# Medicare Monthly Review

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# Selecting Home Health Claims for Probe and Educate Review: Episodes that Begin on or After August 1, 2015 (SE1524)

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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).
Autonomic Function Testing (L36236)
ICD-10-CM codes E11.40, E13.40, G60.9 and G62.9, were added to Group 1 in the “ICD-10-CM Codes that Support Medical Necessity” section.

Bevacizumab (e.g., Avastin™) - Related to LCD L33394 (A52370)
An indication for malignant pleural mesothelioma has been added to the “NON-OPHTHALMOLOGIC INDICATIONS” section of the article. The following ICD-10-CM codes have been added to the Group 1: Codes: C34.00, C34.10, C34.30, C34.80, C34.90, C38.4, C45.0, C49.10, C49.20, C49.3, C50.019, C50.029, C50.119, C50.129, C50.219, C50.229, C50.319, C50.329, C50.419, C50.429, C50.519, C50.529, C50.619, C50.629, C50.819, C50.829, C50.919, C50.929, C56.9, C57.00, C57.10, C57.20, C64.9, C65.9 and Z85.43.
The following ICD-10.CM codes have been put into ranges C34.00 – C34.92, C50.011 – C50.929 and C57.00 – C57.22. ICD-9-CM code V10.43 is being added effective for dates of service on or after 7/1/2014.

Biologic Products for Wound Treatment and Surgical Interventions (L33391)
Based on a reconsideration request, a coverage article for Hyalomatrix® Wound Device has been added effective for dates of service on and after 11/1/2015.

Botulinum Toxins (L33646)
The following paragraph in the “Indications” section under “Spasticity” has been revised to add “shoulder”:
Electromyography or muscle stimulation, rather than site pain or tenderness, to determine injection site(s) for Botulinum toxin may be necessary, especially for spastic conditions of the face, neck, hand and shoulder.
The “Utilization” section has been revised to indicate:
Dose and frequency should be in accordance with the FDA label. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Breast Imaging: Breast Echography/Sonography/Breast MRI/Ductography (L33585)
Based on a provider request, ICD-10-CM codes C50.911 and C50.912 were added to Group 1 in the “ICD-10-CM Codes that Support Medical Necessity” section.

Cardiac Catheterization and Coronary Angiography (L33557)
This note was added to clarify the requirement for two diagnoses for some CPT codes:
(If the same diagnosis appears in both required groups, that one diagnosis is sufficient for coverage.) Example: CPT code 93458 requires a diagnosis from groups 2 and 3. If the patient’s diagnosis is Atherosclerotic heart disease of native coronary artery with unstable angina pectoris, ICD-10 code I25.110 is the correct diagnosis. This code appears in both groups and does not require an additional diagnosis.)

Infliximab (e.g., Remicade™) – Related to LCD L33394 (A52423)
Based on a reconsideration request, the indication for psoriatic arthropathy has been revised. Other indications in the article have also been revised to include reference to Inadequate Response*. A description for inadequate response has been added to the “Indications” section of the article. The "Documentation Requirements" section has been revised and medical record guidelines have been added. The following bulleted item has been added to the "Utilization" section: Infliximab has been associated with adverse outcomes in patients with heart failure, and should not be administered at doses greater than 5 mg/kg in patients with moderate to severe heart failure.
Intravenous Immune Globulin (IVIG) - Related to LCD L33394 (A52446)
CD-10-CM codes M33.00, M33.09, M33.10, M33.20, M33.90 and M33.99 have been added to the “Covered ICD-10 Codes” section and the codes have been put into a range.

Magnetic Resonance Angiography (MRA) (L33633)
The following ICD-10 codes have been added as payable for MRA of the head/neck (Group 1), effective 10/01/2015: I63.00, I63.019, I63.039, I63.10, I63.119, I63.139, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.319, I63.329, I63.339, I63.349, I63.40, I63.419, I63.429, I63.439, I63.449, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.559, I63.9.

Noninvasive Vascular Studies (L33627)
ICD-10 code M54.2 was added to Group 1, payable diagnoses for Cerebrovascular Evaluation (93880, 93882), to be used to report suspicion of carotid artery dissection. For dates of service prior to 10/1/2015, this condition should be reported with ICD-9 code 723.1.

Effective for dates of service on or after 10/1/2015, ICD-10 code I63.9 was added to Group 1, payable diagnoses for Cerebrovascular Evaluation (93880, 93882).

Effective for dates of service on or after 10/1/2015, ICD-10 code I73.9 was added to the payable diagnoses for Extremity Arterial Evaluation (93922, 93923, 93924, 93925, 93926, 93930 and 93931).

Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography) (L33567)
ICD-10 codes H40.10X1, H40.10X2, H40.10X3, and H40.10X4 were added to Group 1, payable diagnoses for CPT codes 92225, 92226, 92228, and 92250, effective 10/1/2015.

Paclitaxel (e.g., Taxol®/Abraxane ™) - Related to LCD L33394 (A52450)
ICD-10-CM codes C34.00, C34.10, C34.30, C34.80, C43.0 – C43.8, C50.019, C50.119, C50.129, C50.219, C50.319, C50.329, C50.419, C50.429, C50.519, C50.529, C50.619, C50.629, C50.819, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C56.9, C57.00, C57.10, C57.20, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8 and D03.91 have been added for albumin-bound paclitaxel.

The following have been put into ranges: C34.00 – C34.92, C43.0 – C43.9, C50.011 – C50.929, C57.00 – C57.22 and D03.0 – D03.9.

ICD-10-CM codes C06.80, C34.00, C34.10, C34.30, C34.80, C34.90, C34.91, C34.92, C43.10, C43.20, C43.60, C43.70, C44.101, C44.111, C44.121, C44.191, C44.201, C44.211, C44.221, C44.291, C44.310, C44.320, C44.01, C44.611, C44.621, C44.691, C44.701, C44.711, C44.721, C44.791, C46.50, C47.10, C47.20, C47.9, C49.10, C49.20, C50.019, C50.119, C50.129, C50.219, C50.319, C50.329, C50.419, C50.429, C50.519, C50.529, C50.619, C50.629, C50.819, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C56.9, C57.00, C57.10, C57.20, C62.00, C62.10, C62.20, C62.90, C62.91, C62.92, C64.9, C65.9, C66.9, C83.99, C84.A6, C84.A8, C85.11, C85.12, C85.13, C85.14, C85.15, C85.17, C85.20, C85.97, C85.98, D03.10, D03.20, D03.60, D03.70, D49.0, D49.1, D49.2, D49.6, D49.89, Z85.00 and Z85.819, have been added for paclitaxel.

The following have been put into ranges: C34.00 – C34.92, C43.0 – C43.9, C44.00 – C44.99, C47.0 – C47.9, C49.0 – C49.99, C50.011 – C50.929, C62.00-C62.92, C85.10 – C85.99 and D03.0 – D03.9.

