# Medicare Monthly Review

**Issue No. MMR 2015-05**  
**May 2015**

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

Medicare policies can be accessed from the Medical Policy Center section of our 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](http://www.NGSMedicare.com).
Revised Local Coverage Determinations and Articles: April and May 2015

April 8 and 15, 2015 Revisions

Erythropoiesis Stimulating Agents (ESA) – Local Coverage Determination (LCD) (L25211)
Added ICD-9-CM code 238.75 to Group 5 in the “ICD-9-CM Codes that Support Medical Necessity” section for HCPCS codes J0881 and J0885. Removed obsolete date information from the “Other Comments” section.

Erythropoiesis Stimulating Agents (ESA) – Supplemental Instructions Article (SIA) (A44399)
ICD-9-CM code 238.75 was added to the following coding guideline:
- Patients with myelodysplastic syndrome - ICD-9-CM codes 238.72, or 238.74, 238.75 or 238.76.
  Note: No ICD-9-CM code for anemia is required.

Left Atrial Appendage Closure or Occlusion – LCD (L35506)
The LCD was revised, effective for services rendered on or after 4/8/2015, to indicate that the FDA had approved the Watchman device on 3/13/2015. Additional literature review has also been added.

May 2015 Revisions

Cardiac Catheterization and Coronary Angiography – (LCD) (L26880)
The LCD was revised to remove coding provisions for add-on CPT/HCPCS codes 92978, 92979, 93462, 93463, 93464, 93563, 93564, 93565, 93566, 93567, 93568, 93571, 93572, 36248, and G0278. A note was added to the ICD-9 section stating that while there are no ICD-9 code lists for add-on codes within this LCD, all provisions for these services, as specified in the Indications and Limitations section of the LCD, must be followed for coverage to apply. In addition, this note was added to the list of ICD-9 codes for Extra-cardiac Angiography: The ICD-9 code list below applies to these procedures only when related to provisions in this LCD.

Cardiac Catheterization and Coronary Angiography – SIA (A50603)
Article revised to update CPT codes that can be billed with CPT 93462: CPT codes 93582, 93653 and 93654 were added and deleted CPT codes 93651 and 93652 were removed.

Combined Ovarian Cancer Biomarker Tests – LCD (L32589)
CPT codes 81500 and 81503 have been added to the LCD effective for dates of service on or after 04/01/2015. Based on CMS Transmittal 3205 - Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – April CY 2015 Update, the status for CPT codes 81500 and 81503 has changed to a procedure status=X. No comment and notice periods required and none given.

EpiFix® - Related to LCD L26003 – SIA (A52159)
Coverage expanded to include venous statis ulcers (VSUs). The “Indications”, “ICD-9-CM Codes that Support Medical Necessity” and “Sources of Information and Basis for Decision” were revised.

Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy – LCD (L35336)
- The last bullet under “General Procedure Requirements” has been revised to state:
  Both diagnostic and therapeutic IA facet joint injections and medial branch blocks (see criteria below) may be acceptably performed without steroids.
- The first bullet under “Diagnostic Facet Joint Injections” has been revised to state:
  Dual MBBs (a series of two MBBs) are necessary to diagnose facet pain due to the unacceptably high false positive rate of single MBB injections.
• The second bullet under “Therapeutic Injections” has been revised to state:
  Recurrent pain at the site of previously treated facet joint may be treated without additional
diagnostic blocks if > 50% pain relief from the previous block(s) lasted at least 3 months.

Noncovered Services – LCD (L32456)
Based on a reconsideration request for prostatic urethral lift (PUL), reviewed sources were added to the
LCD. No change was made to coverage.

Carotid Intima-Media Thickness (CIMT) criteria that were included in the Draft LCD presented in Oct.
2014, have been deleted since, effective January 1, 2015, this service is considered noncovered by
Medicare.

Ranibizumab (Lucentis™) and Aflibercept (Eylea™) – Related to LCD L25820 (A46091)
The article has been revised to add diabetic retinopathy (DR) in patients with DME to the indications for
aflibercept effective for dates of service on or after 03/25/2015. ICD-9-CM code 362.02 has been added
to the Group 2: Codes for aflibercept effective for dates of service on or after 03/25/2015. The “Utilization”
guidelines have been revised to indicate: The dose and frequency of administration should be consistent
with the FDA approved package insert. When dose and/or frequency are different from the FDA approved
package insert, literature support for the specific schedule chosen should be available. The “Sources of
Information” section has been revised to update compendia review date and to remove all but the most
current FDA label information.

Added liraglutide (Saxenda®) (J3590) and insulin glargine injection (Toujeo®) (J3590) effective
6/15/2015.

Added liraglutide (Saxenda®) (J3590) and insulin glargine injection (Toujeo®) (J3590) effective
6/15/2015.

Stem Cell Transplantation - Medical Policy Article (A51834)
Based on provider correspondence, ICD-9-CM codes, 200.40-200.48, for mantle cell lymphoma have
been added to the Group 2: codes for autologous stem cell transplants (CPT code 38241) effective for
dates of service on or after 5/1/2015.

National Government Services Articles for Part A Providers

New Self-Service Tools Available to Assist Calculating FQHC PPS Reimbursement
National Government Services has created new provider self-service tools to assist federally qualified
health centers (FQHCs) with calculating prospective payment system (PPS) reimbursement.

On 10/1/2014, FQHC providers began transitioning to PPS billing and reimbursement. This payment
system was established to provide a base reimbursement rate for FQHCs. The base rate for 2015 of
$158.85 is subject to change based on the FQHC’s location using a Geographic Adjustment Factor
(GAF). The base rate is also subject to increase when services are provided to a new patient, or when an
annual wellness visit (AWV) or initial preventive physical examination (IPPE) is performed as part of the
encounter. New billing guidelines under FQHC PPS include the use of payment codes and associated
charges to identify each billable encounter. Reimbursement is based on the lesser of the adjusted base
PPS rate and the provider’s payment code charges.

Three FQHC PPS calculators are available on our website, www.NGSMedicare.com; select FQHC >
Provider Resources > Calculators & Tools. Please select the appropriate file, based on the date of
The calculators are designed to:

- Identify GAF based on provider location
- Calculate GAF-adjusted base PPS rate
- Apply new patient/IPPE/AWV adjustment
- Compare provider’s payment code charges to adjusted PPS rate to determine provider reimbursement
  - Before application of coinsurance/sequestration

**Using the Calculators**

Enter the facility’s provider number (optional). Using the drop down options, identify the facility’s location to calculate the GAF. Designate whether the tool should apply any adjustments for new patients, AWV and IPPE. Enter the actual charges associated with the reported FQHC payment code. The FQHC PPS reimbursement will be calculated.
Centers for Medicare & Medicaid Services
Articles for Part A&B Providers
NEW product from the Medicare Learning Network® (MLN)

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

MLN Matters® Number: MM8874  Revised Related Change Request (CR) #: CR 8874
Related CR Release Date: April 3, 2015  Effective Date: January 1, 2015
Related CR Transmittal #: R3232CP  Implementation Date: January 5, 2015

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

Note: This article was revised on April 8, 2015, to reflect the revised CR8874 issued on April 3. In the article, the CR release date, transmittal number, and the Web address for accessing CR8874 are revised. In addition, information regarding deductible and coinsurance applicability to HCPCS 00810 services on page 6 of the article is updated. All other information remains the same.

**Provider Types Affected**

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

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

Background

The following outlines the CMS updates:

**Intensive Behavioral Therapy for Obesity**

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

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

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

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

- **Claim Adjustment Reason Code (CARC) 167**: This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- **Remittance Advice Remarks Code (RARC) N386**: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.mcd.search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Effective for claims with dates of service on or after January 1, 2015, beneficiary coinsurance and deductible do not apply to claim lines with HCPCS code G0473.
Note that Medicare pays claims with code G0473 only when submitted by the following provider specialty types as found on the provider's Medicare enrollment record:

- 01 - General Practice
- 08 - Family Practice
- 11 - Internal Medicine
- 16 - Obstetrics/Gynecology
- 37 - Pediatric Medicine
- 38 - Geriatric Medicine
- 50 - Nurse Practitioner
- 89 - Certified Clinical Nurse Specialist
- 97 - Physician Assistant

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

- CARC 8: The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N95: This provider type/provider specialty may not bill this service.
- Group Code CO (if GZ modifier present) or PR (if modifier GA is present).

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

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

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

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

Remember that Medicare will deny claim lines billed for HCPCS codes G0447 and G0473 if billed more than 22 times in a 12-month period using the following codes:
• CARC 119: Benefit maximum for this time period or occurrence has been reached.
• RARC N362: The number of days or units of service exceeds our acceptable maximum.
• Group Code CO (if GZ modifier present) or PR (if modifier GA is present).

**Note:** MACs will display the next eligible date for obesity counseling on all MAC provider inquiry screens.

MACs will allow both a claim for the professional service and a claim for a facility fee for G0473 when that code is billed on type of bill (TOB) 13X or on TOB 85X when revenue code 096X, 097X, or 098X is on the TOB 85X. Payment on such claims is based on the following:

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

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

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

**Digital Breast Tomosynthesis**

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

Effective January 1, 2015, HCPCS code 77063 (Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)), must be billed in conjunction with the screening mammography HCPCS code G0202 (Screening mammography, producing direct digital image, bilateral, all views, 2D imaging only.

Effective January 1, 2015, beneficiary coinsurance and deductible does not apply to claim lines with 77063 (Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)).
Payment for 77063 is made only when billed with an ICD-9 code of V76.11 or V76.12 (and when ICD-10 is effective with ICD-10 code Z12.31). When denying claim lines for 77063 that are submitted without the appropriate diagnosis code, the claim lines are denied using the following messages:

- **CARC 167:** This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- **RARC N386:** This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.mcd.search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

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

On institutional claims:

- **MACs will pay for tomosynthesis, HCPCS code 77063,** on TOBs 12X, 13X, 22X, 23X based on MPFS, and TOB 85X with revenue code other than 096x, 097x, or 098x based on reasonable cost. TOB 85X claims with revenue code 096x, 097x, or 098x are paid based on MPFS (115% of the lesser of the fee schedule amount and submitted charge).

- **MACs will pay for tomosynthesis, HCPCS code 77063 with revenue codes 096X, 097X,** or 098X when billed on TOB 85X Method II based on 115% of the lesser of the fee schedule amount or submitted charge.

