methodology to calculate the hospital value-based incentive payment adjustment factor, the portion of the IPPS payment that will be used to calculate the value-based incentive payment amount, and review and corrections and appeal processes wherein hospitals can review information used to calculate their TPSs and submit requests for corrections to the information before it is made public.

For FY 2015 CMS will continue to implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2015. Table 16B of the FY 2015 IPPS/LTCH PPS final rule (which is available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html) contains the value-based incentive payment adjustment factors for FY 2015.

Table 16B data is used by the MACs to update the Hospital VBP Program participant indicator (VBP Participant) to hold a value of ‘Y’ if the provider is included in the Hospital
VBP Program and the Hospital VBP Program adjustment field (VBP Adjustment) to hold the value-based incentive payment adjustment factor for FY 2015.

Note: The values listed in Table 16A of the IPPS/LTCH PPS Final Rule are proxy values. These values are not used to adjust payments.

**Hospital Readmissions Reduction Program**

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

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

The Hospital Readmissions Reduction Program (HRRP) adjustment factors for FY 2015 are available in Table 15B of the FY 2015 IPPS final rule, which is available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html) on the CMS website. Claims will be reprocessed if a hospital’s HRR Adjustment factor changes when the actual factors are available in the near future. (Note: the values listed in Table 15A of the IPPS/LTCH PPS Final Rule are proxy values. These values are not used to adjust payments.)

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

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Starting in FY 2014, hospitals received 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of this

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uncompensated care pool based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital’s share of uncompensated care is based on its share of insured low income days, defined as the sum of Medicare SSI days and Medicaid days, relative to all Medicare DSH hospitals’ insured low income days.

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

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

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

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

Recalled Devices

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

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report or charges on the Medicare claim. If that medical device was received at a discount, the charges should also be appropriately reduced.


**LTCH PPS FY 2015 Update**

FY 2015 LTCH PPS Rates and Factors are located in the final rule and are displayed below. The LTCH PPS Pricer has been updated with the Version 32.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2014, and on or before September 30, 2015.

<table>
<thead>
<tr>
<th>Federal Rate for discharges from 10/1/14 through 09/30/15</th>
<th>Rates based on successful reporting of quality data.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Full update (quality indicator on PSF = 1): $41,043.71</td>
</tr>
<tr>
<td></td>
<td>• Reduced update (quality indicator on PSF = 0 or blank): $40,240.51</td>
</tr>
<tr>
<td>Labor Share</td>
<td>62.306 percent</td>
</tr>
<tr>
<td>Non Labor Share</td>
<td>37.694 percent</td>
</tr>
<tr>
<td>High Cost Outlier Fixed-Loss Amount</td>
<td>$14,972</td>
</tr>
</tbody>
</table>

**LTCH Quality Reporting (LTCHQR) Program**

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

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

There are no changes to the COLAs for FY 2015, and are the same COLAs established for FY 2014. For reference, a table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2014, can be found in the FY 2015 IPPS/LTCH PPS final rule and is also shown above in the table under **Cost of Living Adjustment (COLA) Update for IPPS PPS.**
Core-Based Statistical Area (CBSA)-based Labor Market Area Updates

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

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

Additional LTCH PPS Policy Changes for FY 2015

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

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

Additional Information


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

The following is a list of changes to CR 8900 that were made in the November 26, 2014 release:

- Renamed attachments and changed reference to attachments throughout policy section
- Revised Table 1 for the corrected FY 2015 IPPS Rates and Factors in attachment 3, FY 2015 Rate Tables
- Corrected maximum new technology add-on payment for a case involving the Voraxaze
- Revised attachment 2, Special Wage Index CR8900
- Added information on updating the PSF for IPPS wage index, reclassifications and redesignations
- Included a new attachments for wage index redesignations and reclassifications
- Revised reference to Hospital Acquired Condition (HAC) Reduction Program data
- Revised reference to Table 16b, Hospital Inpatient Value-Based Purchasing (VBP) Program Adjustment Factors for FY 2015
- Revised reference to corrected Table 15B, FY 2015 Readmissions Adjustment Factors
- Updated attachment 5, Uncompensated Care Payment Per Claim Amounts for Provider Specific File Revised CR8900
- Revised reference to corrected Table 8B, FY 2015 Statewide Average Capital Cost-To-Charge Ratios (CCRs) For Acute Care Hospitals-CN

