# Medicare Monthly Review

**Issue No. MMR 2015-03**  
**March 2015**

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

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This bulletin should be shared with all health care practitioners and managerial members of the providers/suppliers staff. Bulletins issued during the last two years are available at no cost from our website at http://www.NGSMedicare.com.
Revised Local Coverage Determinations and Articles: January-March 2015

January 2015 Revisions

Category III CPT® Codes (L25275)
CPT code 0357T has been added to the group of CPT codes that are considered not medically necessary, effective for services rendered on or after 01/01/2015.

CPT code 0345T has been deleted from the Category III CPT Codes LCD, effective for services rendered on or after 8/7/2014. The National Coverage Decision (NCD) - Transcatheter Mitral Valve Repair (TMVR), allows coverage for TMVR, based on guidance provided in the NCD - Transcatheter Mitral Valve Repair (TMVR) (20.33) and in billing instructions in MLN Matters article MM9002.

Outpatient Physical and Occupational Therapy Services (L26884)
LCD references to maintenance therapy related to the requirement for skilled care, and to CPT codes 97110, 97113, and 97760 were further clarified.

Transthoracic Echocardiography (L27381)
LCD revised for annual HCPCS update for 2015. Effective for dates of service on or after 01/01/2015, HCPCS code J0151 is deleted and is replaced by code J0153.

February 2015 Revisions

Cardiac Catheterization and Coronary Angiography (L26880)
The ICD-9 section of the LCD was revised to clarify diagnosis requirements. The table linking CPT codes to ICD-9 groups has been deleted and the CPT codes have been added to each ICD -9 code group. The Indications section was revised to clarify services included in right heart catheterization, in light of questions raised during an OIG audit.

Transesophageal Echocardiography (TEE) (L27381)
LCD revised to remove the following statement from the asterisk note associated with ICD-9 code 793.2, for CPT codes 93312, 93313 and 93314:

“The list of ICD-9 codes for this secondary diagnosis will be found in the LCD for Transthoracic Echocardiography, L27360, under the list of payable ICD-9 codes for CPT codes 93303 and 93304, and the list of payable ICD-9 codes for CPT codes 93306, 93307 and 93308.”

The same statement was removed from the Supplemental Instructions Article (SIA) (A48398), from the Diagnosis Coding section.

March 2015 Revisions

Intravenous Immune Globulin (IVIG) - Related to LCD L25820 (A47381)
The following revisions have been made to the article:
• The indication for acute and chronic inflammatory demyelinating polyradiculoneuropathy has been separated into separate indications;
• Indication for hemolytic uremic syndrome has been removed;
• Indications for autoimmune hemolytic anemia and autoimmune neutropenia have been added;
• The age criteria for chronic refractory ITP and bone marrow/stem cell transplantation has been removed;
• ICD-9 code 283.11 has been removed from the Covered ICD-9 Codes list;
• Utilization guidelines have been added and the separate dosing guidelines have been deleted;
• Additional documentation requirements have been added to the “Documentation Requirements” section;
• ITP in pregnancy has been moved to Indication #4 - Immune thrombocytopenic purpura (ITP); and
• Wording throughout the article has been revised for clarity.

Speech-Language Pathology (L27404)
CMS Transmittal No. 179, Publication 100-02, Medicare Benefit Policy Manual, Change Request #8458, January 14, 2014 provides revised portions of the relevant chapters of the program manual used by Medicare contractors, in order to clarify that coverage of skilled nursing and skilled therapy services “…does not turn on the presence or absence of a beneficiary’s potential for improvement, but rather on the beneficiary’s need for skilled care.” Skilled care may be necessary to improve a patient’s current condition, to maintain the patient’s current condition, or to prevent or slow further deterioration of the patient’s condition based on the Jimmo v. Sebelius Settlement Agreement. Effective for dates of service on or after January 7, 2014, the citation in the “Indications” section has been revised. The transmittal information was added to the “CMS National Coverage Policy” section.
Centers for Medicare & Medicaid Services
Articles for Part A&B Providers
New Timeframe for Response to Additional Documentation Requests

Note: This article was revised on February 9, 2015, to reflect the revised CR8583 issued on February 4. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

What You Need to Know

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

Background

In certain circumstances, CMS review contractors (MACs, ZPICs, Recovery Auditors, the Comprehensive Error Rate Testing contractor and the Supplemental Medical Review Contractor) may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments or the billing history found in claims processing system (if applicable) or Medicare's Common Working File (CWF).
In those instances, the CMS review contractor will solicit documentation from the provider or supplier by issuing an ADR. The requirements for additional documentation are as follows:

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

- According to the "Medicare Program Integrity Manual," Chapter 3, Section 3.2.3.2, (Verifying Potential Errors and Tracking Corrective Actions), when requesting documentation for pre-payment review, the MAC and ZPIC shall notify providers that the requested documentation is to be submitted within 45 calendar days of the request. 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.
Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)

Provider Types Affected

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

What You Need to Know

Change Request (CR) 8954 is a follow-up to CR8757, Transmittal 2959 and Transmittal 167 (Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)). CR8757 was effective on January 9, 2014, and provided for percutaneous image-guided decompression (PILD) when provided in a clinical study through Coverage with Evidence Development (CED) for beneficiaries with LSS.
Background

CR8954 provides additional direction specifically for PILD, procedure code G0276, when performed in a randomized, blinded clinical trial ONLY, for claims with dates of service on or after January 1, 2015. Healthcare Common Procedure Coding System (HCPCS) G0276 - Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (PILD), or placebo control, performed in an approved coverage with evidence development (CED) clinical trial, is to be used only when the CED PILD trial is blinded, randomized, and controlled and contains a placebo procedure control arm. It appears in the January 2015 updates of the Medicare Physician Fee Schedule Database and the Integrated Outpatient Code Editor (IOCE).

Payment for HCPCS G0276 under the hospital Outpatient Prospective Payment System (OPPS) is available in the latest OPPS Addendum B at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html) on the Centers for Medicare & Medicaid Services (CMS) website.

ALL PILD for LSS claims with dates of service December 31, 2014, and earlier, should be processed with procedure code 0275T ONLY and are not subject to reprocessing regardless of the type of trial in which the services were rendered.

NOTE: Beginning with PILD for LSS claims with dates of service on and after January 1, 2015, there are 2 distinct procedure codes that are to be used: G0276 for clinical trials that are blinded, randomized, and controlled, and contain a placebo procedure control arm (use this CR 8954 for claims processing instructions), and 0275T for all other clinical trials (use CR 8757 for claims processing instructions).


Billing Requirements

Medicare will accept HCPCS code G0276 for PILD for LSS claims received with dates of service on and after January 1, 2015, when those services are provided in a blinded, randomized, controlled trial with a placebo procedure control arm under CED only.

Claims for PILD for LSS with dates of service on and after January 1, 2015, will be accepted when billed in a place of service (POS) 22 (outpatient) or 24 (ambulatory surgical center), using HCPCS G0276, along with:

- ICD-9 diagnosis range 724.01-724.03, or,
• ICD-10 diagnosis range M48.05-M48.07 (when ICD-10 is implemented)

Only when billed with:
• Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) (once ICD-10 is implemented) either in the primary/secondary positions;
• Modifier -Q0; and
• An 8-digit clinical trial identifier number listed on the CMS CED website.

Medicare will return claims for PILD for LSS claims, HCPCS G0276, as unprocessable when billed with a diagnosis code other than 724.01-724.03 (ICD-9), or, M48.05-M48.07 (ICD-10) (when ICD-10 is implemented) using:
• Claim Adjustment Reason Code (CARC) B22: “This payment is adjusted based on the diagnosis.”
• Remittance Advice Remark Code (RARC) N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
• Group Code-Contractual Obligation (CO).

Medicare will return PILD for LSS claims, HCPCS G0276, as unprocessable when billed in a POS other than 22 or 24 using:
• CARC 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.”
• RARC N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
• Group Code- CO.

Medicare will return PILD for LSS claims, HCPCS G0276, as unprocessable if they do not contain the required clinical trial diagnosis code V70.7 (ICD-9) or Z00.6 (ICD-10) (once ICD-10 is implemented) in either the primary/secondary positions with the following:
• CARC B22: “This payment is adjusted based on the diagnosis.”
• RARC M76: “Missing/incomplete/invalid diagnosis or condition”
• RARC N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
• Group Code- CO.

Medicare will return PILD for LSS claims, HCPCS G0276, as unprocessable when billed without a -Q0 modifier with the following:
• CARC 4: “The procedure code is inconsistent with the modifier used or a required modifier is missing.”
• RARC N657: “This should be billed with the appropriate code for these services.”
• RARC N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted."
• Group Code – CO.

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Also, remember that you must submit the numeric, 8-digit clinical trial identifier number in the electronic 837P in Loop 2300 REF02 (REF01=P4) or preceded by "CT" when placed in Field 19 of paper claim form CMS-1500. This requirement is further discussed in MLN Matters® Article MM8401 available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf on the CMS website.