Psychiatry and Psychology Services (L33632)
Based on a request for coverage, ICD-10-CM unspecified codes that were equivalent to the ICD-9-CM unspecified codes present in the retired ICD-9-CM policy were added.

Asterisks were added to ICD-10-CM codes F72*, F73*, and F79* with the following explanatory note:

“Please see Limitations section above regarding ICD-10-CM codes F72, F73, and F79".
Rituximab (Rituxan®) - Related to LCD L33394 (A52452)
The “Indications” section has been revised to add Microscopic Polyangiitis (MPA) which was inadvertently removed with the last update to the ICD-9-CM article. ICD-10-CM code M31.7 has been added effective 10/01/2015.

Routine Foot Care and Debridement of Nails (L33636)
Based on a practitioner request, ICD-10-CM codes E09.51, E10.51, E11.51, I70.291, I70.292 and I70.293 were added to Group 1 in the “ICD-10-CM codes that Support Medical Necessity” section.

Vertebroplasty and Vertebral Augmentation (Percutaneous) (L33569)
Effective for dates of service on or after 10/1/2015, ICD-10 code groups were revised to remove the dual diagnosis requirement for ICD-10 codes that include the fracture and underlying condition required to support medical necessity.

Vertebroplasty and Vertebral Augmentation (Percutaneous) - SIA (A52871)
Coding guidelines were updated to remove specific ICD-10 codes from diagnosis coding requirements and refer providers to the LCD for these details.

December 2015 Revisions
Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L33394)
Based on a reconsideration request, the indication for psoriatic arthropathy has been revised in the Infliximab article (A52423). The Bevacizumab article (A52370) has been revised to add an indication for malignant pleural mesothelioma. The Rituximab article (A52452) has been revised to add Microscopic Polyangiitis (MPA) which was inadvertently removed with the last update to the ICD-9-CM article. ICD-10-CM codes have been added to the following drug articles: Bevacizumab (A52370), Paclitaxel (A52450), IVIG (A52446) and Rituximab (A52452).

Self-Administered Drug Exclusion List - Medical Policy Article (A53021)
Added evolocumab (Repatha™) (C9399, J3590) effective 01/15/2016.

Self-Administered Drug Exclusion List - Medical Policy Article (A53022)
Added evolocumab (Repatha™) (C9399, J3590) effective 01/15/2016.

National Government Services Articles for Part A Providers
Correct Reporting of Units of Drugs: Rituximab (Rituxan®)
CMS identified an issue concerning the incorrect billing of units of drugs for Rituximab.

General Instructions for Billing Units of Drugs
Drugs are billed in multiples of the dosage specified in the HCPCS/CPT code long descriptor. If the drug dose used in the care of a patient is not an exact multiple of the HCPCS/CPT code dosage descriptor, the provider should round to the next highest unit based on the HCPCS/CPT long descriptor for the code in order to report the dose provided.

If the full dosage provided is less than the dosage for the HCPCS/CPT code descriptor specifying the minimum dosage for the drug, the provider reports one unit of the HCPCS/CPT code for the minimum dosage amount.

Using the correct HCPCS codes for the items used, hospitals should report charges for all drugs, biologicals and radiopharmaceuticals, regardless of whether the items are paid separately or packaged. Hospitals billing for these products should make certain that the reported units of service for the reported HCPCS code are consistent with the quantity of the drug, biological, or radiopharmaceutical that was
used in the care of the patient. Drugs or biologicals must meet Medicare coverage requirements including, but not limited to applicable LCDs, NCDs and per CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15.

Ensure that the units of drugs administered to Medicare beneficiaries are accurately reported according to the dosage specified in the full HCPCS code descriptor per the applicable HCPCS manual for the dates of service being billed. Thus, units should be calculated and reported in multiples of the units per the HCPCS code descriptor.

- **Example 1**: If the HCPCS code description for a specific drug HCPCS code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed equal one.

- **Example 2**: If the HCPCS code description for a specific drug HCPCS code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed equals four.

Do not bill for units based on the way the drug is packaged, stored, or stocked. For example, if the HCPCS descriptor for the drug code specifies 1 mg, and a 10 mg vial of that drug was administered to the patient, the facility bills the HCPCS code with 10 units, even though only one vial was administered.

Please note that the HCPCS short descriptors are limited to 28 characters, including spaces; thus, short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes per the HCPCS or CPT coding manual applicable to the year in which the drug was administered.

**Billing for Units of Rituximab**

Rituximab is billed with J9310 and is described in the *2015 HCPCS Coding Manual* as "Injection, Rituximab, 100 mg." Providers should always check the most accurate HCPCS codes and descriptions applicable to the dates of service billed.

- **Rituximab example**: 100 mgs of Rituximab, HCPCS code J9310, were administered; therefore, the number of units billed must equal one.

NGS has an LCD and SIA that provide coverage and billing instructions specific to Rituximab.

**Documentation**

The patient's medical record must contain documentation that fully supports the medical necessity for any drug that is billed to Medicare. Documentation should include, but is not limited to, relevant medical history, physical examination and results of pertinent diagnostic tests or procedures.

The medical record **must** include the following information:

- The name of the drug or biological administered
- The route of administration
- The dosage (e.g., mg, mcg, cc or IU)
- The duration of the administration (for CPT codes that are time-based)
- When a portion of the drug or biological is discarded, from single use vials, the medical record must clearly document the amount administered and the amount wasted or discarded.
  - **Modifier JW**: Not required; can be used to report that a portion of the drug or biological is discarded, from a single use vial only. When modifier JW is billed, the medical record must clearly document the amount administered and the amount wasted or discarded.

**Related Content**

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 50, "Drugs and Biologicals" (1 MB)
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 17; Section 10, "Payment Rules for Drugs and Biologicals" (510 KB)
- Links to the CMS website relevant to LCDs and SIAs are posted to the Medical Policy section of our website: *Medical Policy & Review > Medical Policy Center*, select the link for your jurisdiction to access the LCD or SIA lists.
Hydration Therapy Billing and Medical Necessity Issues

CMS identified two issues relevant to hydration therapy services:

1. Lack of medical necessity to support Medicare coverage; and
2. Number of units billed.

CPT codes 96360 and 96361 are used to report hydration IV infusion consisting of prepackaged fluid and electrolytes. Minimum time duration of 31 minutes of therapeutic hydration is required in order to report this service. These codes are not reported for the purpose of the infusion of drugs or other substances. Hydration that is integral to the performance of a surgical procedure or transfusion or to establish an initial and underlying intravenous (IV) flow for a diagnostic or therapeutic infusion is not separately billable. In addition, hydration is not separately billable when such fluid is used to keep the line open subsequent to a therapeutic infusion or as a free-flowing IV during chemotherapy or other therapeutic infusion.