- **MACs will return to the provider any claim submitted with tomosynthesis, HCPCS code 77063 when the TOB is not 12X, 13X, 22X, 23X, or 85X.**

- **MACs will pay for tomosynthesis, HCPCS code 77063, on institutional claims TOBs 12X, 13X, 22X, 23X, and 85X when submitted with revenue code 0403 and on professional claims TOB 85X when submitted with revenue code 096X, 097X, or 098X.**

- **Effective for claims with dates of service on or after January 1, 2015, MACs will RTP claims for HCPCS code 77063 that are not submitted with revenue code 0403, 096X, 097X, or 098X.**

**Anesthesia Furnished in Conjunction with Colonoscopy**

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

In the CY 2015 PFS Proposed Rule, CMS proposed to revise the definition of “colorectal cancer screening tests” to include anesthesia separately furnished in conjunction with

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

As a result, effective for claims with dates of service on or after January 1, 2015, anesthesia professionals who furnish a separately payable anesthesia service in conjunction with a screening colonoscopy (HCPCS code 00810 performed in conjunction with G0105 and G0121) shall include the following on the claim for the services that qualify for the waiver of coinsurance and deductible:

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

In addition, deductible is not applied to claim lines with HCPCS 00810 services that are billed with the PT modifier for services on or after January 1, 2015. The deductible is also not applied when the PT modifier is appended to at least either one of the CPT codes within the surgical range of CPT codes (10000-69999) or HCPCS codes G6018-G6028 on the claim for services that were furnished on the same date of service as the procedure. But, MACs will apply deductible and coinsurance to claim lines for HCPCS 00810 services billed without modifier 33 or modifier PT.

### Additional Information


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

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

NEW product from the Medicare Learning Network® (MLN)
• Provider Compliance Tips for Computed Tomography (CT) Scans
  Podcast, ICN 909016, downloadable only

MLN Matters® Number: MM9078
Related Change Request (CR) #: CR 9078
Related CR Release Date: February 20, 2015
Effective Date: August 13, 2013
Related CR Transmittal #: R3204CP and R179NCD
Implementation Date: July 6, 2015

National Coverage Determination (NCD) for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers

Provider Types Affected
This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for single chamber and dual chamber permanent cardiac pacemaker services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9078 informs MACs that the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD) and concluded that implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Make sure that your billing staffs are aware of these changes.

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association.
Background

Permanent cardiac pacemakers refer to a group of self-contained, battery-operated, implanted devices that send electrical stimulation to the heart through one or more implanted leads. Single chamber pacemakers typically target either the right atrium or right ventricle. Dual chamber pacemakers stimulate both the right atrium and the right ventricle. On August 13, 2013, CMS issued an NCD, in which CMS concluded that implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible, symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example, syncope, seizures, congestive heart failure, dizziness, or confusion).

The following indications are covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Documented non-reversible symptomatic bradycardia due to sinus node dysfunction.
2. Documented non-reversible symptomatic bradycardia due to second degree and/or third degree atrioventricular block.

The following indications are non-covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Reversible causes of bradycardia such as electrolyte abnormalities, medications or drugs, and hypothermia.
2. Asymptomatic first degree atrioventricular block. *(exception)
3. Asymptomatic sinus bradycardia.
4. Asymptomatic sino-atrial block or asymptomatic sinus arrest. *(exception)
5. Ineffective atrial contractions (for example, chronic atrial fibrillation or flutter, or giant left atrium) without symptomatic bradycardia. *(exception)
6. Asymptomatic second degree atrioventricular block of Mobitz Type I unless the QRS complexes are prolonged or electrophysiological studies have demonstrated that the block is at or beyond the level of the His Bundle (a component of the electrical conduction system of the heart).
7. Syncope of undetermined cause. *(exception)
8. Bradycardia during sleep.
9. Right bundle branch block with left axis deviation (and other forms of fascicular or bundle branch block) without syncope or other symptoms of intermittent atrioventricular block. *(exception)
10. Asymptomatic bradycardia in post-myocardial infarction patients about to initiate long-term beta-blocker drug therapy.

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11. Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of tachycardia. *(exception)
12. A clinical condition in which pacing takes place only intermittently and briefly, and which is not associated with a reasonable likelihood that pacing needs will become prolonged.

MACs will determine coverage under section 1862(a)(1)(A) of the Social Security Act for any other indications for the implantation and use of single chamber or dual chamber cardiac pacemakers that are not specifically addressed in this NCD.

NOTES: MACs shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the practitioner and/or provider of the service that documentation is on file verifying the patient has non-reversible symptomatic bradycardia (symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example, syncope, seizures, congestive heart failure, dizziness, or confusion)).

NOTE: The final decision memorandum addresses Medicare policy specific to implanted permanent cardiac pacemakers, single chamber or dual chamber, for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Medicare coverage of removal/replacement of implanted permanent cardiac pacemakers, single chamber or dual chamber, for the above-noted indications, were not addressed in the final decision. Therefore, it is expected that MACs will continue to apply the reasonable and necessary standard in determining local coverage within their respective jurisdictions for removal/replacement of implanted permanent cardiac pacemakers, single chamber or dual chamber.


Professional claims
Effective for claims with dates of service on or after August 13, 2013, MACs shall pay for implanted permanent cardiac pacemakers, single chamber or dual chamber, for one of the following CPT codes if the claim contains at least one of the designated diagnosis codes in addition to the –KX modifier:

- 33206 - Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial;
- 33207 - Insertion or replacement of permanent pacemaker with transvenous electrode(s) – ventricular; or
- 33208 - Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial and ventricular.

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Institutional claims
Effective for claims with dates of service on or after August 13, 2013, MACs shall pay for implanted permanent cardiac pacemakers, single chamber or dual chamber, for the following HCPCS codes if the claim contains at least one of the designated CPT codes, and at least one of the designated diagnosis codes, in addition to the –KX modifier:

- C1785 – Pacemaker, dual chamber, rate-responsive (implantable);
- C1786 – Pacemaker, single chamber, rate-responsive (implantable);
- C2619 – Pacemaker, dual chamber, nonrate-responsive (implantable);
- C2620 – Pacemaker, single chamber, nonrate-responsive (implantable);
- 33206 – Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial
- 33207 – Insertion or replacement of permanent pacemaker with transvenous electrode(s) – ventricular
- 33208 – Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial and ventricular

MACs have discretion to cover or not cover the following CPT codes:

- 33227 – Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system; or
- 33228 – Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system.

Cardiac Pacemaker ICD-9/ICD-10 Diagnosis Codes

Professional claims
Claims with dates of service on and after August 13, 2013, for implanted permanent cardiac pacemakers, single chamber or dual chamber, are covered if submitted with one of the following CPT codes: 33206, 33207, or 33208, and that contain at least one of the following ICD-9/ICD-10 diagnosis codes (upon ICD-10 implementation) listed below in addition to the –KX modifier:

- 426.0 Atrioventricular block, complete/ I44.2 Atrioventricular block, complete;
- 426.12 Mobitz (type) II atrioventricular block/ I44.1 Atrioventricular block, second degree;
- 426.13 Other second degree atrioventricular block/ I44.1 Atrioventricular block, second degree;
- 427.81 Sinoatrial node dysfunction/ I49.5 Sick sinus syndrome; or
- 746.86 Congenital heart block/ Q24.6 – Congenital heart block.

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The following diagnosis codes can be covered at your MACs discretion if submitted with at least one of the CPT codes and diagnosis codes listed above in addition to the –KX modifier:

- 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block;
- 426.11 First degree atrioventricular block/ I44.0 Atrioventricular block first degree;
- 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block/ I45.19 Other right bundle-branch block;
- 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia;
- 427.31 Atrial fibrillation/ I48.1 Persistent atrial fibrillation/ I48.91, Unspecified atrial fibrillation;
- 427.32 Atrial flutter/ I48.3 Typical atrial flutter/ I48.4 Atypical atrial flutter or I48.91 Unspecified atrial fibrillation; or
- 780.2 Syncope and collapse/R55 Syncope and collapse (R55 is the ICD-10 dx code but is not payable upon implementation of ICD-10 and is only included here for information purposes).

**Institutional claims**

For coverage of claims with dates of service on and after August 13, 2013, for implanted permanent cardiac pacemakers, single chamber or dual chamber, using HCPCS codes: C1785, C1786, C2619, C2620, 33206, 33207, or 33208, the claim must contain at least one of the following procedure codes:

- 37.81 Initial insertion of single chamber device, not specified as rate responsive
- 37.82 Initial insertion of single chamber device, rate responsive
- 37.83 Initial insertion of single chamber device

and at least one of the following diagnosis codes in addition to the –KX modifier:

- 426.0 Atrioventricular block, complete;
- 426.12 Mobitz (type) II atrioventricular block;
- 426.13 Other second degree atrioventricular block;
- 427.81 Sinoatrial node dysfunction; or
- 746.86 Congenital heart block.

The following diagnosis codes can be covered, at the MAC’s discretion, if submitted with at least one of the diagnosis codes listed above in addition to the –KX modifier:

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• 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block;
• 426.11 First degree atrioventricular block/ I44.0 Atrioventricular block first degree;
• 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block/ I45.19 Other right bundle-branch block;
• 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia;
• 427.31 Atrial fibrillation/ I48.1 Persistent atrial fibrillation/ I48.91, Unspecified atrial fibrillation;
• 427.32 Atrial flutter/ I48.3 Typical atrial flutter/ I48.4 Atypical atrial flutter or I48.91 Unspecified atrial fibrillation; or
• 780.2 Syncope and collapse/R55 Syncope and collapse (R55 is the ICD-10 dx code but is not payable upon implementation of ICD-10 and is only included here for information purposes).

**Professional claims**

MACs shall return claims lines for implanted permanent cardiac pacemakers, single chamber or dual chamber, containing one of the following CPT codes: 33206, 33207, or 33208, as unprocessable when the -KX modifier is not present. When returning such claims, MACs shall use the following messages:

- Claim Adjustment Reason Code (CARC) 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.
- Remittance Advice Remarks Code (RARC) N517 - Resubmit a new claim with the requested information.