For hospital outpatient procedures on type of bill (TOB) 13X or 85X, on or after January 1, 2015, Medicare will allow payment for PILD for LSS, HCPCS G0276, along with:

- ICD-9 diagnosis range 724.01-724.03; or,
- ICD-10 diagnosis range M48.05-M48.07 (once ICD-10 is implemented)

Only when billed with:

- Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) (once ICD-10 is implemented) and condition code 30 either in the primary/secondary positions;
- Modifier -Q0; and
- An 8-digit clinical trial identifier number listed on the CMS CED website.

For hospital outpatient procedures on TOB 13X or 85X, on or after January 1, 2015, MACs will line-level deny claims for PILD for LSS, HCPCS G0276, along with:

- ICD-9 diagnosis range 724.01-724.03; or,
- ICD-10 diagnosis range M48.05-M48.07 (once ICD-10 is implemented);

When billed without diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) (once ICD-10 is implemented) and condition code 30 either in the primary/secondary positions, Modifier -Q0, or an 8-digit clinical trial identifier number listed on the CMS CED website, with the following:

- CARC: 50 -These are non-covered services because this is not deemed a “medical necessity” by the payer.
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code –CO.

Additional Information

You can review the list of approved clinical studies related to PILD for LSS at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/PILD.html on the CMS website.

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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?


Also, check out the following resources from the Centers for Disease Control and Prevention (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, antiviral information, CDC flu mobile app, Q&As, toolkit for long term care employers, and other free resources. Review the CDC’s [Antiviral Drugs](http://www.cdc.gov/flu/antivirals/index.html) website for information about how antiviral medications can be used to prevent or treat influenza when influenza activity is present in your community, and view the updated “Influenza Antiviral Medications: Summary for Clinicians.” A CDC Health Update reminding clinicians about the importance of flu antiviral medications was distributed via the CDC Health Alert Network on January 9, 2015, and is available at [http://emergency.cdc.gov/HAN/han00375.asp](http://emergency.cdc.gov/HAN/han00375.asp) on the Internet.

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**February is American Heart Month** – a time to raise awareness about heart disease and heart disease management and prevention strategies. Initiatives such as [Million Hearts®](#), a national initiative to prevent a million heart attacks and strokes by 2017, provide health care professionals and other partners with resources that you can use to help enhance your prevention efforts. Medicare provides coverage for a variety of preventive services that can help identify risk factors and provide information and tools that can assist your Medicare patients in making informed decisions about heart-healthy lifestyle choices. [Read more](#).

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**MLN Matters® Number:** MM8993  
**Related Change Request (CR) #:** CR 8993  
**Related CR Release Date:** February 20, 2015  
**Effective Date:** April 1, 2015  
**Related CR Transmittal #:** R3201CP  
**Implementation Date:** As soon as April 1, 2015, but no later than July 6, 2015

**Healthcare Provider Taxonomy Codes (HPTCs) April 2015 Code Set Update**

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 8993 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and use it to update their internal HPTC tables and/or reference files.

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Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The National Uniform Claim Committee (NUCC) maintains the HPTC set for standardized classification of health care providers, and updates it twice a year with changes effective April 1 and October 1. These changes include the addition of a new code and addition of definitions to existing codes.

You should note that:

1. Valid HPTCs are those that the NUCC has approved for current use;
2. Terminated codes are not approved for use after a specific date;
3. Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears; and
4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

CR 8993 implements the NUCC HPTC code set that is effective on April 1, 2015, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at http://www.wpc-edi.com/codes on the Internet.

When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by the color code:

- New items are green;
- Modified items are orange; and
- Inactive items are red.

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.
Calendar Year (CY) 2015 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

Note: This article was revised on February 24, 2015, to reflect the revised CR8999 issued on February 6. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were updated. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

CMS updates the DMEPOS fee schedules on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the “Medicare Claims Processing Manual,” Chapter 23, Section 60, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf on the CMS website.

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

Key Points

Fee Schedule Files

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

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

The following new codes are effective January 1, 2015:

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

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

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

For gap-filling purposes, the 2014 deflation factors by payment category are in the table below.
### Specific Coding and Pricing Issues

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

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

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

### Diabetic Testing Supplies (DTS)

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

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years.

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as CBP contracts are re-competed. The national competitive bidding program for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016.


Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for Multi-Factor Productivity (MFP), which results in update of 1.5 percent for CY 2015. The single payment amount public use file for the national mail order competitive bidding program is available at http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts on the Internet.

**2015 Fee Schedule Update Factor of 1.5 Percent**

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

**2015 Update to the Labor Payment Rates**

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

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

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

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

**2015 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment**


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

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2014 maintenance and servicing fee is adjusted by the 1.5 percent MFP-adjusted covered item update factor to yield a CY 2015 maintenance and servicing fee of $69.76 for oxygen concentrators and transfilling equipment.
Update to Change Request (CR) 8566
Effective April 1, 2014, payment on a purchase basis was established for capped rental wheelchair accessory codes furnished for use with complex rehabilitative power wheelchairs. Such accessories are considered as part of the complex rehabilitative power wheelchair and associated lump sum purchase option set forth at 42 CFR Section 414.229(a)(5). These changes were implemented in Transmittal 1332, CR8566, dated January 2, 2014. Code E2378 is added to the list of codes eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair.

Additional Information


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

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

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

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February is American Heart Month – a time to raise awareness about heart disease and heart disease management and prevention strategies. Initiatives such as Million Hearts®, a national initiative to prevent a million heart attacks and strokes by 2017, provide health care professionals and other partners with resources that you can use to help enhance your prevention efforts. Medicare provides coverage for a variety of preventive services that can help identify risk factors and provide information and tools that can assist your Medicare patients in making informed decisions about heart-healthy lifestyle choices. Read more.

MLN Matters® Number: MM 9011
Related Change Request (CR) #: CR 9011
Related CR Release Date: February 13, 2015
Effective Date: May 15, 2015
Related CR Transmittal #: R575PI
Implementation Date: May 15, 2015

Incorporation of Revalidation Policies into Pub. 100-08, “Program Integrity Manual (PIM),” Chapter 15

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9011 to incorporate various existing Medicare enrollment revalidation policies into Chapter 15 of the "Program Integrity Manual" (PIM).

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Background

CR9011 incorporates various existing revalidation policies into the PIM. As these policies were previously established via business requirements, those business requirements are not being repeated in this article. The new policies announced in CR9011 are as follows:

- When processing a voluntary termination of a reassignment, the MAC will contact the group to confirm that the group member's Provider Transaction Access Number (PTAN) is being terminated from all locations and, if multiple group member PTANs exist for multiple group locations, each PTAN is terminated.
- Many enrolled providers may actually be subparts of other enrolled providers, and some of those subparts entered their “doing business as name” as their LBN when applying for their NPIs. Once a contractor determines for certain that this situation exists, the contractor shall ask the provider to correct its NPPES information. The provider can (1) change its LBN in NPPES to read in accordance with the IRS CP-575, and (2) report its “doing business as” name in NPPES as an “Other Name” and indicate the type of other name as a “doing business as” name.

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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Also, check out the following resources from the Centers for Disease Control and Prevention (CDC): Influenza (Flu) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza, antiviral information, CDC flu mobile app, Q&As, toolkit for long term care employers, and other free resources. Review the CDC’s Antiviral Drugs website for information about how antiviral medications can be used to prevent or treat influenza when influenza activity is present in your community, and view the updated “Influenza Antiviral Medications: Summary for Clinicians.” A CDC Health Update reminding clinicians about the importance of flu antiviral medications was distributed via the CDC Health Alert Network on January 9, 2015, and is available at [http://emergency.cdc.gov/HAN/han00375.asp](http://emergency.cdc.gov/HAN/han00375.asp) on the Internet.

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REVISED product from the Medicare Learning Network®

- “Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians”
  Web-based Training (WBT)

MLN Matters® Number: MM 9050  Related Change Request (CR) #: CR 9050
Related CR Release Date: February 13, 2015  Effective Date: July 1, 2015
Related CR Transmittal #: R1467OTN  Implementation Date: July 6, 2015

**Reporting Force Balance Claim Payment on the Electronic Remittance Advice (ERA) 835 and Cross Over Beneficiary 837 Claim Transactions**

**Provider Types Affected**

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

**What You Need to Know**

The Centers for Medicare & Medicaid Services (CMS) issued CR 9050 to alert providers that Claim Adjustment Reason Code (CARC) A7 will be replaced on July 1, 2015, by CARC 121 to report force balancing of Out of Balance (OOB) claims payment/adjudication.

**Background**

CR9050 modifies the way MACs report force balancing of OOB claim payment/adjudication. Currently, MACs are using CARC A7− Presumptive Payment Adjustment to report the balancing of OOB payments. CR9050 instructs MACs to use
CARC 121—Indemnification adjustment—compensation for outstanding member responsibility in place of A7. This will be effective July 1, 2015. In addition, MACs will use Group Code OA (Other Adjustment) as the required Group Code.

Finally, MACs will report offsetting of Veterans Affairs claims at the provider level using PLB code J1 "Non-Reimburseable" and an offsetting dollar amount.