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MLN Matters® Number: MM9005  Related Change Request (CR) #: CR 9005
Related CR Release Date: December 19, 2014  Effective Date: January 1, 2015
Related CR Transmittal #: R3135CP  Implementation Date: January 5, 2015

**January 2015 Integrated Outpatient Code Editor (I/OCE) Specifications Version 16.0**

**Provider Types Affected**

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for outpatient services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services when provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System (HH PPS) or claims for services to a hospice patient for the treatment of a non-terminal illness.

**Provider Action Needed**

This article is based on Change Request (CR) 9005 which informs MACs about the changes to the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Integrated OCE that will be utilized under the OPPS and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes.
Background

CR9005 instruction informs the MACs and the Fiscal Intermediary Shared System (FISS) that the I/OCE is being updated for January 1, 2015. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, which eliminates the need to update, install, and maintain two separate OCE software packages on a quarterly basis. The full list of I/OCE specifications can now be found at http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html on the Centers for Medicare & Medicaid Services (CMS) website. There is a summary of the changes for January 2015 in Appendix O (located in Appendixes M or N of prior releases) of Attachment A of CR9005 and that summary is captured in the following table.

Summary of Modifications

<table>
<thead>
<tr>
<th>Type</th>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>24</td>
<td>Modify the software to maintain 28 prior quarters (7 years) of programs in each release. Remove older versions with each release. (The earliest version date included in this January 2015 release is 4/1/2008)</td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>Status Indicator (SI) changes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- New SI - J1 (Hospital Part B services paid through a comprehensive APC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Deactivate SI X</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Modify description for SI Q1 to remove reference to SI X (STV – Packaged Codes)</td>
<td></td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>92</td>
<td>Implement new edit 92 (Device-dependent procedure reported without device code) Edit criteria:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- A device-dependent procedure is reported without a device code - Return to Provider (RTP)</td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td></td>
<td>Implement Comprehensive Ambulatory Payment Classification (APC) logic (new Appendix L):</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Specified device-dependent procedures (SI = J1) are assigned to a comprehensive APC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Multiple J1 procedures may be subject to a complexity adjustment which assigns a different comprehensive APC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Package all other procedures (change the SI to N) present on the same claim, with exceptions for services that are not covered under OPPS (SI = B, E, M) and services that are excluded by statute</td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td></td>
<td>Add new payment adjustment flag value 11 (Multiple units of service present paid at single comprehensive APC rate) and update Appendix G to include new value.</td>
</tr>
<tr>
<td>Type</td>
<td>Effective Date</td>
<td>Edits Affected</td>
<td>Modification</td>
</tr>
<tr>
<td>-------</td>
<td>----------------</td>
<td>----------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>Updates to Appendix F(a) for January 2015:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Add edit 86 for home health bill type 32x</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Add new edit 92 for applicable bill types</td>
<td></td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2014</td>
<td>Update Appendix F(a): Remove edits 61 and 72 from hospice bill types (81x, 82x), effective retroactively to 1/1/2014.</td>
<td></td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>71, 77 Deactivate edits 71 and 77 (procedure/device; device/procedure).</td>
<td></td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>Deactivate special logic for CRT-D (Cardioverter Defibrillator with Pacing Electrode) which conditionally packaged procedure 33225 with 33249.</td>
<td></td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>84 Remove code pairs associated with 33225 from the edit logic for edit 84.</td>
<td></td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>Revise program logic to remove reference to SI X from conditional packaging (STVX-packaging).</td>