**Institutional claims**

MACs shall return to providers claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, when any of the following are not present on the claim: At least one HCPCS code: C1785, C1786, C2619, or C2620, at least one CPT code: 33206, 33207, 33208, 33227, 33228, at least one diagnosis code: 426.0/I44.2, 426.12/I44.1, 426.13/I44.1, 427.81/I49.5, 746.86/Q24.6, at least one procedure code: 37.81/0JH604Z, 0JH634Z, 0JH804Z, 0JH834Z, 37.82/0JH605Z, 0JH635Z, 0JH805Z, 0JH835Z, 38.83/0JH606Z, 0JH636Z, 0JH806Z, 0JH836Z, and the -KX modifier is not present on the claim.

**Cardiac Pacemaker Non-covered ICD-ICD-10 Diagnosis Code**

For claims with dates of service on or after implementation of ICD-10, for implanted permanent cardiac pacemakers, single chamber or dual chamber, using one of the following HCPCS and/or CPT codes: C1785, C1786, C2619, C2620, 33206, 33207, or 33208, ICD-
10 diagnosis code R55 is not covered even if the claim contains one of the valid diagnosis codes listed above.

MACs will use the following messages when denying claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, containing one of the following HCPCS and/or CPT codes: C1785, C1786, C2619, C2620, 33206, 33207, or 33208, and ICD-10 diagnosis code R55 with the following messages:

- CARC 96: Non-covered charge(s).
- RARC N569: Not covered when performed for the reported diagnosis.
- Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed Advance Beneficiary Notice (ABN) is on file.
- Group Code PR assigning financial liability to the beneficiary, if a claim is received with occurrence code 32 indicating a signed ABN is on file, or occurrence code 32 is present with modifier GA.

Additional Information


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

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National Nutrition Month - The Centers for Medicare & Medicaid Services reminds health care professionals that March is National Nutrition Month®- a time to “Bite into a Healthy Lifestyle” with informed food choices now and throughout the year. Medicare provides coverage for a variety of nutrition-related health services that can help eligible beneficiaries reach their nutrition and dietary goals. Read more to learn about nutrition-related health services covered by Medicare.

MLN Matters® Number: MM9095 Revised  Related Change Request (CR) #: CR 9095
Related CR Release Date: March 27, 2015  Effective Date: December 18, 2014
Related CR Transmittal #: R181NCD  Implementation Date: April 6, 2015

Removal of Multiple National Coverage Determinations Using an Expedited Process

Note: This article was revised on March 28, 2015, to reflect the revised CR9095 issued on March 27. 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 who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Effective December 18, 2014, Change Request (CR) 9095 removes Sections 50.6 - Tinnitus masking, 160.4 - Stereotactic Cingulotomy as a Means of Psychosurgery, 160.6 - Carotid Sinus Nerve Stimulator, 160.9 - Electroencephalographic (EEG) Monitoring During Open-Heart Surgery, 190.4 - Electron Microscope, 220.7 - Xenon Scan, and 220.8 - Nuclear...
Radiology Procedure from the Medicare "National Coverage Determinations Manual" or the NCD Manual. Providers and their staffs should be aware that removing an NCD results in coverage determinations being at the discretion of local MACs within their respective jurisdictions.

**Background**


A CMS decision memorandum dated December 18, 2014, contains a summary of the expedited removal process and explicitly removes seven NCDs from the NCD Manual sections as follows:

- 50.6 - Tinnitus masking;
- 160.4 - Stereotactic Cingulotomy as a Means of Psychosurgery;
- 160.6 - Carotid Sinus Nerve Stimulator;
- 160.9 - Electroencephalographic (EEG) Monitoring During Open-Heart Surgery;
- 190.4 - Electron Microscope;
- 220.7 - Xenon Scan; and
- 220.8 - Nuclear Radiology Procedure.


In the absence of an NCD, MACs should revert to historical standing policy and consider whether any Medicare claims for these services are reasonable and necessary under the Social Security Act (Section 1862(a)(1)(A); see [http://www.ssa.gov/OP_Home/ssact/title18/1862.htm](http://www.ssa.gov/OP_Home/ssact/title18/1862.htm)) consistent with the existing guidance for making such decisions when there is no NCD.

**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](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net work-MLN/MLNMattersArticles/index.html) under - How Does It Work.
Clarification of Ordering and Certifying Documentation Maintenance Requirements

Provider Types Affected

This MLN Matters® Article is intended for providers or suppliers who furnish covered ordered items of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), clinical laboratory services, imaging services, or covered ordered/certified home health services to Medicare beneficiaries.

Provider Action Needed

This MLN Matters® Article is based on Change Request (CR 9112) which clarifies the term "access to documentation" in Chapter 15, Section 15.18 of the “Program Integrity Manual” (PIM). Make sure that your billing staffs are aware of this change.

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Background

Under 42 CFR § 424.516(f)(1), a provider or supplier that furnishes covered ordered DMEPOS items, clinical laboratory services, imaging services, or covered ordered/certified home health services is required to:

- Maintain documentation for 7 years from the date of service, and
- Upon the request of CMS or a Medicare contractor, provide access to that documentation.

The documentation to be maintained includes written and electronic documents (including the National Provider Identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician - or, when permitted, other eligible professional - who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for DMEPOS items and clinical laboratory, imaging, and home health services.

Key Points in CR 9112

Maintaining and Providing Access to Documentation

CMS or a Medicare contractor may request access to documentation as described in 42 CFR § 424.516(f). The term “access to documentation” means that the documentation is actually provided or made available in the manner requested by CMS or a Medicare contractor.

All providers and suppliers who either furnish, order, or certify DMEPOS items, clinical laboratory services, imaging services, or covered ordered/certified home health services are subject to this requirement and are individually responsible for maintaining these records and providing them upon request.

CMS recognizes that providers and suppliers often rely upon an employer or another entity to maintain these records on their behalf. However, it remains the responsibility of the individual or entity upon whom/which the request has been made to provide documentation.

All individuals and entities subject to this documentation requirement are responsible for ensuring that documents are provided upon request and may ultimately be subject to the revocation basis associated with not complying with the documentation request.

Examples

To illustrate, if a Medicare contractor requests copies of all orders for wheelchairs from an ordering physician for all beneficiaries with dates of service from November 1, 2014, through November 10, 2014, the ordering physician must provide the copies, in full, according to the specific request. If copies cannot be provided because the physician or eligible professional did not personally maintain the records or can only be partially provided, then the requirement to maintain this documentation and provide access to it will
not have been met and the provider, supplier, physician, or eligible professional may be subject to the revocation basis set forth in 42 CFR § 424.535(a)(10).

Table 1: Examples of Sufficient and Deficient Access

<table>
<thead>
<tr>
<th>Sufficient Access</th>
<th>Deficient Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>All documentation requested</td>
<td>Providing none of the requested documentation</td>
</tr>
<tr>
<td>Documentation specific to the order(s) or certification(s), as requested</td>
<td>Providing only a portion of the requested documentation</td>
</tr>
<tr>
<td>Documentation for the dates of service or billing periods requested</td>
<td>Providing similar documentation that does not contain the order or certification requested</td>
</tr>
<tr>
<td>Providing other documents NOT requested by CMS or a Medicare contractor and/or not specifically directing attention to the requested documentation</td>
<td></td>
</tr>
</tbody>
</table>

Additional Information


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April is Alcohol Awareness Month - Seniors and others covered by Medicare can be screened for alcohol misuse under the Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse benefit. Read more to learn about coverage for this service.

MLN Matters® Number: MM9119  Related Change Request (CR) #: CR 9119
Related CR Release Date: April 10, 2015  Effective Date: May 11, 2015
Related CR Transmittal #: R91GI and R207BP  Implementation Date: May 11, 2015

Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services

Provider Types Affected
This MLN Matters® Article is intended for physicians, Non-Physician Practitioners (NPPs), and Home Health Agencies (HHAs) that submit claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs for services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9119 manualizes policies discussed in the Calendar Year (CY) 2015 Home Health Prospective Payment System (HH PPS) Final Rule published on November 6, 2014. CR9119 instructs MACs to be aware of the revisions to the requirements for physician certification and recertification of patient eligibility for Medicare home health services. MACs are also instructed to be aware of the revised timeframe for therapy functional reassessments. Make sure that your billing staffs are aware of these changes.

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Background

The Centers for Medicare & Medicaid Services (CMS) finalized clarifications and revisions to policies regarding physician certification and recertification of patient eligibility for Medicare home health services in the CY 2015 HH PPS final rule which was published on November 6, 2014 (see http://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26057.pdf). In the final rule, CMS also finalized revisions to the timeframe required for therapy functional reassessments.

Face-to-Face Encounter Requirements

The Affordable Care Act requires that the certifying physician or allowed NPP must have a face-to-face encounter with the beneficiary before they certify the beneficiary’s eligibility for the home health benefit.

CMS is implementing the following three changes to the face-to-face encounter requirements for episodes beginning on or after January 1, 2015. These changes will reduce administrative burden and provide HHAs with additional flexibilities in developing individual agency procedures for obtaining documentation supporting patient eligibility for Medicare home health care.

• CMS is eliminating the narrative requirement. The certifying physician is still required to certify (attest) that a face-to-face patient encounter occurred and document the date of the encounter as part of the certification of eligibility. For medical review purposes, Medicare requires documentation in the certifying physician’s medical records and/or the acute/post-acute care facility’s medical records (if the patient was directly admitted to home health) to be used as the basis for certification of patient eligibility.

• If a HHA claim is denied, the corresponding physician claim for certifying/re-certifying patient eligibility for Medicare-covered home health services is considered non-covered as well because there is no longer a corresponding claim for Medicare-covered home health services.

• CMS is clarifying that a face-to-face encounter is required for certifications, rather than initial episodes; and that a certification (versus a re-certification) is generally considered to be any time a new start of care assessment is completed to initiate care.

Therapy Reassessments

CMS has eliminated the 13th and 19th visit therapy reassessment requirements. For episodes beginning on or after January 1, 2015; at least every 30 calendar days a qualified therapist (instead of an assistant) must provide the needed therapy service and functionally reassess the patient. This policy change will lessen HHAs’ burden of counting visits.

This change will reduce the risk of non-covered visits so that therapists can focus more on providing quality care for their patients, while still promoting therapist involvement and quality treatment for all beneficiaries regardless of the level of therapy provided.

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Additional Information


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Changes to the Laboratory National Coverage Determination (NCD) Software for July 2015

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9124 informs MACs about the changes that will be included in the July 2015 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

Background

CR9124 announces the changes that will be included in the July 2015 quarterly release of the edit module for clinical diagnostic laboratory services. The National Coverage Determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the shared
systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective April 1, 2003.