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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Also, check out the following resources from the Centers for Disease Control and Prevention (CDC): Influenza (Flu) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza, antiviral information, CDC flu mobile app, Q&As, toolkit for long term care employers, and other free resources. Review the CDC’s Antiviral Drugs website for information about how antiviral medications can be used to prevent or treat influenza when influenza activity is present in your community, and view the updated “Influenza Antiviral Medications: Summary for Clinicians.” A CDC Health Update reminding clinicians about the importance of flu antiviral medications was distributed via the CDC Health Alert Network on January 9, 2015, and is available at [http://emergency.cdc.gov/HAN/han00375.asp](http://emergency.cdc.gov/HAN/han00375.asp) on the Internet.
Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens

Note: This article was revised on February 13, 2015, to reflect a revised CR9066 that was issued on February 5. The CR release date, transmittal number, implementation date, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9066 informs MACs about the revisions to the payment of travel allowances when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) Code P9603 and when billed on a flat rate basis using HCPCS Code P9604 for Calendar Year (CY) 2015. These changes are also made to Chapter 16, Section 60.2 of the “Medicare Claims Processing Manual.” Make sure that your billing staffs are aware of these changes.

Background

CR9066 revises the payment of travel allowances when billed on a per mileage basis using HCPCS Code P9603 and when billed on a flat rate basis using HCPCS Code P9604 for CY 2015. Medicare Part B, allows payment for a specimen collection fee and travel allowance.
when medically necessary, for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act. Payment for these services is made based on the clinical laboratory fee schedule.

Travel Allowance

Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician’s salary and travel expenses. MACs have the discretion to choose either a mileage basis or a flat rate, and how to set each type of allowance. Many MACs established local policy to pay based on a flat rate basis only.

Under either method, when one trip is made for multiple specimen collections (for example, at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the MAC.

Per Mile Travel Allowance (P9603)

The per mile travel allowance is to be used in situations where the average trip to the patients’ homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The allowance per mile was computed using the Federal mileage rate of $0.575 per mile plus an additional $0.45 per mile to cover the technician’s time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum $1.03 per mile if local conditions warrant it (actual total of $1.025 rounded up to reflect systems capabilities). Medicare reviews and updates the minimum mileage rate throughout the year, as well as in conjunction with the Clinical Laboratory Fee Schedule (CLFS), as needed. At no time may a laboratory bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

Per Flat-Rate Trip Basis Travel Allowance (P9604)

The per flat-rate trip basis travel allowance is $10.30.

Additional Information

The Internal Revenue Service (IRS) determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating an automobile.


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April 2015 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9084 informs Medicare MACs to download and implement the April 2015 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the January 2015, October 2014, July 2014, and April 2014, ASP drug pricing files for Medicare Part B drugs.

Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 6, 2015, with dates of service April 1, 2015, through June 30, 2015. MACs will not search and adjust claims that have already been processed unless you bring such claims to their attention. Make sure that your billing staffs are aware of these changes.
Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c)) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis.

The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the "Medicare Claims Processing Manual" (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see http://www.cms.gov/manuals/downloads/clm104c04.pdf on the CMS website.)

The following table shows how the quarterly payment files will be applied:

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2015 ASP and ASP NOC</td>
<td>April 1, 2015, through June 30, 2015</td>
</tr>
<tr>
<td>January 2015 ASP and ASP NOC</td>
<td>January 1, 2015, through March 31, 2015</td>
</tr>
<tr>
<td>October 2014 ASP and ASP NOC</td>
<td>October 1, 2014, through December 31, 2014</td>
</tr>
<tr>
<td>July 2014 ASP and ASP NOC</td>
<td>July 1, 2014, through September 30, 2014</td>
</tr>
<tr>
<td>April 2014 ASP and ASP NOC</td>
<td>April 1, 2014, through June 30, 2014</td>
</tr>
</tbody>
</table>

NOTE: The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local MAC processing the claim shall make these determinations.

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-Net work-MLN/MLNMattersArticles/index.html under - How Does It Work.

Disclaimer

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Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) - A Re-Issue of MM7492

Note: This article was revised on February 20, 2015, to add a question and answer at the bottom of page 2 regarding dual processing of ICD-9 and ICD-10 codes. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2015. As a result of CR7492 (and related MLN Matters® Article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013, implementation date for ICD-10. This article updates MM7492
to reflect the October 1, 2015, implementation date. Make sure your billing and coding staffs are aware of these changes.

### Key Points of SE1408

**General Reporting of ICD-10**

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to [http://www.cms.gov/Medicare/Coding/ICD10/index.html](http://www.cms.gov/Medicare/Coding/ICD10/index.html) for more information on the format of ICD-10 codes. In addition, ICD-10 Procedure Codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

**General Claims Submissions Information**

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be Returned to Provider (RTP) as unprocessable. Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2015, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will RTP all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim. For claims with dates of service prior to October 1, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2015. Institutional claims containing ICD-10 codes for services prior to October 1, 2015, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

**Will the Centers for Medicare & Medicaid Services (CMS) allow for dual processing of ICD-9 and ICD-10 codes (accept and process both ICD-9 and ICD-10 codes for dates of service on and after October 1, 2015)?**

No, CMS will not allow for dual processing of ICD-9 and ICD-10 codes after ICD-10 implementation on October 1, 2015. Many providers and payers, including Medicare have already coded their systems to only allow ICD-10 codes beginning October 1, 2015. The scope of systems changes and testing needed to allow for dual processing would require...
significant resources and could not be accomplished by the October 1, 2015, implementation date. Should CMS allow for dual processing, it would force all entities with which we share data, including our trading partners, to also allow for dual processing. In addition, having a mix of ICD-9 and ICD-10 codes in the same year would have major ramifications for CMS quality, demonstration, and risk adjustment programs.

Claims that Span the ICD-10 Implementation Date

CMS has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2015, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2015, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2015. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A – Institutional Providers

<table>
<thead>
<tr>
<th>Bill Type(s)</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>11X</td>
<td>Inpatient Hospitals (incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs))</td>
<td>If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>12X</td>
<td>Inpatient Part B Hospital Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>13X</td>
<td>Outpatient Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>14X</td>
<td>Non-patient Laboratory Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>18X</td>
<td>Swing Beds</td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>Bill Type(s)</td>
<td>Facility Type/Services</td>
<td>Claims Processing Requirement</td>
<td>Use FROM or THROUGH Date</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------------</td>
<td>--------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>21X</td>
<td>Skilled Nursing (Inpatient Part A)</td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>22X</td>
<td>Skilled Nursing Facilities (Inpatient Part B)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>23X</td>
<td>Skilled Nursing Facilities (Outpatient)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>32X</td>
<td>Home Health (Inpatient Part B)</td>
<td>Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>3X2</td>
<td>Home Health – Request for Anticipated Payment (RAPs)*</td>
<td>* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.</td>
<td>*See Note</td>
</tr>
<tr>
<td>34X</td>
<td>Home Health – (Outpatient )</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>71X</td>
<td>Rural Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>72X</td>
<td>End Stage Renal Disease (ESRD)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>73X</td>
<td>Federally Qualified Health Clinics (prior to 4/1/10)</td>
<td>N/A – Always ICD-9 code set.</td>
<td>N/A</td>
</tr>
<tr>
<td>74X</td>
<td>Outpatient Therapy</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
</tbody>
</table>

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### Table B - Special Outpatient Claims Processing Circumstances

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-day /1-day Payment Window</td>
<td>Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2015, the claim must be billed with ICD-10 for those bundled outpatient services.</td>
<td>THROUGH</td>
</tr>
</tbody>
</table>
Table C – Professional Claims

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>All anesthesia claims</td>
<td>Anesthesia procedures that begin on 9/30/2015 but end on 10/1/2015 are to be billed with ICD-9 diagnosis codes and use 9/30/2015 as both the FROM and THROUGH date.</td>
<td>FROM</td>
</tr>
</tbody>
</table>

Table D – Supplier Claims

<table>
<thead>
<tr>
<th>Supplier Type</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH/TO Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMEPOS</td>
<td>Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/2015 (i.e., the FROM date of service occurs prior to 10/1/2015 and the TO date of service occurs after 10/1/2015).</td>
<td>FROM</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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Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers

Note: This article was revised on January 30, 2015, to reflect an extension of the moratoria for another 6 months, as noted in the article.

Provider Types Affected

This MLN Matters® Article is intended for Home Health Agencies, Home Health Agency Sub-units, and Part B ambulance suppliers in parts of Florida, Illinois, Michigan, Texas and New Jersey that provide services to Medicare, Medicaid and CHIP beneficiaries.

Provider Action Needed

Effective January 29, 2015, the temporary moratoria on new Home Health Agencies, Home Health Agency Sub-units, and Part B ambulance suppliers are being extended for an additional 6 months in certain geographic locations.
CAUTION – What You Need to Know

During the 6-month temporary moratorium, initial provider enrollment applications and change of information applications to add additional practice locations, received from Home Health Agencies, Home Health Agency Sub-Units and Part B Ambulance suppliers in the listed counties will be denied. Application fees that are paid for applications that are denied due to this temporary moratorium will be refunded.

GO – What You Need to Do

Effective January 29, 2015, Home Health Agencies, Home Health Agency Sub-units, and Part B Ambulance suppliers should not submit initial enrollment applications or change of information applications to add additional practice locations until the 6-month moratoria has expired. CMS will announce in the Federal Register when the moratorium has been lifted or if it will be extended.