<td></td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>Updates to Appendix K on page 39 to note the deactivation of composite APC 8000.</td>
<td></td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>8 Update to the sex conflict list by adding codes 0357T and 89337 to the female only list.</td>
<td></td>
</tr>
<tr>
<td>Logic</td>
<td>10/1/2014</td>
<td>Modify the Federally Qualified Health Clinic (FQHC) PPS logic to ignore modifier 59 when reported with an established patient mental health visit (G0469).</td>
<td></td>
</tr>
<tr>
<td>Logic</td>
<td>10/1/2014</td>
<td>Update the following for FQHC PPS:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Add HCPCS Q0091 as a qualifying visit code for new and established patient visits</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Add HCPCS G0472 as a preventive service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Remove HCPCS M0064 from qualifying visit code pair (Appendix M) for G0467; code is deleted.</td>
<td></td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>22 Add new modifiers to the valid modifier list: PO: Serv/proc off-campus pbd</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>XE: Separate Encounter</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>XP: Separate Practitioner</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>XS: Separate Structure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>XU: Unusual Non-Overlapping Service</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: XE, XP, XS, XU are designated as National Correct Coding Initiative (NCCI) modifiers</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>
<thead>
<tr>
<th>Type</th>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>75</td>
<td>Edit 75 (Incorrect billing of modifier FB or FC) is deactivated.</td>
</tr>
<tr>
<td>Logic</td>
<td>1/1/2015</td>
<td>87</td>
<td>Updated skin substitute product lists (Lists A and B in Appendix P).</td>
</tr>
<tr>
<td>Logic</td>
<td>6/2/2014</td>
<td>68</td>
<td>Implement mid-quarter approval for G0472.</td>
</tr>
<tr>
<td>Logic</td>
<td>1/9/2014</td>
<td>68</td>
<td>Implement mid-quarter approval for G0276.</td>
</tr>
<tr>
<td>Logic</td>
<td>8/1/2014</td>
<td>67</td>
<td>Implement mid-quarter approval for 90687.</td>
</tr>
<tr>
<td>Content</td>
<td>1/1/2015</td>
<td></td>
<td>Make HCPCS/APC/SI changes as specified by CMS (data change files).</td>
</tr>
<tr>
<td>Content</td>
<td>1/1/2015</td>
<td>20, 40</td>
<td>Implement version 21.0 of the NCCI (as modified for applicable institutional providers).</td>
</tr>
<tr>
<td>Doc</td>
<td>1/1/2015</td>
<td></td>
<td>Rename Appendices from Appendix L forward, to accommodate new Comprehensive APC Processing Logic (new Appendix L); Appendix M – FQHC Processing, Appendix N: OCE Overview, Appendix O: Summary of Modifications, Appendix P: Code Lists.</td>
</tr>
<tr>
<td>Doc</td>
<td>1/1/2015</td>
<td></td>
<td>Update to Appendix D to include notes regarding modifier 50 and comprehensive APCs.</td>
</tr>
<tr>
<td>Doc</td>
<td>1/1/2015</td>
<td></td>
<td>Update Appendix E (Payment Method Flag) to add SI = J1 and note deactivation of SI = X.</td>
</tr>
<tr>
<td>Doc</td>
<td>1/1/2015</td>
<td></td>
<td>Updated IOCE specification document to remove any reference to Fiscal Intermediary or “FI” (includes edit descriptions for edits 11 and 72, and any field description that included a reference to FI/MAC).</td>
</tr>
</tbody>
</table>
| Doc | 10/1/2014 | | Updates related to FQHC PPS:  
  - Correct the output buffer placement of edit 90 from the Procedure Edits Buffer to the Revenue Edits Buffer (only a change to IOCE output placement in the mainframe software)  
  - Added documentation to the specifications regarding bill type 770 (no payment claim), all claim lines are assigned line item action flag 5 but edit 91 is not returned (Appendix M)  
  Added documentation to the specifications regarding the use of SI of E for FQHC non-covered services (Appendix M) |

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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](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.

<table>
<thead>
<tr>
<th>Type</th>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>1/1/2015</td>
<td>Create 508-compliant versions of the specifications &amp; Summary of Data Changes documents for publication on the CMS website.</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1/1/2015</td>
<td>Deliver quarterly software update &amp; all related documentation and files to users via electronic means.</td>
<td></td>
</tr>
</tbody>
</table>

**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 Health Map Vaccine Finder database, register for an account to submit your information in the database. Also, visit the CDC Influenza (Flu) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza.