These changes are effective for services furnished on or after October 1, 2015, for International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10). (There are no ICD-9 updates in the July update.)

CR9124 conveys four changes to the edit module, which are:

- Delete ICD-10-CM code I513 from the list of ICD-10-CM codes that are covered by Medicare for the Partial Prothrombin Time (PTT) (190.16) NCD;
- Add ICD-10-CM code S069X3A to the list of ICD-10-CM codes that are covered by Medicare for the Partial Prothrombin Time (PTT) (190.16) NCD;
- Delete ICD-10-CM codes I513 and T560X4A from the list of ICD-10-CM codes that are covered by Medicare for the Prothrombin Time (PT) (190.17) NCD; and
- Add ICD-10-CM code S069X3A to the list of ICD-10-CM codes that are covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.

Additional Information


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

MLN Matters® Number: MM9125 Related Change Request (CR) #: CR 9125
Related CR Release Date: April 17, 2015 Effective Date: July 1, 2015
Related CR Transmittal #:R3236CP Implementation Date: July 6, 2015

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

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 9125, which updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists. It also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print.
Make sure that your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if they use that software.

## Background

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

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

SSMs have the responsibility to implement code deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR9125, MACs will implement on the date specified on the WPC website. The WPC website is available at [http://www.wpc-edi.com/Reference](http://www.wpc-edi.com/Reference) on the Internet.

CR9125 lists only the changes that have been approved since the last code update CR (CR9004 issued on January 9, 2015, with a related MLN Matters® article available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9004.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9004.pdf)), and does not provide a complete list of codes for these two code sets. The complete list for both CARC and RARC from the WPC website is updated three times a year – around March 1, July 1, and November 1. The WPC website, which has four listings available for both CARC and RARC, is available at [http://www.wpc-edi.com/Reference](http://www.wpc-edi.com/Reference) on the Internet.

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

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**Note:** This recurring Code Update CR lists only the changes approved since the last recurring Code Update CR once. If any modification or deactivation becomes effective at a future date, MACs must make sure that they update on the effective date or the quarterly release date that matches the effective date as posted on the WPC website.

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**Changes in CARC List Since CR 9004**

The following tables are changes in the CARC database since the last code update in CR 9004.

### New Codes – CARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>269</td>
<td>Anesthesia not covered for this service/procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
<td>03/01/2015</td>
</tr>
</tbody>
</table>

### Modified Codes – CARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Modified Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability) This change effective 11/1/2015: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: this must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>55</td>
<td>Procedure/treatment/drug is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>133</td>
<td>The disposition of this service line is pending further review. (Use only with Group Code OA). Note: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).</td>
<td>03/01/2015</td>
</tr>
</tbody>
</table>

### Deactivated Codes – CARC

None

---

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Changes in RARC List Since CR 9004

The following tables are changes in the RARC database since the last code update in CR 9004.

New Codes – RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N735</td>
<td>Adjustment without review of medical/dental record because the requested records were not received or were not received timely.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N736</td>
<td>Incomplete/invalid Sleep Study Report.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N737</td>
<td>Missing Sleep Study Report.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N738</td>
<td>Incomplete/invalid Vein Study Report.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N739</td>
<td>Missing Vein Study Report.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N740</td>
<td>The member’s Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N741</td>
<td>This is a site neutral payment.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N742</td>
<td>Alert: This claim was processed based on one or more ICD-9 codes. The transition to ICD-10 is required by October 1, 2015, for health care providers, health plans, and clearinghouses. More information can be found at <a href="http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html">http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html</a> on the CMS website.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N743</td>
<td>Adjusted because the services may be related to an employment accident.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N744</td>
<td>Adjusted because the services may be related to an auto accident.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N745</td>
<td>Missing Ambulance Report.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N746</td>
<td>Incomplete/invalid Ambulance Report.</td>
<td>03/01/2015</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N747</td>
<td>This is a misdirected claim/service. Submit the claim to the payer/plan where the patient resides.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N748</td>
<td>Adjusted because the related hospital charges have not been received.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N749</td>
<td>Missing Blood Gas Report.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N750</td>
<td>Incomplete/invalid Blood Gas Report.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N751</td>
<td>Adjusted because the drug is covered under a Medicare Part D plan.</td>
<td>03/01/2015</td>
</tr>
<tr>
<td>N752</td>
<td>Missing/incomplete/invalid HIPPS Treatment Authorization Code (TAC).</td>
<td>03/01/2015</td>
</tr>
</tbody>
</table>

**Modified Codes – RARC**

<table>
<thead>
<tr>
<th>Code</th>
<th>Modified Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N10</td>
<td>Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.</td>
<td>03/01/2015</td>
</tr>
</tbody>
</table>

**Deactivated Codes – RARC**

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

The full CARC and RARC lists must be downloaded from the WPC website available at [http://wpc-edi.com/Reference](http://wpc-edi.com/Reference) on the Internet.
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/MLN MattersArticles/index.html under “How Does It Work” on the CMS website.
April is Alcohol Awareness Month - Seniors and others covered by Medicare can be screened for alcohol misuse under the Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse benefit. Read more to learn about coverage for this service.

MLN Matters® Number: MM9154  Related Change Request (CR) #: CR 9154
Related CR Release Date: April 10, 2015  Effective Date: June 19, 2015
Related CR Transmittal #: R1486OTN  Implementation Date: June 19, 2015

Increasing Tax Withholding to 30 Percent for the Internal Revenue Service (IRS) Federal Payment Levy Program (FPLP)

Provider Types Affected

This MLN Matters® Article is intended for physicians, 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) 9154 instructs the Healthcare Integrated General Ledger Accounting System (HIGLAS) system maintainer to make necessary programming changes to increase the tax withhold percentage from 15 percent to 30 percent. If you owe back taxes to the IRS and those taxes are eligible to be withheld from payments due you from Medicare, the withhold rate will increase from the current 15 percent to 30 percent on June 19, 2015.

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Background

In July 2000, the IRS, in conjunction with the Department of the Treasury, Financial Management Service (FMS), started the FPLP which is authorized by the Internal Revenue Code Section 6331 (h) (see http://www.gpo.gov/fdsys/pkg/USCODE-2011-title26/pdf/USCODE-2011-title26-subtitleF-chap64-subchapD-partII-sec6331.pdf), as prescribed by the Taxpayer Relief Act of 1997 Section 1024 (see http://www.gpo.gov/fdsys/pkg/PLAW-105publ34/html/PLAW-105publ34.htm).

Through the FPLP, authority is provided to the Centers for Medicare & Medicaid Services (CMS) to collect overdue taxes through a levy on certain federal payments. This includes federal payments made to Medicare providers.

Consistent with this authority, CMS introduced CR 6125 in October of 2008, which reduced federal payments subjected to the levy by the required 15 percent, or the exact amount of the tax owed if it is less than 15 percent of the payment. You can review the MLN Matters® Article (MM6125) corresponding to CR 6125 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm6125.pdf on the CMS website.

In December 2014, the Internal Revenue Code Section 6331 (h) was amended by the Tax Increase Prevention Act of 2014 Section 209 (a) (see http://www.gpo.gov/fdsys/pkg/BILLS-113hr5771enr/html/BILLS-113hr5771enr.htm), which mandated an increase of the tax levy to 30 percent.

Note: The tax levy is continuous until the overdue taxes are paid in full, or other arrangements are made to satisfy the debt.

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

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

MLN Matters® Number: MM8835 Related Change Request (CR) #: CR 8835
Related CR Release Date: April 17, 2015 Effective Date: May 18, 2015
Related CR Transmittal #: R1488OTN Implementation Date: May 18, 2015

The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2012 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCH)

Provider Types Affected

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

What You Need to Know

Change Request (CR) 8835 provides updated Supplemental Security Income (SSI)/Medicare beneficiary data for determining the Disproportionate Share (DSH) adjustment for IPPS hospitals and the low income patient adjustment for IRFs.
Background

The SSI/Medicare beneficiary data for hospitals are available electronically and contains the:

- Name of the hospital;
- Centers for Medicare & Medicaid Services (CMS) certification number;
- SSI days;
- Total Medicare days; and
- Ratio of Medicare Part A patient days attributable to SSI recipients.

The files are located at the following CMS website addresses:

- **IPPS Hospitals:** [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html)

- **IRFs:** [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/SSIData.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/SSIData.html)

- **Long Term Care Hospitals (LTCHs):** [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html)

The data are used for settlement purposes for IPPS hospitals and IRFs with cost reporting periods beginning during FY 2012 (cost reporting periods beginning on or after October 1, 2011 and before October 1, 2012).

The Consolidated Omnibus Budget Reconciliation Act of 1985 (Section 9105) provides that, for discharges occurring on or after May 1, 1986, an additional payment must be made to IPPS hospitals serving a disproportionate share of low income patients.

The additional payment is determined by multiplying the Federal portion of the Diagnosis-Related Group (DRG) payment by the Disproportionate Share Hospital (DSH) adjustment factor, and beginning for discharges occurring on or after October 1, 2014, the additional payment is determined by multiplying the DRG payment by the DSH adjustment factor reduced by 75 percent. See 42 CFR 412.106 at [http://www.ecfr.gov/cgi-bin/text-idx?SID=f1e0d8aa3e10da210951232e91244cb6&node=42:2.0.1.2.12.7.50.11 on the Internet.](http://www.ecfr.gov/cgi-bin/text-idx?SID=f1e0d8aa3e10da210951232e91244cb6&node=42:2.0.1.2.12.7.50.11)

Under the IRF Prospective Payment System (PPS), IRFs receive an additional payment amount to account for the cost of furnishing care to low income patients. The additional payment is determined by multiplying the Federal prospective payment by the output of the LIP adjustment formula. See 42 CFR 412.624(e)(2) at [http://www.ecfr.gov/cgi-bin/text-](http://www.ecfr.gov/cgi-bin/text-).
Under the LTCH PPS, the payment adjustment for Short-Stay Outlier (SSO) cases at 42 CFR 412.529 requires the calculation of an amount comparable to the amount that would otherwise be paid under the IPPS (that is, the “IPPS comparable amount.”). This calculation includes an “IPPS comparable” DSH adjustment, where applicable, that is determined using the best available SSI data at the time of claim payment. See 42 CFR 412.529(d)(4) at [http://www.ecfr.gov/cgi-bin/text-idx?SID=f1e0dfaa3e10da210951232e91244cb6&node=42:2.0.1.2.12.15.59.14](http://www.ecfr.gov/cgi-bin/text-idx?SID=f1e0dfaa3e10da210951232e91244cb6&node=42:2.0.1.2.12.15.59.14) on the Internet.