Background

In accordance with 42 CFR §424.570(c), the Centers for Medicare & Medicaid Services (CMS) may impose a moratorium on the enrollment of new Medicare providers and suppliers of a specific type or the establishment of new practice locations in a particular geographic area.


Moratoria Extension

Effective January 29, 2015, the temporary moratoria on new Home Health Agencies and Home Health Agency Sub-units is being extended for an additional 6 months in the areas stated in Table 1, below.

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Table 1: Home Health Agencies and Home Health Agency Sub-units under Temporary Moratorium

<table>
<thead>
<tr>
<th>City and State</th>
<th>Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fort Lauderdale, FL</td>
<td>Broward</td>
</tr>
<tr>
<td>Miami, FL</td>
<td>Miami-Dade</td>
</tr>
<tr>
<td></td>
<td>Monroe</td>
</tr>
<tr>
<td>Detroit, MI</td>
<td>Macomb</td>
</tr>
<tr>
<td></td>
<td>Monroe</td>
</tr>
<tr>
<td></td>
<td>Oakland</td>
</tr>
<tr>
<td></td>
<td>Washtenaw</td>
</tr>
<tr>
<td></td>
<td>Wayne</td>
</tr>
<tr>
<td>Dallas, TX</td>
<td>Collin</td>
</tr>
<tr>
<td></td>
<td>Dallas</td>
</tr>
<tr>
<td></td>
<td>Denton</td>
</tr>
<tr>
<td></td>
<td>Ellis</td>
</tr>
<tr>
<td></td>
<td>Kaufman</td>
</tr>
<tr>
<td></td>
<td>Rockwall</td>
</tr>
<tr>
<td></td>
<td>Tarrant</td>
</tr>
<tr>
<td>Houston, TX</td>
<td>Brazoria</td>
</tr>
<tr>
<td></td>
<td>Chambers</td>
</tr>
<tr>
<td></td>
<td>Fort Bend</td>
</tr>
<tr>
<td></td>
<td>Galveston</td>
</tr>
<tr>
<td></td>
<td>Harris</td>
</tr>
<tr>
<td></td>
<td>Liberty</td>
</tr>
<tr>
<td></td>
<td>Montgomery</td>
</tr>
<tr>
<td></td>
<td>Waller</td>
</tr>
<tr>
<td>Chicago, IL</td>
<td>Cook</td>
</tr>
<tr>
<td></td>
<td>DuPage</td>
</tr>
<tr>
<td></td>
<td>Kane</td>
</tr>
<tr>
<td></td>
<td>Lake</td>
</tr>
<tr>
<td></td>
<td>McHenry</td>
</tr>
<tr>
<td></td>
<td>Will</td>
</tr>
</tbody>
</table>

In addition, the temporary moratorium on new Part B ambulance suppliers is being extended for an additional 6 months in the areas stated in Table 2, below.
Table 2: Part B Ambulance Suppliers Under 6-month Temporary Moratoria

<table>
<thead>
<tr>
<th>City and State</th>
<th>Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Houston, TX</td>
<td>Harris</td>
</tr>
<tr>
<td></td>
<td>Brazoria</td>
</tr>
<tr>
<td></td>
<td>Chambers</td>
</tr>
<tr>
<td></td>
<td>Fort Bend</td>
</tr>
<tr>
<td></td>
<td>Galveston</td>
</tr>
<tr>
<td></td>
<td>Liberty</td>
</tr>
<tr>
<td></td>
<td>Montgomery</td>
</tr>
<tr>
<td></td>
<td>Waller</td>
</tr>
<tr>
<td>Philadelphia, PA</td>
<td>Bucks (PA)</td>
</tr>
<tr>
<td></td>
<td>Delaware (PA)</td>
</tr>
<tr>
<td></td>
<td>Montgomery (PA)</td>
</tr>
<tr>
<td></td>
<td>Philadelphia (PA)</td>
</tr>
<tr>
<td></td>
<td>Burlington (NJ)</td>
</tr>
<tr>
<td></td>
<td>Camden (NJ)</td>
</tr>
<tr>
<td></td>
<td>Gloucester (NJ)</td>
</tr>
</tbody>
</table>

Initial provider enrollment applications and change of information applications to add additional practice locations received from Home Health Agencies, Home Health Agency Sub-Units and Part B Ambulance suppliers in the above listed counties will be denied in accordance with 42 CFR §424.570(c). Application fees that are paid for applications that are denied due to this temporary moratorium will be refunded.

**Note:** Home Health Agencies, Home Health Agency Sub-Units and Part B Ambulance suppliers are afforded appeal rights. However, the scope of review will be limited to whether the temporary moratorium applies to the provider or supplier appealing the denial. CMS’ basis for imposing a temporary moratorium is not subject to review.

**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.

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

- “Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 4]”,
  Educational Tool, ICN 909012, downloadable

MLN Matters® Number: MM8581 Revised Related Change Request (CR) #: CR 8581
Related CR Release Date: February 20, 2015 Effective Date: Claims received on or after October 1, 2015
Related CR Transmittal #: R3203CP Implementation Date: October 5, 2015

Note: This article was revised on February 23, 2015 to reflect the revisions to CR8581 issued on December 19, 2014, and February 20, 2015. Clarifications were made regarding the relationship of reopenings to timely filing and also to certain denied claims lines and to clarify the need for a "Remarks" field code for certain reopenings. In addition, the effective and implementation dates are revised. All other information remains the same.

Automation of the Request for Reopening Claims Process

Note: To assist providers with coding a request to reopen claims that are beyond the filing timeframes a Special Edition Article, SE1426, has been developed. That article contains some additional information on this process as well as condition codes and billing scenarios. The article may be reviewed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1426.pdf on the CMS website.

Provider Types Affected

This MLN Matters® Article is intended for providers, including home health and hospice providers, and suppliers submitting institutional claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8581 which informs A/MACs about changes that will allow providers and their vendors to electronically request reopenings of claims. Make sure your
billing staffs are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.

**Background**

When a provider needs to correct or supplement a claim, and the claim remains within timely filing limits, providers may submit an adjustment claim to remedy the error. When the need for a correction is discovered beyond the claims timely filing limit, an adjustment bill is not allowed and a provider must utilize the reopening process to remedy the error.

Generally, reopenings are written requests for corrections that include supporting documentation. However, a standard process across all A/MACs has not been available. In an effort to streamline and standardize the process for providers to request reopenings, CMS petitioned the National Uniform Billing Committee (NUBC) for a “new” bill type frequency code to be used by providers indicating a Request for Reopening and a series of Condition Codes that can be utilized to identify the type of Reopening being requested. These institutional reopenings must be submitted with a “Q” frequency code to identify them as a Reopening.

A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are different from adjustment bills in that adjustment bills are subject to normal claims processing timely filing requirements (i.e., filed within one year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (e.g., claim determinations may be reopened within one year of the date of receipt of the initial determination for any reason, or within one to four years of the date of receipt of the initial determination upon a showing of good cause). Reopenings are only allowed after normal timely filing period has expired.

If the normal timely filing period has not expired, the MAC will return the reopening to the provider and request the provider submit an adjustment claim not a reopening.

Also, MACs interrogate the remarks field for good cause on reopenings that have an adjustment reason code of R2 or R3 and they will return the reopening to the provider when the remarks field is not annotated with one of the following 15 character remarks:

- GOOD_CAUSE: C/A (underline indicates a space)
- GOOD_CAUSE: NME (underline indicates a space)
- GOOD_CAUSE: F/E (underline indicates a space)

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Reopenings are also separate and distinct from the appeals process. A reopening will not be granted if an appeal decision is pending or in process.

MACs will not allow claim lines that have been denied through a Medicare Review process (for example, MR, RAC, CERT, OIG, QIO, etc.) to be reopened, however, other claim lines that were not denied through a Medicare Review process shall be allowed to be reopened.

Also, MACs will not allow Direct Data Entry (DDE) claims that have been fully denied to be reopened. Providers must appeal these claims.

Decisions to allow reopenings are discretionary actions on the part of your A/MAC. An A/MAC’s decision to reopen a claim determination, or refusal to reopen a claim determination, is not an initial determination and is therefore not appealable. Requesting a reopening does not guarantee that request will be accepted and the claim determination will be revised, and does not extend the timeframe to request an appeal. If an A/MAC decides not to reopen an initial determination, the A/MAC will Return To Provider (RTP) the reopening request indicating that the A/MAC is not allowing this discretionary action. In this situation, the original initial determination stands as a binding decision, and appeal rights are retained on the original initial determination. New appeal rights are not triggered by the refusal to reopen, and appeal filing timeframes on the original initial determination are not extended following a contractor’s refusal to reopen. However, when an A/MAC reopens and revises an initial determination, that revised determination is a new determination with new appeal rights.

Providers are reminded that submission of adjustment bills or reopening requests in response to claim denials resulting from review of medical records (including failure to submit medical records in response to a request for records) is not appropriate. Providers must submit appeal requests for such denials.

Additionally, many A/MACs allow reopenings to be submitted hardcopy (by mail or fax) or through a provider online portal. The creation of this new process does not eliminate or negate those processes. Contact your MAC about other ways reopenings may be submitted.