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Centers for Medicare & Medicaid Services
Articles for Part B Providers
Get Your Patients Off to a Healthy Start in 2015 with the *Medicare Annual Wellness Visit* — a yearly office visit that focuses on preventive health, and the *Initial Preventive Physical Examination*, commonly known as the "Welcome to Medicare" Preventive Visit — a one-time service for newly-enrolled beneficiaries. [Read more.](#)

---

**MLN Matters® Number:** MM9021  
**Related Change Request (CR) #:** CR 9021  
**Related CR Release Date:** January 9, 2015  
**Effective Date:** January 1, 2015  
**Related CR Transmittal #:** R3163CP  
**Implementation Date:** January 5, 2015

**January 2015 Update of the Ambulatory Surgical Center (ASC) Payment System**

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 9021 informs MACs about changes to and billing instructions for various payment policies implemented in the January 2015 ASC payment system update. As appropriate, this notification also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure that your billing staff are aware of these changes.

**Background**

Included in this notification are Calendar Year (CY) 2015 payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and covered surgical and ancillary services (ASCFS file).
Many ASC payment rates under the ASC payment system are established using payment rate information in the Medicare Physician Fee Schedule (MPFS). The payment files associated with this transmittal reflect the most recent changes to CY 2015 MPFS payment. Key updates are:

1. **New Device Pass-Through Category and Device Offset for Payment**

Additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the outpatient prospective payment system (OPPS). Section 1833(t)(6)(B) of the Social Security Act (the Act) 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 Act requires that we create additional categories for transitional pass-through payment of new medical devices not described by current or expired categories of devices. This policy was implemented in the 2008 revised ASC payment system.

The Centers for Medicare & Medicaid Services (CMS) is establishing one new HCPCS device pass-through category as of January 1, 2015 for the OPPS and the ASC payment systems. That HCPCS code is HCPCS code C2624 (Wireless pressure sensor) is assigned ASC PI=J7 (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced). Table 1 below shows more details.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>Long descriptor</th>
<th>ASC Payment Indicator (PI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2624</td>
<td>Wireless pressure sensor</td>
<td>Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components</td>
<td>J7</td>
</tr>
</tbody>
</table>

2. **New Service**

The Centers for Medicare & Medicaid Services (CMS) is establishing one new HCPCS surgical procedure code for ASC use effective January 1, 2015, as shown in table 2.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>Long descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9742</td>
<td>Laryngoscopy with injection</td>
<td>Laryngoscopy, flexible fiberoptic, with injection into vocal cord(s), therapeutic, including diagnostic laryngoscopy, if performed</td>
<td>G2</td>
</tr>
</tbody>
</table>
3. Billing for Corneal Tissue

CMS reminds ASCs that, according to the “Medicare Claims Processing Manual,” Chapter 14, Section 40 - Payment for Ambulatory Surgery (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf), corneal tissue is paid based on acquisition cost or invoice. To receive cost based reimbursement for corneal tissue acquisition, ASCs must bill charges for corneal tissue using HCPCS code V2785.

4. 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.”

The CY2015 National Correct Coding Initiative (NCCI) Policy Manual states (in Chapter VIII, Section D, Item 20 in the "Downloads" Section at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html) that injection of a drug during a cataract extraction procedure or other ophthalmic procedure is not separately reportable. Specifically, no separate procedure code may be reported for any type of injection during surgery or in the perioperative period. Injections are a part of the ocular surgery and are included as a part of the ocular surgery and the HCPCS code used to report the surgical procedure.

According to the “Medicare Claims Processing Manual, Chapter 17,” (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf) Section 90.2, 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 Hospital Outpatient Department (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) 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.

5. 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 ASC setting, where there have not previously been specific codes available. These are displayed in Table 3.

