Medicare Monthly Review

Issue No. MMR 2015-08  August 2015

Contents

<table>
<thead>
<tr>
<th>Centers for Medicare &amp; Medicaid Services – Articles for Part A and Part B Providers</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Update to the End-Stage Renal Disease Prospective Payment System (MM9127)</td>
<td>3</td>
</tr>
<tr>
<td>Quarterly Healthcare Common Procedure Coding System Drug/Biological Code Changes - July 2015 Update (MM9167 Revised)</td>
<td>6</td>
</tr>
<tr>
<td>October 2015 Quarterly Average Sales Price Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM9248)</td>
<td>9</td>
</tr>
<tr>
<td>Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers (SE1425 Revised)</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Centers for Medicare &amp; Medicaid Services – Articles for Part A Providers</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Part A Skilled Nursing Facility Prospective Payment System Pricer Update FY 2016 (MM9222 Revised)</td>
<td>16</td>
</tr>
</tbody>
</table>

CMS MLN Connects® Weekly Provider eNews

MLN Connects® Provider e-News for Thursday, July 2, 2015

CMS Begins Implementation of Key Payment Legislation

MLN Connects® Provider e-News for Thursday, July 9, 2015

MLN Connects® Provider e-News for Thursday, July 16, 2015

MLN Connects® Provider e-News for Thursday, July 23, 2015

MLN Connects® Provider e-News for Thursday, July 30, 2015

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

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This bulletin should be shared with all health care practitioners and managerial members of the providers/suppliers staff. Bulletins issued during the last two years are available at no cost from our website at http://www.NGSMedicare.com.
Centers for Medicare & Medicaid Services
Articles for Part A&B Providers
Providers and Suppliers — Browse the MLN Connects® Call Program
Collection of Resources - The CMS MLN Connects® National Provider Call Program has hosted many educational conference calls for the health care community on a variety of topics, including ICD-10, PQRS, Chronic Care Management, Open Payments (the Sunshine Act), 2-Midnight Rule, Medicare Shared Saving Program, ESRD QIP, and Dementia Care in Nursing Homes — just to name a few. Check out our Calls and Events web page for links to slide presentations, audio recordings, written transcripts, and a list of upcoming calls, or view one of our videos on the Medicare Learning Network® Playlist on the CMS YouTube Channel. Become more informed about the Medicare program by reading, listening, or viewing these information-packed programs at your convenience. Visit www.cms.govnpc for more information on the MLN Connects® National Provider Call Program.

MLN Matters® Number: MM9127  Related Change Request (CR) #: CR 9127
Related CR Release Date: May 15, 2015  Effective Date: July 1, 2015
Related CR Transmittal #: R3260CP  Implementation Date: July 6, 2015

Quarterly Update to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS)

Provider Types Affected

This MLN Matters® Article is intended for End-Stage Renal Disease (ESRD) facilities that submit claims to Medicare Administrative Contractors (MACs) for ESRD services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 9127 which provides instructions for new codes added to the Healthcare Common Procedure Coding System (HCPCS) file for anemia.
management. These new codes will be added to the list of items and services subject to the ESRD PPS consolidated billing requirements. Make sure that your billing staff is aware of these changes.

**Background**

The Medicare Improvements for Patients and Providers Act ([MIPPA; Section 153(b)](https://www.cms.gov/medicare-coverage-database/details/nca-coverage-decision.aspx?NCAID=199)) required the implementation of an ESRD PPS effective January 1, 2011. The ESRD PPS provides a single payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment.

The ESRD PPS includes consolidated billing (CB) requirements for limited Part B services included in the ESRD facility’s bundled payment. The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of items and services that are subject to Part B CB and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities. The ESRD PPS provides outlier payments, if applicable, for high-cost patients due to unusual variations in the type or amount of medically necessary care.

Anemia management is a category of drugs and biologicals that are always considered to be used for the treatment of ESRD.

**CR9127 Updates**

- ESRD facilities will not receive separate payment for J0887, J1439, or Q9976 with or without the AY modifier, and the claims will process the line item as covered with no separate payment under the ESRD PPS. Effective July 1, 2015, these new codes will be added to the list of items and services subject to the ESRD PPS CB requirements:
  - J0887 - Injection, Epoetin Beta (For ESRD On Dialysis), 1 microgram
  - J1439 - Injection, ferric carboxymaltose, 1mg
  - Q9976 - Injection ferric pyrophosphate citrate solution; 0.1 mg of iron

Q9976 is administered via dialysate. Therefore, when billing for Q9976, it should be accompanied by the JE modifier as discussed in CR 8256 issued April 26, 2013. You can review the MLN Matters® Article (MM8256) corresponding to CR 8256 at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8256.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8256.pdf) on the CMS website.
In accordance with 42 CFR 413.237(a)(1), HCPCS J0887, J1439, and Q9976 are considered to be eligible outlier services and will be included in the outlier calculation when CMS provides a fee amount on the Average Sales Price fee schedule.