The 2015 CPT Manual defines the codes as:

- 96360 – Intravenous infusion, hydration, initial, 31 minutes to 1 hour
- 96361 – (add on code) each additional hour (for hydration infusion intervals of greater than 30 minutes beyond one hour increments

Documentation to Support Medical Necessity

A physician’s order for the administration of hydration therapy is required and the documented diagnosis codes should support the medical necessity of hydration therapy. In addition, the medical records must support the medical necessity of hydration therapy including an assessment of symptoms warranting hydration. Thus, signs and symptoms of dehydration, the inability to ingest fluids, abnormal fluid losses, abnormal vital signs, abnormal laboratory studies, etc. should be documented. To qualify as medically necessary hydration, the rate of infusion should be documented and support performance of this service for rapid replenishment. Start and stop times or total time infused must be evident in the documentation in order to validate the number of units billed.

Billing Units Correctly

Medicare requires that service units (FL 46 on the Form CMS-1450) must be calculated and reported according to the HCPCS or CPT code description; when necessary, the provider should round up to the nearest whole number.

The CPT Manual instructions specify that hydration of less than 30 minutes is not separately billable. The duration of a hydration infusion must be continuous for more than 30 minutes in order to report an initial unit of hydration therapy to Medicare.

Only one “initial” hydration therapy code should be reported per day. Medicare will deny the second initial hydration therapy service on the same day unless the second separately identifiable initial hydration therapy service provided on the same day has modifier 59 appended.

CAH Method II Note

Outpatient physician involvement for hydration; therapeutic or diagnostic injections and IV infusions (other than hydration); and chemotherapy administration in a Method II CAH is included in the physicians E&M services. Bills must include an appropriate outpatient hospital visit E&M CPT code with revenue code 96X, 97X or 98X on TOB 85X.
Related Content

  - Section 20.4 - Reporting of Service Unit
  - Specifies that the “definition of service units (FL 46 on the Form CMS-1450) where HCPCS code reporting is required is the number of times the service or procedure being reported was performed.”
  - Section 230 - Billing and Payment for Drugs and Drug Administration
  - Section 250.8 - Coding for Administering Drugs in a Method II CAH

- Medicare Quarterly Compliance Newsletters; Guidance to Address Billing Errors:
  - *Volume 5, Issue 2, January 2015* (2.39 MB)
    - “Recovery Auditor Finding: Intravenous Infusion Chemotherapy and Non-chemotherapy-Excessive Units Reported”
  - *Volume 5, Issue 4, July 2015* (1 MB)
Centers for Medicare & Medicaid Services
Articles for Part A&B Providers
The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.
Reporting Principal and Interest Amounts When Refunding Previously Recouped Money on the Remittance Advice (RA)

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

Change Request (CR) 9168 explains to providers who received a favorable appeals decision that it will be easier and consequently more transparent to identify the claim and/or the refund of principal and interest paid by Medicare. Your MAC will make sure that the remittance advices are reporting the refunded principal and interest amounts separately, and provide individual claim information. CR9168 applies to electronic remittance advice (ERA) only.
Background

Currently reporting of refunded principal and interest amounts for all related claims on the Remittance Advice (RA) is shown as one lump sum amount. This practice creates problems for the provider community as this is not conducive to posting payment properly. Providers have the money but are not able to identify the claim and/or the refund of principal and interest paid by Medicare.

CR9168 instructs MACs to report the principal and interest separately, and also to provide individual claim information. Specifically, the reporting will be in the Provider Level Balance (PLB) segment of the 835 as follows:

**PLB Details - Reporting Principal Refunds**

- PLB03-1: WW to report overpayment recovery (negative sign for the amount in PLB04) being refunded
- PLB03-2 Positions 1 – 25: Account Payable (AP) Invoice Number
- PLB03-2 Positions 26 – 50: Claim Adjustment Account Receivable (AR) number
- PLB 04: Refund Amount (Principal Refund Amount)

**PLB Details - Reporting Interest Refunds**

- PLB03-1: RU to report interest paid (negative sign for the amount in PLB04)
- PLB03-2 Positions 1 – 25: AP Invoice Number
- PLB03-2 Positions 26 – 50: Claim Adjustment AR number
- PLB04: Interest Amount on Refund

Additional Information


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

Disclaimer

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REVISED product from the Medicare Learning Network® (MLN)

- “HIPAA EDI Standards”, Web-based Training (WBT)

MLN Matters® Number: MM9246 Related Change Request (CR) #: 9246
Related CR Release Date: October 15, 2015 Effective Date: February 5, 2015
Related CR Transmittal #: R3374CP and Implementation Date: January 4, 2016
R185NCD

Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9246 informs MACs that Medicare covers lung cancer screening with Low Dose Computed Tomography (LDCT) if all eligibility requirements listed in the National Coverage Determination (NCD) are met. Make sure that your billing staffs are aware of these changes.

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Background

Section 1861(ddd)(1) of the Social Security Act (the Act) authorizes the Centers for Medicare & Medicaid Services (CMS) to add coverage of "additional preventive services" through the NCD process. The “additional preventive services” must meet all of the following criteria:

- Be reasonable and necessary for the prevention or early detection of illness or disability;
- Be recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and
- Be appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS reviewed the evidence for lung cancer screening with low dose computed tomography (LDCT) and determined that the criteria listed above were met, enabling CMS to cover this “additional preventive service” under Medicare Part B.

CMS issued NCD 210.14 on August 21, 2105, that provides for Medicare coverage of screening for lung cancer with LDCT. Effective for claims with dates of service on and after February 5, 2015, Medicare beneficiaries must meet all of the following criteria:

- Be 55–77 years of age;
- Be asymptomatic (no signs or symptoms of lung cancer);
- Have a tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
- Be a current smoker or one who has quit smoking within the last 15 years; and,
- Receive a written order for lung cancer screening with LDCT that meets the requirements described in the NCD.

Written orders for lung cancer LDCT screenings must be appropriately documented in the beneficiary’s medical record, and must contain the following information:

- Date of birth;
- Actual pack–year smoking history (number);
- Current smoking status, and for former smokers, the number of years since quitting smoking;
- A statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer); and,
- The National Provider Identifier (NPI) of the ordering practitioner.

Counseling and Shared Decision-Making Visit

Before the first lung cancer LDCT screening occurs, the beneficiary must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision-making visit that includes the following elements and is appropriately documented in the beneficiary’s medical records:

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• Must be furnished by a physician (as defined in section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) as defined in section 1861(aa)(5) of the Act); and

• Must include all of the following elements:
  o Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting;
  o Shared decision-making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
  o Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of co-morbidities, and ability or willingness to undergo diagnosis and treatment;
  o Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions; and,
  o If appropriate, the furnishing of a written order for lung cancer screening with LDCT.