Table 3 – New CY 2015 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

<table>
<thead>
<tr>
<th>CY 2015 HCPCS Code</th>
<th>CY 2015 Long Descriptor</th>
<th>CY 2015 Payment Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9027</td>
<td>Injection, pembrolizumab, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9136</td>
<td>Injection, factor viii, fc fusion protein, (recombinant), per i.u.</td>
<td>K2</td>
</tr>
<tr>
<td>C9349</td>
<td>FortaDerm, and FortaDerm Antimicrobial, any type, per square centimeter</td>
<td>K2</td>
</tr>
<tr>
<td>C9442</td>
<td>Injection, belinostat, 10 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9443</td>
<td>Injection, dalbavancin, 10 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9444</td>
<td>Injection, oritavancin, 10 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9446</td>
<td>Injection, tedizolid phosphate, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9447</td>
<td>Injection, phenylephrine and ketorolac, 4 ml vial</td>
<td>K2</td>
</tr>
<tr>
<td>J7180</td>
<td>Factor XIII anti-hem factor</td>
<td>K2</td>
</tr>
<tr>
<td>J7327</td>
<td>Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose</td>
<td>K2</td>
</tr>
</tbody>
</table>

b) Other CY 2015 HCPCS and CPT Code Changes for Certain Drugs, Biologicals, and Radiopharmaceuticals.

Table 4 notes those separately payable drugs, biologicals, and radiopharmaceuticals that have undergone changes in their HCPCS codes, their long descriptors, or both. Each product’s CY
2014 HCPCS code and CY 2014 long descriptors are noted in the two left-hand columns. The CY 2015 HCPCS code and long descriptors are noted in the adjacent right-hand columns.

Table 4 – 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>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>J7335</td>
<td>Capsaicin 8% patch, per 10 square centimeters</td>
<td>J7336</td>
<td>Capsaicin 8% patch, per square centimeter</td>
</tr>
<tr>
<td>Q9970</td>
<td>Injection, ferric carboxymaltose, 1mg</td>
<td>J1439</td>
<td>Injection, ferric carboxymaltose, 1mg</td>
</tr>
</tbody>
</table>

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 plus six 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 Outpatient Payment Prospective System (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 ASC Drug file.

CMS is not publishing the updated payment rates in this CR implementing the January 2015 update of the ASC Payment System. The updated payment rates effective January 1, 2015, can be found in the January 2015 ASC Addendum BB at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html) on the CMS website.

d. Skin Substitute Procedure Edits

The payment for skin substitute products that do not qualify for OPPS pass-through status are packaged into the OPPS payment for the associated skin substitute application procedure. This policy is also implemented in the ASC payment system. 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 5 lists the skin substitute products and their assignment as either a high cost or a low cost skin substitute product, when applicable. ASCs should not separately bill for packaged skin substitutes (ASC PI=N1).

High cost skin substitute products should only be utilized in combination with the performance of one of the skin application procedures described by CPT codes 15271-15278. Low cost skin substitute products should only be utilized in combination with the performance of one of the skin application procedures described by HCPCS code C5271-C5278. All OPPS pass-through skin substitute products (ASC PI=K2) should be billed in combination with one of the skin application procedures described by CPT codes 15271-15278.