- There is a new HCPCS J0888 for epoetin beta for non-ESRD use. This code will not be permitted on the ESRD type of bill 072x. HCPCS J0888 replaces HCPCS Q9973; and

- Q2047 (Peginesatide) was terminated effective January 1, 2013. Therefore, it is no longer subject to the ESRD PPS consolidated billing requirements.

- In addition, J0890 (Peginesatide) is a recalled drug and should not be furnished to ESRD patients. Therefore effective July 1, 2015, this code will be removed from the list of items and services that are subject to CB requirements.

You can find the updated list of renal dialysis services that are subject to the ESRD PPS CB requirements at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html on the CMS website.

**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?
NEW products from the Medicare Learning Network®

- “The DMEPOS Competitive Bidding Program Repairs and Replacements Fact Sheet”, Fact Sheet, ICN 905283, downloadable

MLN Matters® Number: MM9167 Revised Related Change Request (CR) #: CR 9167
Related CR Release Date: July 10, 2015 Effective Date: July 1, 2015
Related CR Transmittal #: R3292CP Implementation Date: July 6, 2015

Quarterly Healthcare Common Procedure Coding System (HCPCS)
Drug/Biological Code Changes - July 2015 Update

Note: This article was revised on July 20, to reflect the revised CR9167 issued on July 10. In the article, language has been modified to clarify the use of Q9977. Also, the CR release date, transmittal number, and the Web address for accessing CR9167 are revised. On July 22, 2015, the article was revised further to include additional language from the revised CR9167. This additional language is in the note box on page 3 of this article. All other information remains the same.

Provider Types Affected

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

This article is based on Change Request (CR) 9167 and informs Medicare providers about the updating of specific drug and biological HCPCS codes that occur quarterly. It alerts providers that the July file includes new HCPCS Codes.

CR9167 also updates Chapter 17, Section 20.1.2 (Average Sales Price (ASP) Payment Methodology) in the “Claims Processing Manual” to address the use of a compounded drug not otherwise classified (NOC) code on claims for compounded drugs. Make sure that your billing staffs are aware of these changes.

Summary of New HCPCS Codes in CR9167

CR9167 adds the following HCPCS codes with the effective dates noted.

Table 1 - New HCPCS Codes in CR9167

<table>
<thead>
<tr>
<th>Effective for Claims with Dates of Service on or after:</th>
<th>HCPCS Code</th>
<th>Long Description</th>
<th>Short Description</th>
<th>Type of Service (TOS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 6, 2015</td>
<td>Q5101</td>
<td>Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram</td>
<td>Inj filgrastim g-csf biosim</td>
<td>1, P</td>
</tr>
<tr>
<td>July 1, 2015</td>
<td>Q9976</td>
<td>Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron</td>
<td>Inj Ferric Pyrophosphate Cit</td>
<td>1,L</td>
</tr>
<tr>
<td>July 1, 2015</td>
<td>Q9978</td>
<td>Netupitant 300 mg and Palonosetron 0.5 mg, oral</td>
<td>Netupitant Palonosetron oral</td>
<td>1</td>
</tr>
<tr>
<td>July 1, 2015</td>
<td>Q9977</td>
<td>Compounded Drug, Not Otherwise Classified</td>
<td>Compounded Drug NOC</td>
<td>1, P</td>
</tr>
</tbody>
</table>

Note: The Medicare Physician Fee Schedule Status Indicator for all four codes above is E.

CR9167 also updates Section 20.1.2 Average Sales Price (ASP) Payment Methodology in Chapter 17 of the “Medicare Claims Processing Manual” to address the use of a compounded drug NOC code on claims for compounded drugs.

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Please note: The new compounded drug code, Q9977 - Compounded Drug, Not Otherwise Classified, is not a replacement for existing codes. It is intended to distinguish compounded drugs (which may include biologicals) from other “not otherwise classified” codes such as J3490, J3590, J7799, J9999 and existing specific codes for compounded nebulized drugs. The implementation of Q9977 as a means of identifying compounded drug claims does not affect existing payment policy for compounded drugs as outlined in the “Medicare Claims Processing Manual,” Chapter 17, Section 20.1.2.

Additional Information


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

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

MLN Matters® Number: MM9248  Related Change Request (CR) #: CR 9248
Related CR Release Date: July 10, 2015  Effective Date: October 1, 2015
Related CR Transmittal #: R3290CP  Implementation Date: October 5, 2015

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

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9248 which instructs MACs to download and implement the October 2015 Average Sales Price (ASP) drug pricing files and, if released by CMS, the July 2015, April 2015, January 2015, and October 2014, ASP drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 5, 2015, with dates of service October 1, 2015, through December 31, 2015. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

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Background

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

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

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

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

Additional Information


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

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Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers

Note: This article was revised on July 27, 2015, to reflect an extension of the temporary moratoria for an additional 6 months, as noted in the article.