Written orders for subsequent annual LDCT screens may be furnished during any appropriate visit with a physician or qualified non-physician practitioner (PA, NP, or CNS)

There is also specific criteria that the reading radiologist and radiology imaging facility must meet. The radiology imaging facility must collect and submit data to a CMS-approved registry for each LDCT lung cancer screening performed. The data collected and submitted to a CMS-approved registry must include specific elements. Information regarding CMS-approved registries is posted at: [http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Lung-Cancer-Screening-Registries.html](http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Lung-Cancer-Screening-Registries.html) on the CMS website.

Coinsurance and Deductibles
Medicare coinsurance and Part B deductible are waived for this preventive service.

Health Care Common Procedure Coding System (HCPCS) Codes
Effective for claims with dates of service on and after February 5, 2015, the following HCPCS codes are used for lung cancer screening with LDCT:

• G0296 – Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)

• G0297 – Low dose CT scan (LDCT) for lung cancer screening
In addition to the HCPCS code, these services must be billed with ICD-10 diagnosis code Z87.891 (personal history of tobacco use/personal history of nicotine dependence), ICD-9 diagnosis code V15.82.

**NOTE:** Contractors shall apply contractor-pricing to claims containing HCPCS G0296 and G0297 with dates of service February 5, 2015, through December 31, 2015.

**Institutional Billing Requirements**

Effective for claims with dates of service on and after February 5, 2015, providers may use the following Types of Bill (TOBs) when submitting claims for lung cancer screening, HCPCS codes G0296 and G0297: 12X, 13X, 22X, 23X, 71X (G0296 only), 77X (G0296 only), and 85X.

Medicare will pay for these services as follows:

- **Outpatient hospital departments** – TOBs 12X and 13X - based on Outpatient Prospective Payment System (OPPS);
- **Skilled nursing facilities (SNFs)** – TOBs 22X and 23X – based on the Medicare Physician Fee Schedule (MPFS);
- **Critical Access Hospitals (CAHs)** - TOB 85X – based on reasonable cost;
- **CAH Method II** – TOB 85X with revenue code 096X, 097X, or 098X based on the lesser of the actual charge or the MPFS (115% of the lesser of the fee schedule amount and submitted charge) for HCPCS G0296 only;
- **Rural Health Clinics (RHCs)** - TOB 71X - based on the all-inclusive rate for HCPCS G0296 only; and
- **Federally Qualified Health Centers (FQHCs)** – TOB 77X - based on the PPS rate for HCPCS G0296 only.

**NOTE:** For outpatient hospital settings, as in any other setting, services covered under this NCD must be ordered by a primary care provider within the context of a primary care setting and performed by an eligible Medicare provider for these services.

**Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Group Codes**

MACs will use the following CARCs, RARCs, and Group Codes when denying payment for LDCT lung cancer screening, HCPCS G0296 and G0297:

Submitted on a TOB other than 12X, 13X, 22X, 23X, 71X, 77X, or 85X:

- **CARC 170** - Payment is denied when performed/billed by this type of provider. 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 (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).
  
  **NOTE:** For modifier GZ, MACs will use CARC 50.

For TOBs 71X and 77X when HCPCS G0296 is billed on the same date of service with another visit (this does not apply to initial preventive physical exams for 71X TOBs):

- CARC 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
  
  **NOTE:** 77X TOBs will be processed through the Integrated Outpatient Code Editor under the current process.
- Group Code CO assigning financial liability to the provider.

Where a previous HCPCS G0297 is paid in history in a 12-month period (at least 11 full months must elapse from the date of the last screening):

- CARC 119 – Benefit maximum for this time period or occurrence has been reached.
- 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.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).
  
  **NOTE:** For modifier GZ, MACs will use CARC 50.

Because the beneficiary is not between the ages of 55 and 77 at the time the service was rendered (line-level):

- CARC 6: “The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- Group Code: CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).
  
  **NOTE:** For modifier GZ, MACs will use CARC 50.
Because the claim line was not billed with ICD-10 diagnosis Z87.891:

- 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.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp). If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code: CO assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

**NOTE:** For modifier GZ, MACs will use CARC 50.

### Additional Information

The official instruction, CR9246, consists of two transmittals:
1. [Transmittal R3374CP](#), which updates the “Medicare Claims Processing Manual;”
2. [Transmittal R185NCD](#), which updates the “Medicare NCD Manual.”

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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Payment Reduction for Computed Tomography (CT) Diagnostic Imaging Services

Provider Types Affected

This MLN Matters® Article is intended for providers submitting claims for Computed Tomography (CT) diagnostic imaging services to Medicare Administrative Contractors (MACs), including Durable Medical Equipment MACs (DME MACs).

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is creating the modifier “CT” (Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard). Beginning in 2016, claims for CT scans described by related CPT codes that are furnished on non-NEMA Standard XR-29-2013-compliant CT scans must include modifier “CT” that will result in the applicable payment reduction.
Change Request (CR) 9250 informs providers that effective January 1, 2016, a payment reduction of 5 percent applies to CT services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the physician fee schedule. The payment reduction increases to 15 percent in 2017 and subsequent years.

Make sure that your billing staffs are aware of the NEMA standards and the payment reductions related to CT services furnished on equipment inconsistent with the CT equipment standard.

Background

Section 218(a) of the Protecting Access to Medicare Act of 2014 (PAMA) is titled, “Quality Incentives to Promote Patient Safety and Public Health in Computed Tomography Diagnostic Imaging.” It amends the Social Security Act (SSA) by reducing payment for the technical component (and the technical component of the global fee) of the Physician Fee Schedule service (5 percent in 2016 and 15 percent in 2017 and subsequent years) for CT services identified by the following CPT codes:

- 70450-70498;
- 71250-71275;
- 72125-72133;
- 72191-72194;
- 73200-73206;
- 73700-73706;
- 74150-74178;
- 74261-74263; and
- 75571-75574.

This applies when the services identified by these codes are furnished using equipment that does not meet each of the attributes of the NEMA Standard XR-29-2013, entitled, “Standard Attributes on CT Equipment Related to Dose Optimization and Management.”

The statutory provision requires that information be provided and attested to by a supplier and a hospital outpatient department that indicates whether an applicable CT service was furnished that was not consistent with the NEMA CT equipment standard, and that such information may be included on a claim and may be a modifier. The statutory provision also provides that such information shall be verified, as appropriate, as part of the periodic accreditation of suppliers under SSA Section 1834(e) and hospitals under SSA Section 1865(a). Any reduced expenditures resulting form this provision are not budget neutral.