**Additional Information**


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

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**MLN Matters® Number: MM8997 Revised**

**Related Change Request (CR) #: CR 8997**

**Related CR Release Date: April 3, 2015**

**Effective Date: June 15, 2015**

**Related CR Transmittal #: R3230CP and R204BP**

**Implementation Date: June 15, 2015**

**Updates to the Medicare Internet-Only Manual Chapters for Skilled Nursing Facility (SNF) Providers**

**Note:** This article was revised on April 8, 2015, to reflect the revised CR8997 issued on April 3. 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) for services provided to Medicare beneficiaries who are in a Skilled Nursing Facility (SNF).

**Provider Action Needed**

Change Request (CR) 8997 updates sections of the "Medicare Benefit Policy Manual" and the "Medicare Claims Processing Manual" in regards to SNF policy and billing. If you...
provide services to Medicare beneficiaries in a SNF stay, information in CR8997 could impact your payments.

**Background**

Change Request 8997 updates two chapters of the "Medicare Claims Processing Manual" and one chapter of the "Medicare Benefit Policy Manual". The following summarizes these manual updates:

**“Medicare Benefit Policy Manual,” Chapter 8:**

Section 20.2.3 (Readmission to SNF):

- If an individual who is receiving covered post-hospital extended care, leaves a SNF and is readmitted to the same or any other participating SNF for further covered care within 30 days of the last covered skilled day, the 30-day transfer requirement is considered to be met; and

- The same is true if the beneficiary remains in the SNF to receive custodial care following a covered stay, and subsequently develops a renewed need for covered care there within 30 consecutive days. Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the resumption of SNF coverage.

**“Medicare Claims Processing Manual,” Chapter 6:**

Section 20.1.1.2 - Hospital’s “Facility Charge” in Connection with Clinic Services of a Physician

- When a beneficiary receives clinic services from a hospital-based physician, the physician in this situation would bill his or her own professional services directly to the Part B MAC and would be reimbursed at the facility rate of the Medicare physician fee schedule--which does not include overhead expenses.

- The hospital historically has submitted a separate Part B “facility charge” for the associated overhead expenses to its Part A MAC. The hospital’s facility charge does not involve a separate service (such as a diagnostic test) furnished in addition to the physician’s professional service; rather, it represents solely the overhead expenses associated with furnishing the professional service itself.

- Accordingly, hospitals bill for “facility charges” under the physician evaluation and management (E&M) codes in the range of 99201-99245 and G0463 (for hospitals paid under the Outpatient Prospective Payment System).

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CPT only copyright 2014 American Medical Association.
• E&M codes, representing the hospital’s “facility charge” for the overhead expenses associated with furnishing the professional service itself, are excluded from SNF Consolidated Billing (CB). Effective for claims with dates of service on or after January 1, 2006, Medicare's Common Working File will bypass CB edits when billed with revenue code 0510 (clinic visit) with an E&M HCPCS code in the range of 99201-99245 and, effective January 1, 2014 with HCPCS code G0463.

Section 30.1 - Health Insurance Prospective Payment System (HIPPS) Rate Code:

• The HIPPS rate code consists of the three-character resource utilization group (RUG) code that is obtained from the “Grouper” software program followed by a 2 digit assessment indicator (AI) that specifies the type of assessment associated with the RUG code obtained from the Grouper. Providers may access the Resident Assessment Instrument (RAI) manual located at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html on the Centers for Medicare & Medicaid Services (CMS) website.

Section 30.2: - Coding PPS Bills for Ancillary Services

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown, for example, 0250 - Pharmacy, 042x - Physical Therapy, in conjunction with the appropriate entries in Service Units and Total Charges.

• SNFs are required to report the number of units based on the procedure or service.

• For therapy services, that is revenue codes 042x, 043x, and 044x, units represent the number of calendar days of therapy provided. For example, if the beneficiary received physical therapy, occupational therapy or speech-language pathology on May 1, that would be considered one calendar day and would be billed as one unit.

• SNFs are required to report the actual charge for each line item, in Total Charges.

Section 30.3: Adjustment Requests

Adjustment requests based on corrected assessments must be submitted within 120 days of the service “through” date. The “through” date will be used to calculate the period during which adjustment requests may be submitted based on corrected RAI assessments. The “through” date indicates the last day of the billing period for which the HIPPS code is billed. Adjustment requests based on corrected assessments must be submitted within 120 days of the “through” date on the bill. For HIPPS changes resulting from an MDS correction, providers must append a condition code D2 on their adjustment claim. An edit is in place to limit the time for submitting this type of adjustment request to 120 days from the service “through” date.
CMS expects that most HIPPS code corrections will be made during the course of the beneficiary’s Medicare Part A stay. Therefore, providers that routinely submit corrections after the beneficiary’s Part A stay has ended may be subject to focused medical review.

Adjustment requests to change a HIPPS code may not be submitted for any claim that has already been medically reviewed. This applies whether or not the medical review was performed either pre- or post-payment. All adjustment requests submitted are subject to medical review. Information regarding medical review is located in the “Medicare Program Integrity Manual.”

Section 40.3.5.2 - Leave of Absence:

- Leave of absence (LOA) days are shown on the bill with revenue code 018X and LOA days as units. However, charges for LOA days are shown as zero on the bill, and the SNF cannot bill the beneficiary for them except as specified in Chapter 1 of this manual at section 30.1.1.1. Occurrence span code 74 is used to report the LOA from and through dates.

- Providers should review the RAI manual to clarify situations where an LOA is not appropriate, for example observation stays in a hospital lasting greater than 24 hours.

Medicare Claims Processing Manual, Chapter 13:

Section 90.5 (Transportation of Equipment Billed by a SNF to a MAC):

- When a SNF resident receives a portable x-ray service during the course of a Medicare-covered stay in the SNF, only the service’s professional component (representing the physician’s interpretation of the test results) is a separately billable physician service under Part B (see section 20 of Chapter 6).

- By contrast, the technical component representing the procedure itself, including any associated transportation and setup costs, would be subject to consolidated billing (CB) (the SNF “bundling” requirement for services furnished to the SNF’s Part A residents), and must be included on the SNF’s Part A bill for the resident’s covered stay (Bill Type 21x) rather than being billed separately under Part B.

Additional Information

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

Note: This article was revised on April 23, 2015, to reflect updated Change Request (CR) 9097 on April 14, 2015 and April 22, 2015. The first update corrected the payment rate for C9447. There was also a correction made to the business requirement 9097.3 (see g. below on page 7). In addition, references to HCPCS codes J0365 and J7180 were removed from Section 4 of the Business Requirements document (and page 4 below) and the table “Drugs and Biological with Revised Status Indicators” was deleted from attachment in CR 9097 (and on page 4 below). The second update corrected table references. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

CR 9097 describes changes to and billing instructions for various payment policies implemented in the April 2015 Outpatient Prospective Payment System (OPPS) update. Make sure your billing staffs are aware of these changes.
Background

The April 2015 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR9097.


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

**Changes to Device Edits for April 2015**

The most current list of device edits can be found under "Device and Procedure Edits" at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS) on the CMS website. Failure to pass these edits will result in the claim being returned to the provider.

**New Device Pass-Through Categories**

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

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

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Effective Date</th>
<th>SI</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2623</td>
<td>04/01/15</td>
<td>H</td>
<td>Cath, translum, drug-coat</td>
<td>Catheter, transluminal angioplasty, drug-coated, non-laser</td>
</tr>
</tbody>
</table>

Dispaly statement

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a. Device Offset from Payment

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

CMS has determined that a portion of the APC payment amount associated with the cost of C2623 is reflected in procedures assigned to various peripheral transluminal angioplasty codes in APC 0083, APC 0229, and APC 0319. The C2623 device may be billed with various peripheral transluminal balloon angioplasty codes that are assigned to these three APCs for CY 2015. The device offset from payment represents a deduction from pass-through payments for the device in category C2623.

New Services

No New services have been assigned for payment under the OPPS effective April 1, 2015.

Drugs, Biologicals, and Radiopharmaceuticals

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

For CY 2015, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP+6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2015, a single payment of ASP+6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2015 and drug price restatements can be found in the April 2015 update of the OPPS Addendum A and Addendum B at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html) on the CMS website.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2015

Six drugs and biologicals have been granted OPPS pass-through status effective April 1, 2015. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

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

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9445</td>
<td>C-1 esterase, Ruconest</td>
<td>Injection, c-1 esterase inhibitor (recombinant), Ruconest, 10 units</td>
<td>9445</td>
<td>G</td>
</tr>
<tr>
<td>C9448</td>
<td>Oral netupitant palonosetron</td>
<td>Netupitant 300mg and palonosetron 0.5 mg, oral</td>
<td>9448</td>
<td>G</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9449</td>
<td>Inj, blinatumomab</td>
<td>Injection, blinatumomab, 1 mcg</td>
<td>9449</td>
<td>G</td>
</tr>
<tr>
<td>C9450²</td>
<td>Flucinolone acetonide</td>
<td>Injection, flucinolone acetonide intravitreal implant, 0.01 mg</td>
<td>9450</td>
<td>G</td>
</tr>
<tr>
<td>C9451</td>
<td>Injection, peramivir</td>
<td>Injection, peramivir, 1 mg</td>
<td>9451</td>
<td>G</td>
</tr>
<tr>
<td>C9452</td>
<td>Inj, ceftolozane/tazobactam</td>
<td>Injection, ceftolozane 50 mg and tazobactam 25 mg</td>
<td>9452</td>
<td>G</td>
</tr>
</tbody>
</table>

Notes: ¹ HCPCS codes listed in Table 2 are new codes effective April 1, 2015.
² HCPCS code C9450 is associated with Iluvien® and should not be used to report any other flucinolone acetonide intravitreal implant (e.g., Retisert®). Hospitals should note that the dosage descriptor for Iluvien is 0.01 mg. Because each implant is a fixed dose containing 0.19 mg of flucinolone acetonide, hospitals should report 19 units of C9450 for each implant.

c. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates
Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html) on the CMS website. Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

d. Reassignment of Skin Substitute Products from the Low Cost Group to the High Cost Group
Two existing skin substitute products have been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. These products are listed in Table 3 below.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Status Indicator</th>
<th>Low/High Cost Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4150</td>
<td>Allowrap DS or Dry 1 sq cm</td>
<td>N</td>
<td>High</td>
</tr>
<tr>
<td>Q4153</td>
<td>Dermavest 1 square cm</td>
<td>N</td>
<td>High</td>
</tr>
</tbody>
</table>

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e. Other Changes to CY 2015 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Effective April 1, 2015, HCPCS code Q9975 Factor VIII FC Fusion Recomb, will replace HCPCS code C9136 Factor viii (Eloctate). The SI will remain G, “Pass-Through Drugs and Biologicals.” Table 4 describes the HCPCS code change and effective date.