Provider Types Affected

This MLN Matters® Article is intended for home health agencies, home health agency sub-units, and part B ground ambulance suppliers in certain geographic areas of Florida, Illinois, Michigan, Texas, Pennsylvania and New Jersey that provide services to Medicare, Medicaid and CHIP beneficiaries.

Provider Action Needed

Effective July 29, 2015, the temporary moratoria on new home health agencies, home health agency sub-units, and part B ground ambulance suppliers are being extended for an additional 6 months in certain geographic locations.
CAUTION – What You Need to Know

During the 6-month temporary moratoria, initial provider enrollment applications and change of information applications to add additional practice locations, received from home health agencies, home health agency sub-units, and part B ground ambulance suppliers in the moratoria counties will be denied. Application fees that are paid for applications that are denied due to the temporary moratoria will be refunded.

GO – What You Need to Do

Effective July 29, 2015, home health agencies, home health agency sub-units, and part B ground ambulance suppliers should not submit initial enrollment applications or change of information applications to add additional practice locations until the 6-month moratoria has expired. CMS will announce in the Federal Register when the moratorium has been lifted, extended, or changed.

Background

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

On July 28, 2015, CMS announced, in a Federal Register notice (http://federalregister.gov/a/2015-18327), the extension of temporary moratoria on the enrollment of new home health agencies, home health agency sub-units and part B ambulance suppliers in designated geographic locations.

The moratoria initially became effective on July 30, 2013, and the implementation was announced in the Federal Register which may be accessed on the internet at: https://federalregister.gov/a/2013-18394. The moratoria were expanded on January 30, 2014, and the expansion was announced in the Federal Register which may be accessed at: https://federalregister.gov/a/2014-02166.

Moratoria Extension

Effective July 29, 2015, the temporary moratorium on new home health agencies and home health agency sub-units is being extended for an additional 6 months in the areas stated in Table 1, below.
Table 1: Home Health Agencies and Home Health Agency Sub-units under Temporary Moratorium

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

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

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

Initial provider enrollment applications and change of information applications to add additional practice locations received from home health agencies, home health agency sub-units, and Part B ground ambulance suppliers in the above listed counties will be denied in accordance with 42 CFR §424.570(c). Application fees that are paid for applications that are denied due to the temporary moratoria will be refunded.

**Note:** Home health agencies, home health agency sub-units, and Part B ground ambulance suppliers are afforded appeal rights. However, the scope of review will be limited to whether the temporary moratorium applies to the provider or supplier appealing the denial. CMS’ basis for imposing a temporary moratorium is not subject to review.

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number, which is available at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html) on the CMS website.
Centers for Medicare & Medicaid Services
Articles for Part A Providers
REVISED product from the Medicare Learning Network®

- “Resources For Medicare Beneficiaries” Fact Sheet, ICN 905183, downloadable

MLN Matters® Number: MM9222 Revised Related Change Request (CR) #: CR 9222
Related CR Release Date: July 2, 2015 Effective Date: October 1, 2015
Related CR Transmittal #: R3289CP Implementation Date: October 5, 2015

Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2016

Note: This article was revised on July 9, 2015, to reflect the revised CR9222 issued on July 2. In the article, the CR release date, transmittal number, and the Web address for accessing CR9222 are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for Skilled Nursing Facilities (SNFs) submitting claims to Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries paid under the Skilled Nursing Facility (SNF) Prospective Payment System (PPS).

Provider Action Needed

Change Request (CR) 9222 describes the updates to the payment rates used under the PPS for SNFs, for Fiscal Year (FY) 2016, as required by statute. Make sure that your billing staffs are aware of these changes.

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Background

Annual updates to the SNF PPS rates are required by the Social Security Act (Section 1888(e); see http://www.ssa.gov/OP_Home/ssact/title18/1888.htm), as amended by the Medicare, Medicaid, and the State Children’s Health Insurance Plan (SCHIP) Balanced Budget Refinement Act of 1999 (the BBRA), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.

Each July, the Centers for Medicare & Medicaid Services (CMS) publishes the SNF payment rates for the upcoming fiscal year (October 1, 2015 through September 30, 2016) in the Federal Register, available online at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/List-of-SNF-Federal-Regulations.html on the CMS website.

The update methodology is identical to that used in the previous year, which includes a forecast error adjustment whenever the difference between the forecasted and actual change in the SNF market basket exceeds 0.5 percentage point. The statute mandates an update to the Federal rates using the latest SNF full market basket adjusted for productivity. The payment rates will be effective October 1, 2015.

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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