To implement this provision, CMS will create modifier “CT.” Beginning in 2016, claims for CT scans described by above-listed CPT codes (and by successor codes) that are furnished...
on non-NEMA Standard XR-29-2013-compliant CT scans must include modifier “CT” that will result in the applicable payment reduction.

Beginning January 1, 2016, a payment reduction of 5 percent applies to the technical component (and the technical component of the global fee) for CT services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the physician fee schedule. This payment reduction becomes 15 percent for 2017 and succeeding years.

When such payment reductions are made, MACs will supply:

- Claim Adjustment Reason Code 237 – Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
- Remittance Advice Remark Code N759 – Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013; and
- Group Code: CO (contractual obligation).

**Additional Information**


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- “837P and Form CMS-1500” Web-Based Training (WBT) has been revised and is now available.

MLN Matters® Number: MM9297 Related Change Request (CR) #: CR 9297
Related CR Release Date: November 6, 2015 Effective Date: January 1, 2016
Related CR Transmittal #: R1572OTN Implementation Date: April 4, 2016

Removal of Device Portion from Certain Discontinued Device-Intensive Ambulatory Surgical Center (ASC) Procedures Prior to the Administration of Anesthesia

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9297 informs providers that MACs will remove the device portion from certain device intensive ASC procedures when the ASC surgical or ancillary service procedure is terminated prior to anesthesia and Modifier 73 is on the claim.

Background

Currently, when an ASC covered surgical procedure or ancillary service is terminated prior to the administration of anesthesia, the ASC adds modifier 73 to the procedure line item on the claim.

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The Modifier 73 identifies a covered surgical procedure or ancillary service for which anesthesia is planned but discontinued after the patient is prepared and taken to the room where the procedure is to be performed but before anesthesia is administered. Medicare processes these line items by removing one-half of the full program allowance and the beneficiary copayment amounts when processing the 73 modifier.

**Key Points**

In the CY 2016 Outpatient Prospective Payment System/ASC) Final Rule, the Centers for Medicare & Medicaid Services (CMS) finalized a payment policy for device intensive covered surgical procedures which removes the unused device portion of the program payment prior to the program payment reduction when the 73 modifier is appended to the claim.

- This policy does not apply to procedures and services that are discontinued after the administration of anesthesia and include the 74 modifier.
- The MAC will identify and process device intensive procedures and services billed with the 73 modifier, by using the program payment amount appearing in the ‘FB Mod Reduced Price’ field on the ASC Fee Schedule (FS) record layout as the full program payment, with the device portion removed, prior to processing the 73 modifier payment calculations.
- If there is no payment amount in the FB Mod Reduced Price field of the ASCFS, then the procedure is not device intensive and this new policy would not apply.

To process claims correctly, when device intensive procedures and services are billed with the 73 modifier and FB (full device credit)/FC (partial credit received for replaced device) modifiers, the FB/FC modifier is ignored for this line item unused device, and the line item would continue to be processed as stated above.

For ASCs subject to the ASC Quality Reporting (QR) program payment reduction, contractors will use the procedure payment amount located in the respective Penalty FB Mod Reduced Price field on the ASCFS in place of the payment amount in the FB Mod Reduced Price field or the Penalty Price field on the ASCFS in place of the payment amount in the Price field, as appropriate.

In summary:

1. Effective for dates of service beginning January 1, 2016, when the 73 modifier is included on the ASC claim line, Medicare contractors will edit to determine if the ASCFS “FB Mod Reduced Price” field is zero filled.
2. If the corresponding “FB Mod Reduced Price” field is zero filled on the ASCFS, contractors will continue to apply the value in the ASCFS “Price” field.
3. If the ASC is subject to the ASCQR payment reduction, contractors, as appropriate, will use the payment from the "Penalty Price" field on the ASCFS instead of the "Price" field.

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4. If the corresponding “FB Mod Reduced Price” field is not zero filled on the ASCFS, contractors will apply the value contained in the ASCFS “FB Mod Reduced Price” field instead of the value in the ASCFS “Price” field.

5. If the ASC is subject to the ASCQR payment reduction, contractors, as appropriate, will use the payment from the "Penalty FB MOD Reduced Price" field on the ASCFS instead of the "FB MOD Reduced Price" field.

6. Medicare contractors will ignore the FB or FC modifier if submitted on the claim line with the 73 modifier, and allow the claim to process.

Additional Information


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

REVISED product from the Medicare Learning Network® (MLN)

- “Medicare Enrollment for Institutional Providers” Fact Sheet, ICN 903783, Downloadable only

MLN Matters® Number: MM9317 Related Change Request (CR) #: CR 9317
Related CR Release Date: October 9, 2015 Effective Date: January 1, 2016
Related CR Transmittal #: R3368CP Implementation Date: January 1, 2016

New Values for Incomplete Colonoscopies Billed with Modifier 53

Provider Types Affected

This MLN Matters® Article is intended for providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries related to incomplete colonoscopies billed with Modifier 53.

Provider Action Needed

STOP – Impact to You

Change Request (CR) 9317, from which this article is taken, revises the method for calculating payment for discontinued procedures. New payment rates will apply when Modifier 53 (discontinued procedure) is appended to codes 44388, 45378, G0105, and G0121.

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Effective for services performed on or after January 1, 2016, the Medicare Physician Fee Schedule (MPFS) database will have specific values for Current Procedural Terminology (CPT) codes 44388-53; 45378-53; G0105-53; and G0121-53.

Make sure that your billing staffs are aware of these revisions for calculating payments for discontinued procedures using Modifier 53. Incomplete colonoscopies are reported with Modifier 53. Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes.

Background

According to CPT instruction, prior to calendar year (CY) 2015, an incomplete colonoscopy was defined as a colonoscopy that did not evaluate the colon past the splenic flexure (the distal third of the colon). Physicians were previously instructed to report an incomplete colonoscopy with 45378 and append Modifier 53 (discontinued procedure), which is paid at the same rate as a sigmoidoscopy.

In CY 2015, the CPT instruction changed the definition of an incomplete colonoscopy to a colonoscopy that does not evaluate the entire colon. The 2015 CPT Manual states:

“When performing a diagnostic or screening endoscopic procedure on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, report 45378 (colonoscopy) or 44388 (colonoscopy through stoma) with modifier 53 and provide appropriate documentation.”

Therefore, in accordance with the change in CPT Manual language, the Centers for Medicare and Medicaid Services (CMS) has applied specified values in the Medicare Physician Fee Schedule (MPFS) database for the following codes:

- 44388-53 (colonoscopy through stoma);
- 45378-53 (colonoscopy);
- G0105-53 (colorectal cancer screening; colonoscopy on individual at high risk); and
- G0121-53 (colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk).