**Table 4 – New HCPCS Codes for Certain Drugs and Biologicals Effective April 1, 2015**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Added Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9136</td>
<td>Factor viii (Eloctate)</td>
<td>Injection, factor viii, fc fusion protein, (recombinant), per i.u.</td>
<td>G</td>
<td>1656</td>
<td>01/01/2015</td>
<td>03/31/2015</td>
</tr>
<tr>
<td>Q9975</td>
<td>Factor VIII FC Fusion Recomb</td>
<td>Injection, factor viii, fc fusion protein, (recombinant), per i.u.</td>
<td>G</td>
<td>1656</td>
<td>04/01/2015</td>
<td></td>
</tr>
</tbody>
</table>


The beneficiary copayment for HCPCS code J7315 was erroneously set to 20 percent of the APC payment rate in the OPPS Pricer from January 1, 2014, through March 31, 2015. The corrected copayment is listed in Tables 5 through 9 below. For claims impacted with HCPCS J7315, APC 1448, instructions for mass adjusting claims will be provided in future notification.

**Table 5 – Corrected Copayment Rate for HCPCS Code J7315 Effective January 1, 2014, Through March 31, 2014**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7315</td>
<td>G</td>
<td>1448</td>
<td>Ophthalmic mitomycin</td>
<td>$379.47</td>
<td>$0</td>
</tr>
</tbody>
</table>
Table 6 – Corrected Copayment Rate for HCPCS Code J7315 Effective
April 1, 2014, Through June 30, 2014

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7315</td>
<td>G</td>
<td>1448</td>
<td>Ophthalmic mitomycin</td>
<td>$379.66</td>
<td>$0</td>
</tr>
</tbody>
</table>

Table 7 – Corrected Copayment Rate for HCPCS Code J7315 Effective
July 1, 2014, Through September 30, 2014

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7315</td>
<td>G</td>
<td>1448</td>
<td>Ophthalmic mitomycin</td>
<td>$379.59</td>
<td>$0</td>
</tr>
</tbody>
</table>

Table 8 – Corrected Copayment Rate for HCPCS Code J7315 Effective
October 1, 2014, Through December 31, 2014

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7315</td>
<td>G</td>
<td>1448</td>
<td>Ophthalmic mitomycin</td>
<td>$366.88</td>
<td>$0</td>
</tr>
</tbody>
</table>

Table 9 – Corrected Copayment Rate for HCPCS Code J7315 Effective
January 1, 2015, Through March 31, 2015

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7315</td>
<td>G</td>
<td>1448</td>
<td>Ophthalmic mitomycin</td>
<td>$372.80</td>
<td>$0</td>
</tr>
</tbody>
</table>

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g. Corrected Copayment Rate for HCPCS Code C9447 Effective January 1, 2015, Through March 31 2015

The beneficiary copayment for HCPCS code C9447 was erroneously set to 20 percent of the APC payment rate in the OPPS Pricer from January 1, 2015, through March 31, 2015. The corrected copayment is listed in Table 10 below, and has been installed in the April 2015 OPPS Pricer, effective for services furnished on January 1, 2015, through March 31, 2015. The MACs will adjust claims, as appropriate, that is brought to their attention that contain HCPCS code listed in table 10; have dates of service that fall on or after January 1, 2015, through April 1, 2015; and were originally processed prior to the installation of the April 2015 OPPS Pricer.

Table 10 – Corrected Copayment Rate for HCPCS Code C9447 Effective January 1, 2015, Through March 31, 2015

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9447</td>
<td>G</td>
<td>1663</td>
<td>Inj, phenylephrine ketorolac</td>
<td>$492.90</td>
<td>$0</td>
</tr>
</tbody>
</table>

h. New Vaccine CPT Codes

Three new vaccine CPT codes have been established. The following table lists these new vaccine codes, their OPPS status indicator, and effective date.

Table 11 – New Vaccine CPT Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>CY 2015 SI</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>90620</td>
<td>Menb rp w/omv vaccine im</td>
<td>Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B, 2 dose schedule, for intramuscular use</td>
<td>E</td>
<td>2/1/2015</td>
</tr>
<tr>
<td>90621</td>
<td>Menb rlp vaccine im</td>
<td>Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use</td>
<td>E</td>
<td>2/1/2015</td>
</tr>
<tr>
<td>90697</td>
<td>Dtap-ipv-hib-hepb vaccine im</td>
<td>Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenza type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP- IPV-Hib-HepB), for intramuscular use</td>
<td>E</td>
<td>1/1/2015</td>
</tr>
</tbody>
</table>
**Inpatient Only List**

CMS is revising billing instructions to allow payment for inpatient only procedures that are provided to a patient in the outpatient setting on the date of the inpatient admission or during the 3 calendar days (or 1 calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission to be bundled into billing of the inpatient admission, according to Medicare policy for the payment window for outpatient services treated as inpatient services.

Effective April 1, 2015, inpatient only procedures that are provided to a patient in the outpatient setting on the date of the inpatient admission or during the 3 calendar days (or 1 calendar day for a non-subsection (d) hospital) preceding the date of the inpatient admission that would otherwise be deemed related to the admission, according to the policy for the payment window for outpatient services treated as inpatient services will be covered by CMS and are eligible to be bundled into the billing of the inpatient admission.

CMS is updating the “Medicare Claims Processing Manual,” (Chapter 4, Sections 10.12 and 180.7) to reflect the revised inpatient only payment policy. This revised section is included as an attachment to CR9097.

**Reporting of the “PO” HCPCS Modifier for Outpatient Service Furnished at an Off-Campus Provider-Based Department (PBD)**

As stated in the CY 2015 OPPS Final Rule, CMS finalized the instructions related to the reporting of the “PO” modifier (the short descriptor “Serv/proc off-campus pbd,” and the long descriptor “Services, procedures and/or surgeries furnished at off-campus provider-based outpatient departments.”). The “PO” HCPCS modifier is to be reported with every code for outpatient hospital services furnished in an off-campus PBD of a hospital. Reporting of this new modifier will be voluntary for 1 year (CY 2015), with reporting required beginning on January 1, 2016. The modifier should not be reported for remote locations of a hospital, satellite facilities of a hospital, or for services furnished in an emergency department.

CMS is updating the “Medicare Claims Processing Manual,” (Chapter 4, Section 20.6.11) to include the use of the “PO” HCPCS modifier. The revised manual section is included as an attachment to CR9097.

**Clarification Regarding Propel and Propel Mini coding**

Hospitals may report C2625 (Stent, non-coronary, temporary, with delivery system) when utilizing the Propel™ and Propel Mini™ drug eluting sinus implants by Intersect ENT. These implants are appropriately described by C2625.

**Clarification Regarding Cysview® Coding**

When billing for cystoscopy procedures using Cysview® (hexaminolevulinate hydrochloride), hospitals are reminded to report HCPCS code C9275 (Injection, Hexaminolevulinate Hydrochloride, 100 mg, per study dose) on a separate claim line from...
the cystoscopy procedure code. Consistently reporting charges for C9275 in addition to the appropriate cystoscopy procedure code will ensure that CMS has accurate claims data for future ratesetting.

**Coverage Determinations**

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

**Additional Information**


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


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) 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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April is Alcohol Awareness Month - Seniors and others covered by Medicare can be screened for alcohol misuse under the Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse benefit. Read more to learn about coverage for this service.

MLN Matters® Number: MM9114  Related Change Request (CR) #: CR 9114
Related CR Release Date: April 3, 2015  Effective Date: May 4, 2015
Related CR Transmittal #: R205BP  Implementation Date: May 4, 2015

Updates on Hospice Election Form, Revocation, and Attending Physician

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9114 informs MACs about the implementation of changes finalized in the Fiscal Year (FY) 2015 hospice rule regarding hospice election, revocation, and designation of attending physician. These changes are detailed in the revised portion of the “Medicare Benefit Policy Manual,” which is attached to CR9114. Make sure that your billing staffs are aware of these changes.

Background

Upon electing hospice care, the beneficiary waives the right to Medicare payment for any Medicare services related to the terminal illness and related conditions during a hospice election, except when provided by, or under arrangement by, the designated hospice or individual’s attending physician if he/she is not employed by the designated hospice (42 CFR...
418.24(d)). Prompt filing of the Notice of Election (NOE) with the MAC is required to properly enforce this waiver, and prevent inappropriate payments to non-hospice providers. The effective date of hospice election is the same as the hospice admission date.

**Choosing an Attending Physician**

Hospice beneficiaries have the right to choose their attending physician. Attending physician means a—

1. (i) Doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs that function or action; or

   (ii) Nurse Practitioner (NP) who meets the training, education, and experience requirements as described in Section 410.75 (b) of 42 CFR 410.

2. A physician identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care. (42 CFR 418.3)

The election statement must include the patient’s choice of attending physician. The information identifying the attending physician should be recorded on the election statement in enough detail so that it is clear which physician or NP was designated as the attending physician. This must include, but is not limited to, the attending physician’s name and National Provider Identifier (NPI). Hospices have the flexibility to include this information on their election statement in whatever format works best for them, provided the content requirements in Section 418.24(b) are met. The language on the election form should include an acknowledgement by the patient (or representative) that the designated attending physician was the patient’s (or representative’s) choice.

If a patient (or representative) wants to change his or her designated attending physician, he or she must follow a procedure similar to that which currently exists for changing the designated hospice. Specifically, the patient (or representative) must file a signed statement with the hospice that identifies the new attending physician in enough detail so that it is clear which physician or NP was designated as the new attending physician. The statement must include the date the change is to be effective, the date that the statement is signed, and the patient’s (or representative’s) signature, along with an acknowledgement that this change in the attending physician is the patient’s (or representative’s) choice. The effective date of the change in attending physician cannot be earlier than the date the statement is signed.