Additional Information


For additional information regarding the distinction between adjustment bills, which are subject to normal claims processing timely filing limits, and reopenings, which may be requested beyond timely filing limitations, review Chapter 1, Section 70.5 of the "Medicare Claims Processing Manual" (IOM 100-4). That manual chapter is available at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf) on the CMS website.


Attachment 1 will assist providers with coding claim’s request for reopening.
**Attachment 1 - Coding Requirements:**

These claims must be submitted with a “Q” in the 4th position of the Type of Bill (TOB xxxQ) to identify them as a Reopening.

**Condition Code Definitions for Reopening**

<table>
<thead>
<tr>
<th>Condition Code</th>
<th>Title</th>
<th>Definition</th>
</tr>
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<tr>
<td>R1</td>
<td>Request for Reopening Reason Code - Mathematical or Computational Mistakes</td>
<td>Mathematical or computational mistakes</td>
</tr>
<tr>
<td>R2</td>
<td>Request for Reopening Reason Code - Inaccurate Data Entry</td>
<td>Inaccurate data entry, e.g., mis-keyed or transposed provider number, referring NPI, date of service, procedure code, etc.</td>
</tr>
<tr>
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<td>Misapplication of a fee schedule</td>
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<td>R5</td>
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</tr>
<tr>
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<td>Other clerical errors or minor errors and omissions not specified in R1-R5 above.</td>
</tr>
<tr>
<td>R7</td>
<td>Request for Reopening Reason Code - Corrections other than Clerical Errors</td>
<td>Claim corrections other than clerical errors within one year of the date of initial determination.</td>
</tr>
<tr>
<td>R8</td>
<td>Request for Reopening Reason Code - New and Material Evidence</td>
<td>A reopening for good cause (one to four years from the date of the initial determination) due to new and material evidence that was not available or known at the time of the determination or decision and may result in a different conclusion.</td>
</tr>
<tr>
<td>R9</td>
<td>Request for Reopening Reason Code - Faulty Evidence</td>
<td>A reopening for good cause (one to four years from the date of the initial determination) because the evidence that was considered in making the determination or decision clearly shows that an obvious error was made at the time of the determination or decision.</td>
</tr>
</tbody>
</table>
MLN Matters® Number: MM8961
Related Change Request (CR) #: CR 8961
Related CR Release Date: January 30, 2015
Effective Date: For claims received on or after July 1, 2015
Related CR Transmittal #: R3181CP
Implementation Date: July 6, 2015

Implementation of New National Uniform Billing Committee (NUBC) Condition Code “53” - “Initial placement of a medical device provided as part of a clinical trial or a free sample”

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8961 implements Condition Code "53" (Initial placement of a medical device provided as part of a clinical trial or a free sample) for reporting on the outpatient hospital claim. Make sure your billing staffs are aware of the new Condition Code of 53.

Background

Current system edits require a condition code to be billed for outpatient claims when the provider bills value code “FD” (Credit Received from the Manufacturer for a Replaced Medical Device), indicating that they have received a credit on the device.
A new Medicare outpatient payment policy was implemented on January 1, 2014, requiring reporting of value code FD for medical devices furnished without cost to the hospital or when the hospital receives a full or partial credit for the device. (See the Federal Register December 10, 2013, pages 75005-75008, IV. OPPS Payment for Devices, B. Adjustment to OPPS Payment for No Cost/Full Credit and Partial Credit Devices at https://www.federalregister.gov/articles/2013/12/10/2013-28737/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical on the Internet.)

Under this policy, outpatient hospitals are required to report the amount of the credit in the amount portion for value code “FD” (Credit Received from the Manufacturer for a Medical Device) when the hospital receives a credit for a device listed in Table 31 of Federal Register December 10, 2013 that is 50 percent or greater than the cost of the device.

Currently, hospitals must use either condition code 49 (Product Replacement within Product Lifecycle) or 50 (Product Replacement for Known Recall of a Product) along with value code FD. These two condition codes describe only replacement devices. They do not describe a reduced cost for initially implanted (non-replacement) devices, which are commonly supplied to Medicare beneficiaries, especially in the context of medical device clinical trials. Therefore, a new condition code is needed to describe initially implanted medical devices that are not replacement devices.

Effective January 1, 2014 (and for claims received on or after July 1, 2015), an additional new condition code "53" was created for institutional provider use. This new code is used to identify and track medical devices that are provided by a manufacturer at no cost or with full credit to the hospital due a clinical trial or a free sample.

Please note that you are no longer required to append the “FB” or “FC” modifier when receiving a device at no cost or with a full or partial credit. Additionally, the Centers for Medicare & Medicaid Services (CMS) limits the Outpatient Prospective Payment System (OPPS) payment deduction for device-intensive Average Production Costs (APCs) to the total amount of the device offset when the “FD” value code appears on a claim.

When a hospital furnishes a device for which it incurs no cost, (these cases include, but are not limited to, devices replaced under warranty, due to recall, or due to defect in a previous device; devices provided in a clinical trial; or devices provided as a sample) the hospital charge for a device furnished to the hospital at no cost should equal $0.00. However, some hospital billing systems require a charge be reported for separately billable codes in order for the claim to be submitted for payment, even items for which the hospital incurs no cost.

Hospitals paid under the OPPS that implant a device furnished at no cost to the hospital shall report a charge of zero for the device, or, if the hospital’s billing system requires that a charge be entered, the hospital shall submit a token charge (e.g. $1.00) on the line with the device code.

CMS recognizes that showing a charge for a device that has been furnished without cost is not optimal, but showing a token charge in this circumstance will allow claims for reasonable and necessary services to be adjudicated.
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 - For information on coverage and billing of the influenza vaccine and its administration, please refer to 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.”

Also, check out the following resources from the Centers for Disease Control and Prevention (CDC): Influenza (Flu) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza, antiviral information, CDC flu mobile app, Q&As, toolkit for long term care employers, and other free resources. Review the CDC’s Antiviral Drugs website for information about how antiviral medications can be used to prevent or treat influenza when influenza activity is present in your community, and view the updated “Influenza Antiviral Medications: Summary for Clinicians.” A CDC Health Update reminding clinicians about the importance of flu antiviral medications was distributed via the CDC Health Alert Network on January 9, 2015, and is available at [http://emergency.cdc.gov/HAN/han00375.asp](http://emergency.cdc.gov/HAN/han00375.asp) on the Internet.
MLN Matters® Number: MM9016  Related Change Request (CR) #: CR 9016
Related CR Release Date: January 30, 2015  Effective Date: July 1, 2015
Related CR Transmittal #: R1459OTN  Implementation Date: July 6, 2015

Continuation of Systematic Validation of Payment Group Codes for Prospective Payment Systems (PPS) Based on Patient Assessments

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9016 informs MACs about the changes needed to implement the Fiscal Intermediary Standard System (FISS) changes required to refine the interface between FISS and the Quality Improvement and Evaluation Service. These changes include new fields to house an Assessment Identification Number (AIN) for each Health Insurance Prospective Payment System (HIPPS) Revenue Code line on submitted claims. Make sure your billing staffs are aware of these changes.

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Background

The PPS case-mix groups used to determine payments under Home Health (HH) PPS, SNF PPS, and the IRF PPS are based on clinical assessments of the beneficiary.

In all three payment systems, the assessments are entered into software at the provider site that encodes the data from the individual assessments into a standard transmission format and transmits the assessments to the State survey agency or a national repository. In addition, the software runs the data from the individual assessments through grouping software that generates a case-mix group to be used on Medicare PPS claims via a Health Insurance PPS (HIPPS) code. Although the Centers for Medicare & Medicaid Services (CMS) provides grouping software, many providers create their own software due to their need to integrate these data entry and grouping functions with their own administrative systems.

Currently, the transmission of assessment data and transmission of HIPPS codes on claims to MACs are an entirely separate processes. The FISS has limited matching access to the assessment databases. Based on current business needs in order to more accurately match assessments, this process needs further refinement. Providers sending the AIN will provide more accurate matching.

Providers may report the AIN for each HIPPS Revenue Code line in various manners based on the type of claim submission that individual providers use.

When providers choose to submit assessment identification using the 837I claims submission, they are to report the AIN for each HIPPS Revenue Code line as follows:

NTE*UPI*123456789012345~

The AIN submitted in the NTE02 segment must be right-justified and zero-filled. Repeat this segment for each HIPPS Revenue code Line (that is, a SNF claim with multiple Revenue Code lines [0022] with a HIPPS code that has a different assessment indicator (positions 4 and 5 of the HIPPS code) as necessary, as follow:

NTE*UPI*123456789012345~NTE*UPI*123456789012345~NTE*UPI*123456789012345~

If there is more than one AIN for each HIPPS Revenue Code line (that is, IRF Revenue Code line [0024] Inactivation/Modification), when providers choose to submit, they must report multiple assessments up to two (2) per each HIPPS Revenue code line in the 837I claim submission as follows:

NTE*UPI*123456789012345223456789012345~

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In this example, the first AIN will represent the most current original/modified assessment and the second AIN (which is in italics beginning with “223” represents a prior original inactivation/modified assessment.