Effective for services performed on or after January 1, 2016, the MPFS database will have specific values for the codes listed above. Given that the new CPT definition of an incomplete colonoscopy also include colonoscopies where the colonoscope is advanced past the splenic flexure but not to the cecum, CMS has established new values for incomplete diagnostic and screening colonoscopies performed on or after January 1, 2016. Incomplete colonoscopies are reported with Modifier 53. Medicare will pay for the interrupted colonoscopy at a rate that is calculated using one-half the value of the inputs for the codes.
Note: Chapters 12, Section 30.1 and Chapter 18, Section 60.2 of the “Medicare Claims Processing Manual” have been revised to reflect the information contained in CR 9317.

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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Raising Awareness of Diabetes in November - American Diabetes Month®, Diabetic Eye Disease Month, and World Diabetes Day promote diabetes awareness and the impact of diabetes on public health. Take this opportunity to recommend appropriate Medicare preventive services for detection and treatment, including Diabetes Screening, Diabetes Self-Management Training, Medical Nutrition Therapy, and Glaucoma Screening.

- Preventive Services Educational Tool
- Medicare Vision Services Fact Sheet

MLN Matters® Number: MM9336  Related Change Request (CR) #: CR 9336
Related CR Release Date: October 16, 2015  Effective Date: November 16, 2015
Related CR Transmittal #: R3379CP, R211BP, and R94GI  Implementation Date: November 16, 2015

Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (2015)

Provider Types Affected

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

Provider Action Needed

The purpose of Change Request (CR) 9336 is to update the Medicare manuals to correct various minor technical errors and omissions. These changes are intended only to clarify the existing content and no policy, processing, or system changes are anticipated.

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Background

CR9336 revises the following Medicare manuals:

- “Medicare General Information, Eligibility, and Entitlement Manual” (Publication 100-01);
- “Medicare Benefit Policy Manual” (Publication 100-02); and
- “Medicare Claims Processing Manual” (Publication 100-04).

“Medicare General Information, Eligibility, and Entitlement Manual” Revision Summary

Chapter 1: General Overview

In Section 10.1, the final paragraph’s discussion about tracking the utilization of Part A benefit days (as added previously by CR8044) is clarified by removing the inappropriate reference to utilization of home health services, which is actually measured in terms of visits rather than benefit days.

Chapter 4: Physician Certification and Recertification of Services

Section 10.6 is revised to explain more completely the reference to “alternate placement” days that CRs 8044 and 8669 had previously added to the fifth paragraph of Section 20.1 of the “Medicare Benefit Policy Manual.” The revised section now reads:

- “A physician who certifies or recertifies to the need for continued inpatient stay should use the same criteria that apply to the hospital’s utilization review committee. These criteria include not only medical necessity, but also the availability of out-of-hospital facilities and services which will assume continuity of care. In accordance with the regulations at 42 CFR 424.13(c), a physician should certify or recertify need for continued hospitalization if the physician finds that the patient could receive treatment in a SNF but no bed is available in the participating SNF. Where the basis for the certification or recertification is the need for continued inpatient care because of the lack of SNF accommodations, the certification or recertification should so state. The physician is expected to continue efforts to place the patient in a participating SNF as soon as the bed becomes available. Coverage of these additional, ‘alternate placement’ days in the hospital can continue until the earliest of the following events occurs:
  - A bed becomes available in a participating SNF;
  - The beneficiary’s care needs drop below SNF-level; or
  - The beneficiary has exhausted all of the available days of Part A inpatient hospital benefits in that benefit period.”

“Medicare Benefit Policy Manual” Revision Summary

Chapter 8: Coverage of Extended Care (SNF) Services Under Hospital Insurance
In Section 20.1, the fourth paragraph’s reference (as added previously by CR8044) to the limitation of liability policy discussed in the “Medicare Claims Processing Manual,” Chapter 30, Section 130.2.A. is clarified to reflect the referenced policy more accurately. Specifically, Chapter 8, Section 20.1 now clarifies that in some instances, the limitation of beneficiary liability for a hospital stay may apply only a portion of the hospital stay, so that it would still be possible for the remainder of the hospital stay to count toward a “qualifying,” medically necessary 3-day stay for SNF benefit purposes.

“Medicare Claims Processing Manual” Revision Summary

Chapter 6: Inpatient Part A Billing and SNF Consolidated Billing

Sections 20.1.2 and 20.1.2.1 are each revised by removing a parenthetical reference to revenue codes (originally added in CR3070) that has become obsolete.

In Section 20.4 (Screening and Preventive Services), the description of screening services in the first paragraph (as added by CR8044) is revised for greater clarity. Also, for a phrase (under Part B) that appears near the end of the sixth paragraph of that section, the emphasized font that was inadvertently removed in the course of manualizing CR 8669 is now restored. The updated paragraph now reads as follows:

Paragraph Six: “Further, it is worth noting that unlike preventive services covered under Part B, those preventive vaccines covered under Part D are not subject to SNF CB, even when furnished to an SNF’s Part A resident. This is because Section 1862(a)(18) of the Act specifies that SNF CB applies to ‘. . . covered skilled nursing facility services described in Section 1888(e)(2)(A)(i) . . .’ Section 1888(e)(2)(A)(i) of the Act, in turn, defines ‘covered skilled nursing facility services’ specifically in terms of (I) Part A SNF services, along with (II) those non-excluded services that (if not for the enactment of SNF CB) would be types of services ‘. . . for which payment may be made under Part B . . .’

Additional Information

The official instruction, CR9336, issued to your MAC regarding this change consists of three transmittals. Those are:

- **R3379CP**, which updates the “Medicare Claims Processing Manual;”
- **R211BP**, which updates the “Medicare Benefit Policy Manual;” and
- **R94GI**, which updates the “Medicare General Information, Eligibility, and Entitlement Manual.”

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” on the CMS website.

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Raising Awareness of Diabetes in November

American Diabetes Month®, Diabetic Eye Disease Month, and World Diabetes Day promote diabetes awareness and the impact of diabetes on public health. Take this opportunity to recommend appropriate Medicare preventive services for detection and treatment, including Diabetes Screening, Diabetes Self-Management Training, Medical Nutrition Therapy, and Glaucoma Screening.

MLN Matters® Number: MM9352 Revised
Related Change Request (CR) #: CR 9352
Related CR Release Date: November 5, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R3396CP
Implementation Date: January 4, 2016

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2016

Note: This article was revised on November 6, 2015, to reflect the revised CR9352 issued on November 5, 2015. The CR was revised to change the effective date. In addition, the transmittal number, CR release date, and the Web address for accessing CR9352 are revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9352 informs MACs about the changes that will be included in the January 2016 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

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Background

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 Medicare's claims processing systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective April 1, 2003.