<table>
<thead>
<tr>
<th>CY 2015 HCPHC Code</th>
<th>CY 2015 Short Descriptor</th>
<th>ASC PI</th>
<th>Low/High Cost Skin Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9349</td>
<td>Fortaderm, fortaderm antimic</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>CY 2015 HCPCS Code</td>
<td>CY 2015 Short Descriptor</td>
<td>ASC PI</td>
<td>Low/High Cost Skin Substitute</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------------</td>
<td>--------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>C9358</td>
<td>SurgiMend, fetal</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>C9360</td>
<td>SurgiMend, neonatal</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>C9363</td>
<td>Integra Meshed Bil Wound Mat</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4100</td>
<td>Skin substitute, NOS</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4101</td>
<td>Apligraf</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4102</td>
<td>Oasis wound matrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4103</td>
<td>Oasis burn matrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4104</td>
<td>Integra BMWD</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4105</td>
<td>Integra DRT</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4106</td>
<td>Dermagraft</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4107</td>
<td>Graftjacket</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4108</td>
<td>Integra Matrix</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4110</td>
<td>Primatrix</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4111</td>
<td>Gammagraft</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4112</td>
<td>Cymetra injectable</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4113</td>
<td>GraftJacket Xpress</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4114</td>
<td>Integra Flowable Wound Matrix</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4115</td>
<td>AlloSkin</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4116</td>
<td>Alloderm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4117</td>
<td>Hyalomatrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4118</td>
<td>Matristem Micromatrix</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4119</td>
<td>Matristem Wound Matrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4120</td>
<td>Matristem Burn Matrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4121</td>
<td>Theraskin</td>
<td>K2</td>
<td>High</td>
</tr>
<tr>
<td>Q4122</td>
<td>Dermacell</td>
<td>K2</td>
<td>High</td>
</tr>
<tr>
<td>Q4123</td>
<td>AlloSkin</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>CY 2015 HCPCS Code</td>
<td>CY 2015 Short Descriptor</td>
<td>ASC PI</td>
<td>Low/High Cost Skin Substitute</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------</td>
<td>--------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Q4124</td>
<td>Oasis Tri-layer Wound Matrix</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4125</td>
<td>Arthroflex</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4126</td>
<td>Memoderm/derma/tranz/integup</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4127</td>
<td>Talymed</td>
<td>K2</td>
<td>High</td>
</tr>
<tr>
<td>Q4128</td>
<td>Flexhd/Allopatchhd/matrixhd</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4129</td>
<td>Unite Biomatrix</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4131</td>
<td>Epifix</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4132</td>
<td>Grafix core</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4133</td>
<td>Grafix prime</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4134</td>
<td>HMatrix</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4135</td>
<td>Mediskin</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4136</td>
<td>EZderm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4137</td>
<td>Amnioexcel or Biodexcel, 1cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4138</td>
<td>BioDfence DryFlex, 1cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4139</td>
<td>Amniomatrix or Biodmatrix, 1cc</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4140</td>
<td>Biodfence 1cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4141</td>
<td>Alloskin ac, 1 cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4142</td>
<td>Xcm biologic tiss matrix 1cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4143</td>
<td>Repriza, 1 cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4145</td>
<td>Epifix, 1mg</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4146</td>
<td>Tensix, 1cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4147</td>
<td>Architect ecm px fx 1 sq cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4148</td>
<td>Neox 1k, 1cm</td>
<td>N1</td>
<td>High</td>
</tr>
<tr>
<td>Q4149</td>
<td>Excellagen, 0.1 cc</td>
<td>N1</td>
<td>N/A</td>
</tr>
<tr>
<td>Q4150</td>
<td>Allowrap DS or Dry 1 sq cm</td>
<td>N1</td>
<td>Low</td>
</tr>
<tr>
<td>Q4151</td>
<td>AmnioBand, Guardian 1 sq cm</td>
<td>N1</td>
<td>Low</td>
</tr>
</tbody>
</table>
### CY 2015 HCPCS Code | CY 2015 Short Descriptor | ASC PI | Low/High Cost Skin Substitute
---|---|---|---
Q4152* | Dermapure 1 square cm | N1 | High
Q4153 | Dermavest 1 square cm | N1 | Low
Q4154 | Biovance 1 square cm | N1 | High
Q4155 | NeoxFlo or ClarixFlo 1 mg | N1 | N/A
Q4156 | Neox 100 1 square cm | N1 | High
Q4157 | Revitalon 1 square cm | N1 | Low
Q4158 | MariGen 1 square cm | N1 | Low
Q4159 | Affinity 1 square cm | N1 | High
Q4160 | NuShield 1 square cm | N1 | 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.

#### 6. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals based on ASP methodology may 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://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html](http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html) on the CMS website.

Suppliers, who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections, may request their MAC's adjustment of the previously processed claims.

#### 7. CY2015 ASC Wage index

As discussed and finalized in the CY 2015 OPPS/ASC final rule with comment (79 FR 66937), in CY2015, CMS is using the new Core Based Statistical Area (CBSA) delineations issued by the Office of Management and Budget (OMB) in OMB Bulletin 13-01, dated February 28, 2013, for the IPPS hospital wage index. Therefore, because the ASC wage indexes are the pre-floor and pre-reclassified IPPS hospital wage indexes, the CY 2015 ASC wage indexes reflect the new OMB delineations.