For Direct Data Entry (DDE) claims, providers using DDE should enter the AIN into these newly created fields on the DDE screens. Providers submitting paper claims should use Form Locator 43 to provide this information.

**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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**Seasonal Flu Vaccinations** - For information on coverage and billing of the influenza vaccine and its administration, please refer to [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.”

Also, check out the following resources from the Centers for Disease Control and Prevention (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, antiviral information, CDC flu mobile app, Q&As, toolkit for long term care employers, and other free resources. Review the CDC’s [Antiviral Drugs](http://www.cdc.gov/flu/antivirals/index.htm) website for information about how antiviral medications can be used to prevent or treat influenza when influenza activity is present in your community, and view the updated “Influenza Antiviral Medications: Summary for Clinicians.” A CDC Health Update reminding clinicians about the importance of flu antiviral medications was distributed via the CDC Health Alert Network on January 9, 2015, and is available at [http://emergency.cdc.gov/HAN/han00375.asp](http://emergency.cdc.gov/HAN/han00375.asp) on the Internet.

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Preventing Inappropriate Payments on Home Health Low Utilization Payment Adjustment (LUPA) Claims

Provider Types Affected

This MLN Matters® Article is intended for providers and Home Health Agencies (HHAs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in a Home Health period of coverage.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9027 to notify providers of new edits in Original Medicare systems to ensure Low Utilization Payment Adjustment (LUPA) payments under the Home Health Prospective Payment System (HH PPS) are made appropriately. CR9027 clarifies billing instructions for HH PPS claims. No new policy is created by CR9027; these new requirements improve the enforcement of existing Original Medicare payment policies. Make sure your billing staffs are aware of these changes.
Background

Since January 2008, the HH PPS has included an additional payment when HH PPS episodes subject to LUPAs are the first episode in a sequence of adjacent episodes or are the only episode of care received by a beneficiary. This payment is often referred to as the “LUPA add-on.” Medicare systems apply the LUPA add-on only when certain coding is present on a claim. Medicare systems ensure that if this coding is present, earlier adjacent episodes have not been processed for the same beneficiary. This coding and enforcement is described in CR5877, which was implemented July 7, 2008, and a related MLN Matters® article is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5877.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5877.pdf) on the CMS website.

MACs have reported that in two limited circumstances, Medicare systems may allow more than one LUPA add-on payment during a sequence of adjacent episodes. Those circumstances are:

1. Cases where an incoming claim coded for a LUPA add-on overlaps an earlier episode for the same beneficiary which was also paid a LUPA add-on. When this occurs, Medicare systems currently auto-cancel the earlier episode and trigger the unsolicited response process that ensures the earlier episode's statement dates are adjusted. (This is the same unsolicited response that ensures Partial Episode Payment (PEP) adjustments are applied correctly, though no PEP adjustment is triggered in this case.) Because the earlier episode is canceled and has not yet been re-processed, the incoming claim appears to be the first episode and the LUPA add-on is allowed. The requirements of CR9027 change Medicare systems to identify the duplicate LUPA add-on payment before the earlier episode is canceled and to ensure the add-on is not paid.

2. Cases where two adjacent episodes coded for a LUPA add-on for the same beneficiary by the same provider are processed out of sequence. When the later dated episode is received first, it may appear to Medicare systems to be the first episode and the LUPA add-on is allowed. When the earlier dated episode is received later, Medicare systems look for an earlier episode and find none, so this also appears to be the first episode and the LUPA add-on is allowed. Medicare systems do not currently check to see if a LUPA add-on for a later date has already been paid. The requirements of CR9027 change Medicare systems to identify that a LUPA add-on has already been paid and return the earlier dated claim to the provider. The provider must then correct the admission date on the claim for the later dated episode before the earlier dated claim can be paid.

Finally, per Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act, to be eligible to receive Medicare Home Health services the beneficiary must have a skilled need (that is, require intermittent Skilled Nursing (SN) services, Physical Therapy (PT), and/or Speech-Language Pathology (SLP) services or have a continuing need for Occupational
Therapy (OT) services). The first OT service, which is a dependent service, is covered only when preceded by an intermittent SN visit, PT visit, or SLP visit. The requirements below change Medicare systems to return to the provider any claims for episodes subject to LUPAs that are the first episode in a sequence of adjacent episodes or are the only episode of care received by a beneficiary for which patient eligibility for the Medicare Home Health benefit has not been established (i.e., no SN, PT, or SLP visits reported on the claim).

The following summarizes the “Medicare Claims Processing Manual” revisions that highlight the requirements of CR9027:

1. Chapter 10/Section 10.1.17/Adjustments of Episode Payment –LUPAs
   
   • One criterion that Medicare uses to determine whether a LUPA add-on payment applies is that the claim Admission Date matches the claim “From” Date. HHAs should take care to ensure that they submit accurate admission dates, especially if episodes are submitted out of sequence. Inaccurate admission dates may result in Medicare systems returning LUPA claims where an add-on payment applies, but the add-on was paid inappropriately on a later dated episode in the same sequence of adjacent episodes.
   
   • Medicare systems may return to the provider LUPA claims if the claim meets the criteria for a LUPA add-on payment but it contains no qualifying skilled service. In these cases, the HHA may add the skilled visit to the claim if it was omitted in error and re-submit the claim. Otherwise, the HHA may only re-submit the claim using condition code 21, indicating a billing for a denial notice.

2. Chapter 10/Section 40.1/Request for Anticipated Payment (RAP) and Section 40.2/HH PPS Claims
   
   • For initial episodes, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode. For subsequent episodes, the HHA reports on the 0023 revenue code the date of the first visit provided during the episode line, regardless of whether the visit was covered or non-covered.

As a result of CR9027, Providers should note that a claim will be rejected for repricing if the following conditions are met:

• The Type of Bill is 032x,

• Pricer return code 14 is present, indicating a LUPA add-on,
• The claim "From" date falls within the "From" and "Through" dates of a paid claim in history for the same beneficiary, and
• Pricer return code 14 is also present on the paid claim in history.

As a result of CR9072, claims will be returned to the provider if any of the following conditions are met:
• The Type of Bill is 032x;
• There are 4 or fewer covered visits (occurrences of revenue codes 042x, 043x, 044x, 055x, 056x and 057x);
• The Admission Date matches the From Date;
• The first position of the HIPPS code is 1 or 2; or
• Condition code 47 is not present, and there is no qualifying skilled service (at least one covered occurrence of revenue codes 042x, 044x or 055x).

Additional Information


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

Seasonal Flu Vaccinations - For information on coverage and billing of the influenza vaccine and its administration, please refer to 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.”

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MLN Matters® Number: MM9031 Revised  Related Change Request (CR) #: CR 9031
Related CR Release Date: February 18, 2015  Effective Date: July 1, 2015
Related CR Transmittal #: R1471OTN  Implementation Date: July 6, 2015

Renaming PPS-FLX6- PAYMENT Field in the Inpatient Prospective Payment System (IPPS) Pricer Output

Note: This article was revised on February 23, 2015, to reflect the revised CR9031 issued on February 18. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9031 informs MACs about the changes to the PPS-FLX6-PAYMENT field in the IPPS PRICER output record, created in CR8546. The field will be renamed to identify the field as the Hospital Acquired Condition (HAC) Reduction Amount. Make sure that your billing staffs are aware of these changes.
Background

Section 3008 of the Affordable Care Act established a program, beginning in Fiscal Year (FY) 2015, for IPPS hospitals to improve patient safety by imposing financial penalties on hospitals that perform poorly with regard to certain Hospital Acquired Conditions (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, hospitals that rank in the lowest-performing quartile of selected HAC measures will be subject to a reduction of what they would otherwise be paid under the IPPS.

The HAC payment reduction amount is currently displayed in the PPS-FLX6- PAYMENT field. The new name for this field will be HAC PAYMENT AMT.

Additional Information


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

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MLN Matters® Number: MM9042  Related Change Request (CR) #: CR 9042
Related CR Release Date: January 30, 2015  Effective Date: January 1, 2014
Related CR Transmittal #: R1455OTN  Implementation Date: July 6, 2015

Corrections to Processing Service Facility Information on Hospice Claims

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9042 informs providers that MACs have reported that the Medicare system is incorrectly replacing the billing facility ZIP code with the service facility location ZIP code, resulting in inaccurate billing provider information and incorrect payments. The hospice benefit does not make payment based on the service facility location and CR9042 will require the Medicare system to correctly use the billing facility location and not to replace the billing facility location with the service facility location.

Background

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), the Centers for Medicare & Medicaid Services (CMS) issued instructions for optional reporting effective January 1, 2014 and mandatory reporting effective April 1, 2014, for hospice agencies billing Medicare for services provided in a facility other than their billing location.

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to report the facility location information in the 5010 electronic claim transaction loop 2310E. Under the requirements of the 5010 electronic claim, this field has situational usage and must be reported when appropriate. For hospice claims, this data is informational only and not used for payment purposes.

The MACs that process hospice claims have reported that the Medicare system is applying the service facility location zip code to the billing facility record, resulting in inaccurate billing provider information and inaccurate payments for some physician services.