CR9352 communicates requirements to Medicare's Shared System Maintainers (SSMs) and MACs notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for January 2016. Changes are being made to the NCD code lists as follows:

- Add ICD-10-CM codes N131 and N132 to the list of ICD-10-CM codes that are covered by Medicare for the Urine Culture, Bacterial (190.12) NCD.
- Add ICD-10-CM code I481 to the list of ICD-10-CM codes that are covered by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.
- Add ICD-10-CM code S069X0A to the list of ICD-10-CM codes that are covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.
- Add ICD-10- ICD-10-CM code I481 to the list of ICD-10-CM codes that are covered by Medicare for the Thyroid Testing (190.22) NCD.

These changes are effective for services furnished on or after 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.

Document History

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Billing of the Transportation Fee by Portable X-ray Suppliers

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 9354 which removes the word “Medicare” before “patient” in the “Medicare Claims Processing Manual” (Publication 100-04, Chapter 13, Section 90.3) and clarifies guidance when more than one patient is X-rayed at the same location. Make sure that your billing staff are aware of these changes.

Background

Portable X-ray suppliers receive a transportation fee for transporting portable X-ray equipment to the location where portable X-rays are taken. If more than one patient at the same location is X-rayed, the portable X-ray transportation fee is allocated among the patients. The Centers for Medicare & Medicaid Services (CMS) believes it would be more...
appropriate to allocate the transportation fee among all patients who receive portable X-ray services in a single trip. Medicare should not pay for more than its share of the transportation costs for portable X-ray services.

CMS has revised the “Medicare Claims Processing Manual” to remove the word “Medicare” before “patient” in Section 90.3. Also, CMS is clarifying the guidance for the billing of the transportation fee of portable X-ray suppliers. The revised part of Section 90.3 is as follows:

90.3 - Transportation Component (HCPCS Codes R0070 - R0076)
“This component represents the transportation of the equipment to the patient. Establish local RVUs for the transportation R codes based on Medicare Administrative Contractor (MAC) knowledge of the nature of the service furnished. The MACs shall allow only a single transportation payment for each trip the portable X-ray supplier makes to a particular location. When more than one patient is X-rayed at the same location, the single transportation payment under the Physician Fee Schedule is to be prorated among all patients (Medicare Parts A and B, and non-Medicare) receiving portable X-ray services during that trip, regardless of their insurance status. For example, for portable X-ray services furnished at a SNF, the transportation fee should be allocated among all patients receiving portable X-ray services at the same location in a single trip irrespective of whether the patient is in a Part A stay, a Part B patient, or not a Medicare beneficiary at all. If the patient is in a Part A SNF stay, payment for the allocated portion of the transportation fee (and the X-ray) would be the SNF’s responsibility. For a privately insured patient, it would be the responsibility of that patient’s insurer. For a Medicare Part B patient, payment would be made under Part B for the share of the transportation fee attributable to that patient.”

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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Update to the List of Compendia as Authoritative Sources for Use in the Determination of a “Medically-Accepted Indication” of Drugs and Biologicals Used Off-label in an Anti-Cancer Chemotherapeutic Regimen

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 9386 which announces that effective for services on or after August 12, 2015, the Centers for Medicare & Medicaid Services (CMS) is adding Wolters Kluwer Lexi-Drugs® to the list of authoritative compendia for use in the determination of a medically-accepted indication of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen.
Background

The Social Security Act (Section 1861(t)(2)(B)(ii)(I); as amended by the Deficit Reduction Act of 2005 (Pub. Law 109-171; Section 6001(f)(1)), recognized the following three compendia as authoritative sources for use in the determination of a "medically accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

1. American Medical Association Drug Evaluations (AMA-DE);
2. United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication; and

These authoritative sources could be used in the determination of a "medically-accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen, unless:

- The Secretary of Health and Human Services (HHS) determined that the use is not medically appropriate; or
- The use is identified as not indicated in one or more such compendia.

This provision was implemented through instructions to the MACs in the “Medicare Benefit Policy Manual” (Chapter 15, Section 50.4.5).

Due to changes in the pharmaceutical reference industry:

- The AHFS-DI was the only remaining statutorily-named compendia available for CMS reference;
- The AMA-DE and USP-DI are no longer published;
- Thomson Micromedex designated Drug Points was the successor to USP-DI; but
- Drug Points has since been deleted from the list of recognized compendia.

In January 2008, CMS established, via the Physician Fee Schedule Final Rule for calendar year 2008:

- A process for revising the list of compendia, as authorized under the Social Security Act (Section 1861(t)(2)), and
- A definition for “compendium.”

This sub-regulatory process for revising the list of compendia is described in the “Medicare Benefit Policy Manual” (Chapter 15, Section 50.4.5.1).

Based on this process, CMS updated the list in 2008 to include the following four compendia:

1. Existing - American Hospital Formulary Service-Drug Information (AHFS-DI),
2. Effective June 5, 2008 - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium,
3. Effective June 10, 2008 - Truven Health Analytics Micromedex DrugDex, and


On August 12, 2015, CMS announced the addition of Wolters Kluwer Lexi-Drugs® to the above list of four compendia used by the Medicare program in the determination of a "medically-accepted indication" for off-label drugs and biologics used in an anticancer chemotherapeutic treatment regimen. This is effective for services on or after August 12, 2015.

Further details on this issue are in the revised Chapter 15, Section 50.4.5.1 of the “Medicare Benefit Policy Manual,” which is an attachment to CR9386.

**Additional Information**


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

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**Each Office Visit is an Opportunity to Recommend Influenza Vaccination.**

Protect your patients, your staff, and yourself. Medicare Part B covers one influenza vaccination and its administration each influenza season for Medicare beneficiaries. If medically necessary, Medicare may cover additional seasonal influenza vaccinations.

- **Preventive Services** Educational Tool

- **Influenza Vaccine Payment Allowances** MLN Matters Article

- **Influenza Resources for Health Care Professionals** MLN Matters Article

- **CDC Influenza** website

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Ambulance Inflation Factor for CY 2016 and Productivity Adjustment

Provider Types Affected

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

Provider Action Needed

CR 9412 furnishes the CY 2016 ambulance inflation factor (AIF) for determining the payment limit for ambulance services. Make sure that your billing staffs are aware of the change.

Background

CR 9412 furnishes the CY 2016 ambulance inflation factor (AIF) for determining the payment limit for ambulance services required by Section 1834(l)(3)(B) of the Social Security Act (the Act). It also clarifies the “Medicare Claims Processing Manual”, Chapter 15 (Ambulance), Section 20.3 (Air Ambulance) and updates Section 20.4 (Ambulance Inflation Factor (AIF)). You will find these updated Manual chapters as an attachment to this CR.
Section 1834(l)(3)(B) of the Act provides the basis for an update to the payment limits for ambulance services that is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year. Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to apply a productivity adjustment to this update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity beginning January 1, 2011. The resulting update percentage is referred to as the AIF.