**Timely Filing of the NOE**

Remember that timely-filed hospice NOEs must be filed within five calendar days after the hospice admission date. A timely-filed NOE is a NOE that is submitted to the MAC and accepted by the MAC within five calendar days after the hospice admission date. In instances
where a NOE is not timely-filed, Medicare will not cover and pay for the days of hospice care from the hospice admission date to the date the NOE is submitted to, and accepted by, the MAC. These days are a provider liability, and the provider shall not bill the beneficiary for them.

**Example 1:** The date of hospice election is October 1. A timely-filed NOE would be submitted and accepted by the MAC on or before October 6.

**Example 2:** The date of hospice election is October 1. The NOE was not submitted and accepted by the MAC until October 10. Provider liable days would be October 1 through October 9.

If a hospice fails to file a timely-filed NOE, it may request an exception which, if approved, waives the consequences of filing a NOE late. The four circumstances that may qualify the hospice for an exception to the consequences of filing the NOE more than five calendar days after the hospice admission date are as follows:

1. Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice’s ability to operate;

2. An event that produces a data filing problem due to a Centers for Medicare & Medicaid Services (CMS) or MAC systems issue that is beyond the control of the hospice;

3. A newly Medicare-certified hospice that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its MAC; or

4. Other circumstances determined by the MAC or CMS to be beyond the control of the hospice.

**Termination of Hospice Care and Resuming Medicare Coverage**

Upon discharge from hospice or revocation of hospice care, the beneficiary immediately resumes the Medicare coverage that had previously been waived by the hospice election. As such, hospices should record the beneficiary’s discharge or revocation in the claims processing system promptly. Doing so protects the beneficiary from experiencing possible delays in accessing needed care.

An individual or representative may revoke the election of hospice care at any time in writing; however, a hospice cannot “revoke” a patient’s election. To revoke the election of hospice care, the individual must file a document with the hospice that includes:

- A signed statement that the individual revokes the election for Medicare coverage of hospice care for the remainder of that election period; and
• The effective date of that revocation. An individual may not designate an effective date earlier than the date that the revocation is made.

Note that a verbal revocation of benefits is NOT acceptable. The individual forfeits hospice coverage for any remaining days in that election period.

Upon revoking the election of Medicare coverage of hospice care for a particular election period, the individual is no longer covered under the Medicare hospice benefit, and resumes Medicare coverage of the benefits waived when hospice care was elected. An individual may, at any time, elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive.

Additional Information


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

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NEW product from the Medicare Learning Network®

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

MLN Matters® Number: SE1505  
Related Change Request (CR) #: N/A

Related CR Release Date: N/A  
Effective Date: N/A

Related CR Transmittal #: N/A  
Implementation Date: N/A

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

**Provider Types Affected**

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

**Provider Action Needed**

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

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Background

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

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

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

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

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

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

**Additional Information**

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

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

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Partial Hospitalization Program (PHP) Claims Coding & CY2015 per Diem Payment Rates

Provider Types Affected

This MLN Matters® Special Edition is intended for hospitals and Community Mental Health Centers (CMHCs) that submit claims to Medicare Administrative Contractors (MACs) for Partial Hospitalization Program (PHP) services provided to Medicare beneficiaries.

What You Need to Know

This article alerts providers that the Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2015 final corrected per diem payment rates for PHP services. See the Additional Information section of this article for specifics.

Background

CMS reminds hospitals and CMHCs that provide PHP services to follow existing claims coding requirements given in the “Medicare Claims Processing Manual,” Chapter 4, section

Those requirements include using acceptable revenue codes and appropriate Healthcare Common Procedure Coding System (HCPCS) codes for reporting PHP services. Acceptable revenue codes for hospitals and CMHCs providing PHP services are as shown in the following table:

### Table 1: Acceptable Revenue Codes for Hospitals and CMHCs Providing PHP Services

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0250</td>
<td>Drugs and Biologicals</td>
</tr>
<tr>
<td>043X</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>0900</td>
<td>Behavioral Health Treatment/Services</td>
</tr>
<tr>
<td>0904</td>
<td>Activity Therapy</td>
</tr>
<tr>
<td>0914</td>
<td>Individual Therapy</td>
</tr>
<tr>
<td>0915</td>
<td>Group Therapy</td>
</tr>
<tr>
<td>0916</td>
<td>Family Therapy</td>
</tr>
<tr>
<td>0918</td>
<td>Testing</td>
</tr>
<tr>
<td>0942</td>
<td>Education Training</td>
</tr>
</tbody>
</table>

PHP providers (other than critical access hospitals) are required to report appropriate HCPCS codes on their claims. As described in the “Medicare Claims Processing Manual,” the appropriate HCPCS codes for services paid in the PHP per diem rate are as presented in the following table:

### Table 2: HCPCS Codes for Services Paid in the PHP Per Diem Rate

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>043X</td>
<td>G0129</td>
</tr>
<tr>
<td>0900</td>
<td>90791 or 90792</td>
</tr>
<tr>
<td>0904</td>
<td>G0176</td>
</tr>
<tr>
<td>0914</td>
<td>90785, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90865, or 90880</td>
</tr>
<tr>
<td>0915</td>
<td>G0410 or G0411</td>
</tr>
</tbody>
</table>
### Revenue Code and HCPCS Code

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0916</td>
<td>90846 or 90847</td>
</tr>
<tr>
<td>0918</td>
<td>96101, 96102, 96103, 96116, 96118, 96119, or 96120</td>
</tr>
<tr>
<td>0942</td>
<td>G0177</td>
</tr>
</tbody>
</table>

**Note:** Remember that revenue code 0250 does not require HCPCS coding. Medicare does not cover drugs that can be self-administered. Your MAC will edit to ensure that HCPCS codes are present when the above revenue codes are billed and that they are valid HCPCS codes.

### CY 2015 PHP Final Corrected Per Diem Payment Rates

The CY 2015 final corrected per diem payment rates for PHP services are as follows:

**Table 3: CY 2015 PHP Final Corrected Per Diem Payment Rates**

<table>
<thead>
<tr>
<th>Ambulatory Payment Classification (APC)</th>
<th>Group Title</th>
<th>Status Indicator (SI)</th>
<th>Relative Weight</th>
<th>Payment Rate</th>
<th>National Unadjusted Copayment</th>
<th>Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0172</td>
<td>Level I Partial Hospitalization (3 services) for CMHCs</td>
<td>P</td>
<td>1.3016</td>
<td>$96.54</td>
<td>$19.31</td>
<td></td>
</tr>
<tr>
<td>0173</td>
<td>Level II Partial Hospitalization (4 or more services) for CMHCs</td>
<td>P</td>
<td>1.5406</td>
<td>$114.27</td>
<td>$22.86</td>
<td></td>
</tr>
<tr>
<td>0175</td>
<td>Level I Partial Hospitalization (3 services) for Hospital-based PHPs</td>
<td>P</td>
<td>2.4157</td>
<td>$179.18</td>
<td>$35.84</td>
<td></td>
</tr>
<tr>
<td>0176</td>
<td>Level II Partial Hospitalization (4 or more services) for Hospital-based PHPs</td>
<td>P</td>
<td>2.6384</td>
<td>$195.70</td>
<td>$39.14</td>
<td></td>
</tr>
</tbody>
</table>

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The CY 2015 PHP final rule per diem payment rates were published in Addendum A to the Hospital Outpatient Prospective Payment Final Rule with Comment Period and CY2015 Payment Rates, which is available online at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html) on the CMS website.

The per diem rates were corrected, and the final rates are now posted at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html) on the CMS website.

The Correction Notice is available at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-CN.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-CN.html) on the CMS website.

### Additional Information

If you have any questions, please contact your DME 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” on the CMS website.

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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: MM9100 Revised Related Change Request (CR) #: CR 9100
Related CR Release Date: April 15, 2015 Effective Date: April 1, 2015
Related CR Transmittal #: R3234CP Implementation Date: April 6, 2015

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

Note: This article was revised on April 17, 2015, to reflect the revised CR9100 issued on April 15, 2015. The article was revised to correct a numbering error in the business requirements, and to update the BR9100.12 filename in the Change Request (CR). In addition, the CR transmittal number, release 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 and Ambulatory Surgical Centers (ASCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

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Provider Action Needed

Change Request (CR) 9100 describes changes to and billing instructions for various payment policies implemented in the April 2015 ASC payment system update and includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure your billing staffs are aware of these changes.

Key Points of CR9100

1. New Device Pass-Through Category and Device Offset from Payment
Additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the Outpatient Prospective Payment System (OPPS). Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that additional categories be created for transitional pass-through payment of new medical devices not described by current or expired categories of devices. This policy was implemented in the 2008 revised ASC payment system.

CMS is establishing one new HCPCS device pass-through category as of April 1, 2015 for the OPPS and the ASC payment systems. The table, below, provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment. HCPCS code C2623 (Catheter, transluminal angioplasty, drug-coated, non-laser) is assigned ASC PI= J7 (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced).

New Device Pass-Through Code HCPCS

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>Long descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2623</td>
<td>Cath, translumin, drug-coat</td>
<td>Catheter, transluminal angioplasty, drug-coated, non-laser</td>
<td>J7</td>
</tr>
</tbody>
</table>

a. Device Offset from Payment:
The C2623 device should always be billed with CPT Code 37224 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty), or CPT Code 37226 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed).

The Centers for Medicare & Medicaid Services (CMS) has determined that a portion of the OPPS payment associated with the cost of HCPCS code C2623 is reflected in the OPPS payment for CPT codes 37224 and 37226. The ASC Code Pair File will be used to establish the reduced ASC payment amount for CPT codes 37224 and 37226, when billed with HCPCS code C2623.

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b. **Billing Instructions for CPT codes 37224 and 37226:**

Pass-through category C2623 (Catheter, transluminal angioplasty, drug-coated, non-laser), is to be billed, and paid for, as a pass-through device when provided with CPT Code 37224 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty), or CPT Code 37226 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed) beginning on and after C2623’s effective date of April 1, 2015.

2. **New Services**

No new services have been assigned for payment in the ASC payment system effective April 1, 2015.

3. **Drugs, Biologicals, and Radiopharmaceuticals**

a. **New April 2015 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals.**

For April 2015, six new HCPCS codes, shown in the table below, have been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available.