CR9042 requires the Medicare system to stop using the service facility location for the billing facility. MACs are required to correct provider records and claim payments when an error is brought to their attention by the billing facility within 6 months of the implementation date of CR9042. MACs may override timely-filing edits as necessary to correct claims.

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/MLN MattersArticles/index.html under - How Does It Work?

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**Payment Codes on Home Health Claims Will Be Matched Against Patient Assessments**

**Provider Types Affected**

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

**What You Need to Know**

Beginning on April 1, 2015, Medicare systems will compare the Health Insurance Prospective Payment System (HIPPS) code on a Medicare home health claim to the HIPPS code generated by the corresponding Outcomes and Assessment Information Set (OASIS) assessment before the claim is paid. If the HIPPS code from the OASIS assessment differs, Medicare will use the OASIS-calculated HIPPS code for payment. At this time, if no corresponding OASIS assessment is found the claim will process normally.
Background

Original Medicare determines payments of Home Health (HH) claims using case-mix groups based on the OASIS assessment of the beneficiary. OASIS assessments are entered into software at the HHA that transmits the data to a national quality data repository. In addition, the software runs the data from each assessment through a grouping program that generates a case-mix group. The HHA submits the case-mix group on their claim as a HIPPS code. Although the Centers for Medicare & Medicaid Services (CMS) provides free grouping software, many providers create their own software to integrate these data entry and grouping functions with their own administrative systems.

Previously, the transmission of assessment data and the submission of claims were entirely separate processes. The Fiscal Intermediary Shared System (FISS), which processes all Original Medicare HH claims, did not have access to the quality data repository. As a result, FISS could not validate the submitted HIPPS code against the associated OASIS assessment. This created a payment vulnerability for the Medicare program which the Office of Inspector General (OIG) identified in several studies.

Implementing the Change

In 2012, CMS issued Change Request (CR) 7760, which required the FISS system to create a file exchange interface with the national quality data repository, the Quality Information Evaluation System (QIES). This interface provided the infrastructure to validate HIPPS codes against OASIS assessments and to also perform similar validations of Inpatient Rehabilitation Facility (IRF) and Skilled Nursing Facility (SNF) claims. The interface was implemented October 1, 2012.

The QIES required additional changes to perform the matching of the claim data to its corresponding assessment and to return to the FISS the HIPPS code calculated from the assessment. In order to best manage risk, CMS decided to test and implement the matching process in phases. The MACs tested the IRF matching process during 2013 and implemented it in claims processing in February 2014. The MACs successfully tested the HH matching process during the remainder of 2014. For HH PPS claims received on or after April 1, 2015, Medicare will validate the submitted HIPPS code against the OASIS-calculated HIPPS code present in QIES.

Impact on Home Health Agencies

HHAs do not need to make any changes to their billing systems. HH PPS claims will be suspended temporarily during processing to allow for the file exchange between FISS and QIES. The claims will be suspended with FISS reason code 37071 in status/locations SMFRX0-SMFRX4. This will occur during the 14 day payment floor period and should not delay payments to HHAs.

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If the matching process determines that the OASIS-calculated HIPPS code is different from the one submitted on the claim, the OASIS-calculated HIPPS code will be used for payment. If the HIPPS code matches or if an OASIS assessment corresponding to the claim is not found, the claim will process normally at this time.

If the matching process changes the HIPPS code used for payment, special coding on the remittance advice will notify the HHA. Claim Adjustment Reason Code 186 (Level of care change adjustment) and Remittance Advice Remark Code N69 (PPS code changed by claims processing system) will identify the recoded claims. These are the same codes used to identify claims recoded due to changes in therapy services. The electronic remittance advice will also return to the HHA the HIPPS code used for payment.

**Understanding Changed HIPPS Codes in FISS**

The FISS will display a new field in Direct Data Entry (DDE) that will contain the OASIS-calculated HIPPS code. The field will be named “RETURN-HIPPS1.” When the OASIS-calculated HIPPS code is used for payment, the code in this field will match the code on the electronic remittance advice.

It is also possible that an OASIS-calculated HIPPS code may be re-coded further by Medicare systems. The OASIS-calculated HIPPS code will be sent to the HH PPS Pricer program which may change the code based on changes in therapy services or whether the claim is for an early or later episode. In this case, the Pricer re-coded HIPPS code will be used for payment and will continue to be recorded in the APC-HIPPS field. HHAs will be able to recognize this case because there will be three HIPPS codes on the claim record in DDE:

<table>
<thead>
<tr>
<th>Field in DDE</th>
<th>DDE Map</th>
<th>Represents</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCPC</td>
<td>MAP171E</td>
<td>HHA-submitted HIPPS code</td>
</tr>
<tr>
<td>RETURN-HIPPS1</td>
<td>MAP171E</td>
<td>OASIS-calculated HIPPS code</td>
</tr>
<tr>
<td>APC-HIPPS</td>
<td>MAP171A</td>
<td>Pricer re-coded HIPPS code</td>
</tr>
</tbody>
</table>

**Next Steps**

Per the Code of Federal Regulations (CFR) at 42 CFR 484.210(e), submission of an OASIS assessment for all HH episodes of care is a condition of payment. If the OASIS is not found during medical review of a claim, the claim is denied. At this time, if no corresponding OASIS assessment is found by the claims matching process Medicare will release the claim to process normally, unless the claim is selected for medical review. However, the OIG...

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recommended that the Medicare program use this claims matching process to further enforce the condition of payment.

CMS plans to use the claims matching process to enforce this condition of payment in the earliest available Medicare systems release. At that time, Medicare will deny claims when a corresponding assessment is past due in the QIES but is not found in that system. CMS will provide notice to HHAs as soon as possible after we determine the implementation date.

Additional Information


The recommendations of the OIG regarding this project are available at http://oig.hhs.gov/oei/reports/oei-01-10-00460.asp on the OIG website.

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

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Centers for Medicare & Medicaid Services
Articles for Part B Providers
Coding for ICD-10-CM: More of the Basics MLN Connects™ Video - In this MLN Connects™ video on Coding for ICD-10-CM: More of the Basics, Sue Bowman from the American Health Information Management Association (AHIMA) and Nelly Leon-Chisen from the American Hospital Association (AHA) provide a basic introduction to ICD-10-CM coding. The objective of this video is to enhance viewers’ understanding of the characteristics and unique features of ICD-10-CM, as well as similarities and differences between ICD-9-CM and ICD-10-CM. Run time: 36 minutes.

MLN Matters® Number: MM9035 Related Change Request (CR) #: CR 9035
Related CR Release Date: January 30, 2015 Effective Date: January 1, 2015
Related CR Transmittal #: R3182CP Implementation Date: April 6, 2015

Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9035 informs MACs about the HCPCS codes for 2015 that are both subject to and excluded from CLIA edits. CR 9035 also includes the HCPCS codes discontinued as of December 31, 2014.

Make sure that your billing staffs are aware of these CLIA-related changes for 2015 and that you remain current with CLIA certification requirements.
Background

CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that the Centers for Medicare & Medicaid Services (CMS) only pay for laboratory tests performed in certified facilities, each claim for a HCPCS code that is considered a CLIA laboratory test is currently edited at the CLIA certificate level.

The HCPCS codes that are considered a laboratory test under CLIA change each year, and your Medicare contractors need to be informed about the new HCPCS codes that are both subject to CLIA edits and excluded from CLIA edits.

Discontinued HCPCS Codes

The HCPCS codes listed in Table 1 below were discontinued on December 31, 2014.