In CY2015, where the CY 2015 ASC wage index value with the CY 2015 CBSAs is lower than the CY 2014 CBSA values, CMS calculates, or blends, the CY 2015 ASC wage index...
adjusted payment rates such that it will equal 50 percent of the ASC wage index based on the CY 2014 CBSA value and 50 percent of the ASC wage index based on the new CY 2015 CBSA value. The blending of these specific wage index values will mitigate any short-term instability to ASC payments. CY2015 CBSAs with wage index values that are higher than the CY2014 are not transitioned or blended and reflect the full higher wage index value. For additional information on this ASC wage index policy, please refer to page 66937 in the CY 2015 OPPS/ASC Final Rule (CMS-1613-FC), which is accessible at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html) on the CMS website.

8. Coverage Determinations

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

**Additional Information**


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

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NEW products from the Medicare Learning Network® (MLN)

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

MLN Matters® Number: SE1311 Revised Related Change Request (CR) #: Not applicable
Related CR Release Date: N/A Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

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

Note: This article was revised on January 14, 2015, to add clarifying language, on the "opt-out" process and requirements, especially in regards to the definition of “opt-out.” All other information is unchanged.

Provider Types Affected

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

What You Need to Know

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

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

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

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

Filing an Affidavit to Opt-out

Physicians and non-physician practitioners who want to opt-out must file a written affidavit with Medicare in which they agree to opt-out of Medicare for a period of two years and to meet certain other criteria.
In general, the law requires that during that 2-year period of time, physicians and non-physician practitioners who have filed affidavits opting out of Medicare must sign private contracts with all Medicare beneficiaries to whom they furnish services that would otherwise be covered by Medicare, except those who are in need of emergency or urgently needed care.

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

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

Opt out affidavits are only valid for 2 years, after which the physician or practitioner may renew an opt out without interruption by filing an affidavit with each Medicare contractor who has jurisdiction over claims the physician/practitioner would otherwise file with Medicare, provided the affidavits are filed within 30 days after the current opt-out period expires.

The Centers for Medicare & Medicaid Services (CMS) does not have a standard affidavit form, however, many MACs have a form available on their website. To locate your MAC’s website, refer to [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf) on the CMS website. Otherwise, those physicians and practitioners who wish to opt-out must provide the information mentioned in writing to the MAC within their service jurisdiction. Currently there is not an option to submit an opt-out affidavit online.

The affidavit must be in writing and signed by the physician/non-physician practitioner.

It must include various statements to which the physician/non-physician practitioner must agree; for example, the physician/non-physician practitioner must agree not to submit claims to Medicare for any services furnished during the opt-out period, except for emergency or urgent care services furnished to beneficiaries with whom the physician/non-physician practitioner has not previously entered into a private contract.

It must identify the physician/non-physician practitioner sufficiently so that the Medicare contractor can ensure that no payment is made to the physician/non-physician practitioner during the opt-out period.

It must be filed with all Medicare contractors who have jurisdiction over the claims the physician/non-physician practitioner would have otherwise filed with Medicare and must be filed no later than 10 days after entering into the first private contract to which the affidavit applies.
The following specific information must be included in the affidavit:

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

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

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

- The 2-year opt-out period begins the date the affidavit is signed, provided the affidavit is filed within 10 days after he or she signs his or her first private contract with a Medicare beneficiary.
- Physicians or practitioners that opt out in multiple contractor jurisdictions are required to file a separate affidavit with each contractor. If the physician or practitioner does not timely file all required affidavits, the 2-year opt-out period begins when the last such affidavit is filed. Any private contract entered into before the last required affidavit is filed becomes effective upon the filing of the last required affidavit. The furnishing of any items or services to a Medicare beneficiary under such contract before the last required affidavit is filed is subject to standard Medicare rules.

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

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

**Opt-Out Providers Who May Order and Certify Items and Services**

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

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

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

CMS would like to highlight the following limitations:

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

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

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

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

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

**Additional Information**


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

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