**New April 2015 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9445</td>
<td>Injection, c-1 esterase inhibitor (recombinant), Ruconest, 10 units</td>
<td>K2</td>
</tr>
<tr>
<td>C9448</td>
<td>Netupitant 300mg and palonosetron 0.5 mg, oral</td>
<td>K2</td>
</tr>
<tr>
<td>C9449</td>
<td>Injection, blinatumomab, 1 mcg</td>
<td>K2</td>
</tr>
<tr>
<td>C9450</td>
<td>Injection, fluocinolone acetonide intravitreal implant, 0.01 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9451</td>
<td>Injection, peramivir, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9452</td>
<td>Injection, ceftolozane 50 mg and tazobactam 25 mg</td>
<td>K2</td>
</tr>
</tbody>
</table>

**Notes:**
1. HCPCS codes listed in the above table are new codes effective April 1, 2015.
2. HCPCS code C9450 is associated with Iluvien® and should not be used to report any other fluocinolone acetonide intravitreal implant (e.g., Retisert®). ASCs should note that the dosage descriptor for Iluvien is 0.01 mg. Because each implant is a fixed dose containing 0.19 mg of fluocinolone acetonide, ASCs should report 19 units of C9450 for each implant.
b. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2015
For CY 2015, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. Additionally, in CY 2015, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items.

Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2015, are available the April 2015 ASC Addendum BB, which is at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html on the CMS website.

4. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates
Some drugs and biologicals based on ASP methodology may have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payment rates will be accessible on the first date of the quarter at http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html on the CMS website.

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

a. Revised ASC Payment Indicator for HCPCS Codes J0365
Effective April 1, 2015, the ASC payment indicator for HCPCS code J0365 (Injection, aprotinin, 10,000 kiu) will change from K2 to Y5. This code is listed in the following table 3, along with the effective date for the revised status indicator.

<table>
<thead>
<tr>
<th>Drugs and Biologicals with Revised ASC Payment Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCPCS Code</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>J0365</td>
</tr>
</tbody>
</table>

b. Other Changes to CY 2015 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals
Effective April 1, 2015, HCPCS code Q9975 (Factor VIII FC Fusion Recomb) will replace HCPCS code C9136 Factor viii (Eloctate). The payment indicator for Q9975 will remain K2. Code C9136 has a termination date of March 31, 2015.
The following table describes the HCPCS code change and effective date.

**New HCPCS Codes for Certain Drugs and Biologicals Effective April 1, 2015**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
<th>Added Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9975</td>
<td>Factor VIII FC Fusion Recomb</td>
<td>Injection, factor viii, fc fusion protein, (recombinant), per i.u.</td>
<td>K2</td>
<td>04/01/2015</td>
</tr>
</tbody>
</table>

**5. Billing Guidance for Corneal Allograft Tissue**
ASCs can bill for corneal allograft tissue used for coverage (CPT code 66180) or revision (CPT code 66185) of a glaucoma aqueous shunt with HCPCS code V2785. Contractors pay for corneal tissue acquisition reported with HCPCS code V2785 based on acquisition/invoice cost.

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

**7. Claim Adjustment**
Your MAC will adjust, as appropriate, claims that you bring to their attention that:

1. Have dates of service January 1, 2015- March 31, 2015, and were originally processed prior to the installation of the revised January 2015 ASC DRUG File.
2. Have dates of service April 1, 2014- June 30, 2014, and were originally processed prior to the installation of the revised April 2014 ASC DRUG File.
3. Have dates of service July 1, 2014- September 30, 2014, and were originally processed prior to the installation of the revised July 2014 ASC DRUG File.
4. Have dates of service October 1, 2014- December 30, 2014, and were originally processed prior to the installation of the revised October 2014 ASC DRUG File.

**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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March is Save Your Vision Month - Medicare provides payment for some vision-related services provided to patients with Medicare, subject to certain eligibility criteria. CMS has developed the following resources to help health care professionals understand coverage, coding, and payment guidelines for these services:

- Medicare Learning Network® “Medicare Vision Services” Fact Sheet
- Medicare Learning Network® “Quick Reference Information: Preventive Services” Educational Tool
- Medicare Learning Network® “Ophthalmology Resource Information Center” Web Page

MLN Matters® Number: MM9108  
Related Change Request (CR) #: CR 9108

Related CR Release Date: March 27, 2015  
Effective Date: July 1, 2015

Related CR Transmittal #: R3222CP  
Implementation Date: July 6, 2015

Quarterly Update to the Correct Coding Initiative (CCI) Edits, Version 21.2, Effective July 1, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9108 informs MACs about the release of the latest package of National Correct Coding Initiative (NCCI) edits, Version 21.2, which will be effective July 1, 2015. Make sure that your billing staffs are aware of these changes.

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Background

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

The latest package of CCI edits, Version 21.2, effective July 1, 2015, will be available via the CMS Data Center (CDC). A test file will be available on or about May 2, 2015, and a final file will be available on or about May 17, 2015.

Version 21.2 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: Column 1/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits. In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two Correct Coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for OCE. It will only be necessary to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits. CMS no longer publishes a Mutually Exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single Column One/Column Two Correct Coding edit file on each website. The edits previously contained in the Mutually Exclusive edit file are NOT being deleted but are being moved to the Column One/Column Two Correct Coding edit file.

Additional Information


Refer to the CMS NCCI webpage for additional information at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html on the CMS website.

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

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Implementation Date: July 13, 2015

Private Contracting: Definition of Emergency Care Services and Appeals of Opt Out Determinations

Provider Types Affected

This MLN Matters® Article is intended for physicians and practitioners who opt-out of Medicare, and beneficiaries that receive services from opt out physicians and practitioners.

Note: The private contracting regulation at 42 CFR 405.450 describes certain opt-out determinations made by Medicare, and the process that physicians, practitioners, and beneficiaries may use to appeal those determinations. The cross references to the processes used to appeal the determinations described in Section 405.450 were updated in the November 13, 2014 Federal Register (Volume 79, Number 219). The definition of Emergency care services at 42 CFR 405.400 was also corrected in that November 13, 2014 Federal Register.

Provider Action Needed

STOP – Impact to You
The cross reference to Section 405.803 in Section 405.450(a) of the private contracting regulations was replaced with a cross reference to Section 498.3(b). The cross reference to

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Section 405.803 in Section 405.450(b) of the private contracting regulations was replaced with a cross reference to Section 405.924. Corresponding edits to Section 498.3(b) and Section 405.924 were also made to note that the determinations under Section 405.450(a) and (b) of the private contracting regulations are initial determinations. The definition of Emergency care services at Section 405.400 was also revised to cite to the definition of Emergency services in Section 424.101.

**CAUTION – What You Need to Know**

Be aware that a physician or practitioner who is dissatisfied with a Medicare determination under Section 405.450(a) may utilize the enrollment appeals process currently available for providers and suppliers in Part 498. Be aware that a determination described in Section 405.450(b) (that payment cannot be made to a beneficiary for services furnished by a physician or practitioner who has opted out) is an initial determination for the purposes of Section 405.924 and may be challenged through the existing claims appeals procedures in Part 405 subpart I. Be aware that emergency care services means inpatient or outpatient hospital services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.

**GO – What You Need to Do**

Make sure that your billing staffs are aware of this information.

**Background**

Emergency care services means inpatient or outpatient hospital services that are necessary to prevent death or serious impairment of health and because of the danger to life or health, which require use of the most accessible hospital available that is equipped to furnish those services.

Congress intended that the term “emergency or urgent care services” not be limited to emergency services since they also included “urgent care services.” Urgent Care Services are defined in 42 CFR 405.400 as services furnished within 12 hours in order to avoid the likely onset of an emergency medical condition.

For example, if a beneficiary has an ear infection with significant pain, the Centers for Medicare & Medicaid Services (CMS) would view that as requiring treatment to avoid the adverse consequences of continued pain and perforation of the eardrum. The patient’s condition would not meet the definition of emergency medical condition because immediate care is not needed to avoid placing the health of the individual in serious jeopardy or to avoid serious impairment or dysfunction. However, although it does not meet the definition of emergency care, the beneficiary needs care within a relatively short period of time (which CMS defines as 12 hours) to avoid adverse consequences and the beneficiary may not be able to find another physician or practitioner to provide treatment within 12 hours.
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.
Food and Drug Administration Approval of First Biosimilar Product

Provider Types Affected

This article is intended for health care professionals who submit claims to Medicare Administrative Contractors (MACs) for Medicare Part B services furnished to Medicare beneficiaries.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is aware that the Food and Drug Administration (FDA) has approved the first biosimilar product. CMS policies will ensure Medicare beneficiaries will have access to this new product, as it does for other drugs that receive FDA approval. The purpose of this article is to address questions that have arisen regarding biosimilar products.
Questions and Answers About Biosimilar Products

Question:
How will a health care professional that administers this product get reimbursed under Medicare Part B?

Answer:
Medicare Part B payment for newly approved drugs and biologicals is available once the product is approved by the FDA. CMS will incorporate biosimilars that are approved under the abbreviated biological approval pathway into the Average Sales Price (ASP) payment methodology, and issue additional guidance as necessary. Initially, once the manufacturer’s wholesale acquisition cost (WAC) is available, Medicare will pay 106 percent of the WAC for the product until ASP information is available. Once ASP information is available for this biosimilar product, Medicare payment will equal the ASP for the biosimilar product plus six percent of the ASP for the reference product.

Question:
How soon will CMS be releasing coding information related to Part B reimbursement?

Answer:
CMS anticipates including the approved biosimilar in the next quarterly Healthcare Common Procedure Coding System (HCPCS) tape release in the coming weeks, appearing in the claims processing system on July 1, 2015, effective retroactively to the FDA approval date.

Question:
Will CMS be assigning unique codes to each biosimilar released?

Answer:
CMS will create a separate code to distinguish the biosimilar from the reference biological. CMS is considering policy options for coding of additional biosimilars, and will release further guidance in the future.

Question:
Will use of a distinguishing identifier to biological products make it harder to achieve Medicare reimbursement?

Answer:
Distinguishing identifiers will have no bearing on coding and payment.

Question:
How will CMS address providing access to biosimilars through Medicare Part D?
Answer:
Although coverage for filgrastim will generally be provided through Part B, it could also be covered under Part D in certain circumstances (for example, nursing homes or Intermediate Care Facilities for Individuals with Intellectual Disabilities ICF/IID). CMS will be releasing guidance to plans confirming that biosimilars approved by the FDA will be subject to existing rules for prescription drugs under Part D.

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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