Table 1: HCPCS Codes Discontinued on December 31, 2014

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0417</td>
<td>Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, 21-40 specimens</td>
</tr>
<tr>
<td>G0418</td>
<td>Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, 41-60 specimens</td>
</tr>
<tr>
<td>G0419</td>
<td>Surgical pathology, gross and microscopic examination, for prostate needle biopsy, any method, &gt;60 specimens</td>
</tr>
<tr>
<td>80100</td>
<td>Drug screen, multiple drugs</td>
</tr>
<tr>
<td>80101</td>
<td>Drug screen</td>
</tr>
<tr>
<td>80102</td>
<td>Drug confirmation test</td>
</tr>
<tr>
<td>80103</td>
<td>Tissue preparation for drug analysis</td>
</tr>
<tr>
<td>80104</td>
<td>Drug screen, multiple drugs</td>
</tr>
<tr>
<td>80152</td>
<td>Amitriptyline (antidepressant) level</td>
</tr>
<tr>
<td>80154</td>
<td>Benzodiazepines level</td>
</tr>
<tr>
<td>80160</td>
<td>Desipramine level</td>
</tr>
<tr>
<td>80166</td>
<td>Assay of doxepin</td>
</tr>
<tr>
<td>80172</td>
<td>Gold level</td>
</tr>
<tr>
<td>80174</td>
<td>Imipramine level</td>
</tr>
<tr>
<td>80182</td>
<td>Nortriptyline level</td>
</tr>
<tr>
<td>80196</td>
<td>Salicylate (aspirin) level</td>
</tr>
<tr>
<td>HCPCS Code</td>
<td>Descriptor</td>
</tr>
<tr>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>80440</td>
<td>Thyrotropin releasing hormone (TRH) (hypothalamus hormone) stimulation panel</td>
</tr>
<tr>
<td>82000</td>
<td>Acetaldehyde blood test</td>
</tr>
<tr>
<td>82003</td>
<td>Acetaminophen level</td>
</tr>
<tr>
<td>82055</td>
<td>Alcohol (ethanol) level</td>
</tr>
<tr>
<td>82101</td>
<td>Urine alkaloids level</td>
</tr>
<tr>
<td>82145</td>
<td>Amphetamine or methamphetamine level</td>
</tr>
<tr>
<td>82205</td>
<td>Barbiturates level</td>
</tr>
<tr>
<td>82520</td>
<td>Cocaine (drug) level</td>
</tr>
<tr>
<td>82646</td>
<td>Dihydrocodeinone (drug) measurement</td>
</tr>
<tr>
<td>82649</td>
<td>Dihydromorphinone (drug) level</td>
</tr>
<tr>
<td>82651</td>
<td>Dihydrotestosterone (DHT) level</td>
</tr>
<tr>
<td>82654</td>
<td>Dimethadione (drug) level</td>
</tr>
<tr>
<td>82666</td>
<td>Epiandrosterone (synthetic hormone) level</td>
</tr>
<tr>
<td>82690</td>
<td>Ethchlorvynol (drug) level</td>
</tr>
<tr>
<td>82742</td>
<td>Flurazepam (drug) level</td>
</tr>
<tr>
<td>82953</td>
<td>Glucose (sugar) tolerance test</td>
</tr>
<tr>
<td>82975</td>
<td>Glutamine (amino acid by product) level</td>
</tr>
<tr>
<td>82980</td>
<td>Glutethimide (drug) level</td>
</tr>
<tr>
<td>83008</td>
<td>Guanosine monophosphate (cellular chemical) level</td>
</tr>
<tr>
<td>83055</td>
<td>Sulfhemoglobin (hemoglobin) analysis</td>
</tr>
<tr>
<td>83071</td>
<td>Hemosiderin (hemoglobin breakdown product) level</td>
</tr>
<tr>
<td>83634</td>
<td>Urine lactose (carbohydrate) analysis</td>
</tr>
<tr>
<td>83805</td>
<td>Meprobamate (sedative) level</td>
</tr>
<tr>
<td>83840</td>
<td>Methadone level</td>
</tr>
<tr>
<td>83858</td>
<td>Methsuximide (drug) level</td>
</tr>
<tr>
<td>83866</td>
<td>Mucopolysaccharides (protein) screening test</td>
</tr>
<tr>
<td>83887</td>
<td>Nicotine level</td>
</tr>
<tr>
<td>83925</td>
<td>Opiates (drug) measurement</td>
</tr>
</tbody>
</table>
New HCPCS Codes for 2015

The HCPCS codes listed in Table 2 below are new for 2015 and are subject to CLIA edits. The list does not include new HCPCS codes for waived tests or provider-performed procedures. The HCPCS codes listed in Table 2 require a facility to have either a:

1. CLIA certificate of registration (certificate type code 9);
2. CLIA certificate of compliance (certificate type code 1); or
3. CLIA certificate of accreditation (certificate type code 3).

The following facilities are not permitted to be paid for these tests:

1. A facility without a valid, current, CLIA certificate;
2. A facility with a current CLIA certificate of waiver (certificate type code 2); or
3. A facility with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4).

Note: The HCPCS code 89337 [Frozen preservation of mature eggs] is new for 2015, is excluded from CLIA edits and does not require a facility to have any CLIA certificate.

Table 2: New HCPCS Codes Subject to CLIA Edits for 2015

Note: Does not include new HCPCS codes for waived tests or provider-performed procedures.
<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>G6030</td>
<td>Amitriptyline</td>
</tr>
<tr>
<td>G6031</td>
<td>Benzodiazepines</td>
</tr>
<tr>
<td>G6032</td>
<td>Desipramine</td>
</tr>
<tr>
<td>G6034</td>
<td>Doxepin</td>
</tr>
<tr>
<td>G6035</td>
<td>Gold</td>
</tr>
<tr>
<td>G6036</td>
<td>Assay of imipramine</td>
</tr>
<tr>
<td>G6037</td>
<td>Nortriptyline</td>
</tr>
<tr>
<td>G6038</td>
<td>Salicylate</td>
</tr>
<tr>
<td>G6039</td>
<td>Acetaminophen</td>
</tr>
<tr>
<td>G6040</td>
<td>Alcohol (ethanol) any specimen except breath</td>
</tr>
<tr>
<td>G6041</td>
<td>Alkaloids, urine, quantitative</td>
</tr>
<tr>
<td>G6042</td>
<td>Amphetamine or methamphetamine</td>
</tr>
<tr>
<td>G6043</td>
<td>Barbiturates, not elsewhere specified</td>
</tr>
<tr>
<td>G6044</td>
<td>Cocaine or metabolite</td>
</tr>
<tr>
<td>G6045</td>
<td>Dihydrocodeinone</td>
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<tr>
<td>G6046</td>
<td>Dihydromorphinone</td>
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<tr>
<td>G6047</td>
<td>Dihydrotestosterone</td>
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<tr>
<td>G6048</td>
<td>Dimethadione</td>
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<td>G6049</td>
<td>Epiandrosterone</td>
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<td>Flurazepam</td>
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<td>Meprobamate</td>
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<td>Methadone</td>
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<tr>
<td>G6054</td>
<td>Methsuximide</td>
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<tr>
<td>G6055</td>
<td>Nicotine</td>
</tr>
<tr>
<td>G6056</td>
<td>Opiate(s), drug and metabolites, each procedure</td>
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<tr>
<td>G6057</td>
<td>Phenothiazine</td>
</tr>
<tr>
<td>G6058</td>
<td>Drug confirmation, each procedure</td>
</tr>
<tr>
<td>80163</td>
<td>Digoxin level</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
</tr>
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<tr>
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<td>Valproic acid level</td>
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<tr>
<td>80300</td>
<td>Drug screen</td>
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<td>80301</td>
<td>Drug screen</td>
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<td>80302</td>
<td>Drug screen</td>
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<td>Drug screen</td>
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<td>80304</td>
<td>Drug screen</td>
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<td>80320</td>
<td>Alcohols levels</td>
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<td>Amphetamines levels</td>
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<td>Antiepileptics levels</td>
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<td>Antiepileptics levels</td>
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<tr>
<td>80342</td>
<td>Antipsychotics levels</td>
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<tr>
<td>HCPCS Code</td>
<td>Descriptor</td>
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<tr>
<td>80343</td>
<td>Antipsychotics levels</td>
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<td>Barbiturates levels</td>
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<td>Benzodiazepines levels</td>
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<td>Benzodiazepines levels</td>
</tr>
<tr>
<td>80348</td>
<td>Buprenorphine level</td>
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<tr>
<td>80349</td>
<td>Cannabinoids levels</td>
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<td>Cannabinoids levels</td>
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<td>Cannabinoids levels</td>
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<td>Fentanyl level</td>
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<td>80355</td>
<td>Gabapentin level nonblood</td>
</tr>
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<td>Heroin metabolite level</td>
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<td>80357</td>
<td>Ketamine and norketamine levels</td>
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<td>Methadone level</td>
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<td>Methylendioxyamphetamine levels</td>
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<td>Methylphenidate level</td>
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<td>Opiates levels</td>
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<td>Pregabalin level</td>
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<td>80367</td>
<td>Propoxyphene level</td>
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<td>80368</td>
<td>Sedative hypnotics (nonbenzodiazepines) levels</td>
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<td>Synthetic stimulants levels</td>
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<td>HCPCS Code</td>
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<td>Test for detecting genes associated with heart disease</td>
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<td>81470</td>
<td>Test for detecting genes associated with intellectual disability</td>
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</table>
On November 19, 2014, CMS released CR 8871 which mentioned that effective for services performed on or after June 2, 2014, the new HCPCS G0472, HCV screening, will be recognized as a covered service. G0472 is a code that:

- Is considered a test under CLIA;
- Is subject to CLIA edits; and
- Would require a facility to have either:
  - A CLIA certificate of registration (certificate type code 9),
  - A CLIA certificate of compliance (certificate type code 1), or
  - A CLIA certificate of accreditation (certificate type code 3).

<table>
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<tr>
<th>HCPCS Code</th>
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<tr>
<td>81471</td>
<td>Test for detecting genes associated with intellectual disability</td>
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<td>Test for detecting genes associated with breast cancer</td>
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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.

Seasonal Flu Vaccinations - For information on coverage and billing of the influenza vaccine and its administration, please refer to 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.”

Also, check out the following resources from the Centers for Disease Control and Prevention (CDC): Influenza (Flu) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza, antiviral information, CDC flu mobile app, Q&As, toolkit for long term care employers, and other free resources. Review the CDC’s Antiviral Drugs website for information about how antiviral medications can be used to prevent or treat influenza when influenza activity is present in your community, and view the updated “Influenza Antiviral Medications: Summary for Clinicians.” A CDC Health Update reminding clinicians about the importance of flu antiviral medications was distributed via the CDC Health Alert Network on January 9, 2015, and is available at http://emergency.cdc.gov/HAN/han00375.asp on the Internet.

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