Section 3401 of the Affordable Care Act requires that specific Prospective Payment System (PPS) and Fee Schedule (FS) update factors be adjusted by changes in economy-wide productivity. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as projected by the Secretary of Health and Human Services for the 10-year period ending with the applicable fiscal year, cost reporting period, or other annual period).

The MFP for calendar year (CY) 2016 is 0.5 percent and the CPI-U for 2016 is 0.1 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for CY 2016 is -0.4 percent.

Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule. The 2016 ambulance fee schedule file is available in November 2015. It may be retrieved at any time and will reside indefinitely for your access. It may be updated with each quarterly Common Working File (CWF) update.

Additional Information


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

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

MLN Matters® Number: SE1408 Revised    Related Change Request (CR) #: 7492
Related CR Release Date: N/A      Effective Date: October 1, 2014
Related CR Transmittal #: N/A      Implementation Date: N/A

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

Note: This article was revised on October 30, 2015, to add language to Table A on page 3 regarding Inpatient Psychiatric Facilities (IPFs) and Long Term Care Hospital (LTCH) PPS. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

Key Points of SE1408

General Reporting of ICD-10

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

General Claims Submissions Information

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

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

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

**Claims that Span the ICD-10 Implementation Date**

There may be times when a claim spans the ICD-10 implementation date for institutional, professional, and supplier claims. For example, the beneficiary is admitted as an inpatient in late September, 2015 and is discharged after October 1, 2015. Another example is a DME claim for monthly billing that spans between September and October, 2015 (that is, the monthly billing dates are September 15, 2015 – October 14, 2015). The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

**Table A – Institutional Providers**

<table>
<thead>
<tr>
<th>Bill Type(s)</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>11X</td>
<td>Inpatient Hospitals (including TEFRA hospitals, Inpatient Prospective Payment System (PPS) hospitals and Critical Access Hospitals (CAHs))</td>
<td>If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>11X</td>
<td>Inpatient Psychiatric Facility (IPF) and Long Term Care Hospital (LTCH) PPS</td>
<td>* NOTE: If the hospital claim has a discharge and/or through date on or after 10/1/15, and a benefits exhaust occurrence code with a September 2015 date does not exist, the entire claim is billed using ICD-10. If a benefits exhaust occurrence code with a September 2015 date exists, the provider must split bill the claim using the benefits exhaust occurrence code date as the through date on the first claim and bill with ICD-9 codes. The subsequent claim is billed as a no pay claim with appropriate ICD-10 coding.</td>
<td>* See Note</td>
</tr>
<tr>
<td>12X</td>
<td>Inpatient Part B Hospital Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>13X</td>
<td>Outpatient Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
</tbody>
</table>

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<td>14X</td>
<td>Non-patient Laboratory Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>18X</td>
<td>Swing Beds</td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>21X</td>
<td>Skilled Nursing (Inpatient Part A)</td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>22X</td>
<td>Skilled Nursing Facilities (Inpatient Part B)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>23X</td>
<td>Skilled Nursing Facilities (Outpatient)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>32X</td>
<td>Home Health (Inpatient Part B)</td>
<td>Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>3X2</td>
<td>Home Health – Request for Anticipated Payment (RAPs)*</td>
<td>* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.</td>
<td>*See Note</td>
</tr>
<tr>
<td>34X</td>
<td>Home Health – (Outpatient)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>71X</td>
<td>Rural Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>72X</td>
<td>End Stage Renal Disease (ESRD)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
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<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>73X</td>
<td>Federally Qualified Health Clinics <em>(prior to 4/1/10)</em></td>
<td>N/A – Always ICD-9 code set.</td>
<td>N/A</td>
</tr>
<tr>
<td>74X</td>
<td>Outpatient Therapy</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>75X</td>
<td>Comprehensive Outpatient Rehab facilities</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>76X</td>
<td>Community Mental Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>77X</td>
<td>Federally Qualified Health Clinics <em>(effective 4/4/10)</em></td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>81X</td>
<td>Hospice- Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>82X</td>
<td>Hospice – Non hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>83X</td>
<td>Hospice – Hospital Based</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>85X</td>
<td>Critical Access Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
</tbody>
</table>
Table B - Special Outpatient Claims Processing Circumstances

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

Table C – Professional Claims

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

Table D – Supplier Claims

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

Additional Information


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Document History

- This article was revised on June 27, 2015, to clarify language on page 2 under “Claims that Span the ICD-10 Implementation Date.“
- The article was revised on October 30, 2015, to add information in Table A regarding Inpatient Psychiatric Facilities (IPF) and Long Term Care Hospital (LTCH) PPS guidance.
Centers for Medicare & Medicaid Services
Articles for Part A Providers
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/ 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: MM9347  Related Change Request (CR) #: CR 9347
Related CR Release Date: October 16, 2015  Effective Date: January 1, 2016
Related CR Transmittal #: R3375CP  Implementation Date: January 4, 2016

Announcement of Payment Rate Increase for Rural Health Clinics (RHCs) for Calendar Year (CY) 2016

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 9347, which informs MACs about instructions for calendar year (CY) 2016 payment rate increase for RHCs. Make sure that your billing staff are aware of these changes.

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Background

CR9347 provides instructions to the MACs for Calendar Year (CY) 2016 payment rate increases for RHCs. As authorized by section 1833(f) of the Social Security Act (the Act) (see http://www.ssa.gov/OP_Home/ssact/title18/1833.htm), the RHC payment limit for a subsequent year will be increased in accordance with the rate of increase in the Medicare Economic Index.

Effective January 1, 2016, through December 31, 2016, the RHC payment limit per visit for CY 2016 is $81.32.

The CY 2016 RHC rate reflects a 1.1 percent increase above the CY 2015 payment limit of $80.44. The effective date of January 1, 2016 for the RHC payment rate increase is necessary in order to update the payment rates in accordance with the Act (section 1833(f)). Your MAC will not retroactively adjust individual RHC bills paid at previous upper payment limits.

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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MLN Matters® Number: MM9348  Related Change Request (CR) #: CR 9348
Related CR Release Date: October 9, 2015  Effective Date: January 1, 2016
Related CR Transmittal #: R3369CP  Implementation Date: January 4, 2016

**Update to the Federally Qualified Health Centers (FQHC) Prospective Payment System (PPS) – Recurring File Updates**

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 9348 updates the FQHC PPS base payment rate and the geographic adjustment factors (GAFs) for the FQHC Pricer for calendar year (CY) 2016. Please ensure your billing staffs are aware of these changes.

**Background**

Section 10501(i)(3)(A) of the Affordable Care Act (Pub. L. 111-148 and Pub. L. 111-152) added section 1834(o) of the Social Security Act (the Act) to establish a payment system for the costs of FQHC services under Medicare Part B based on prospectively set rates. In compliance with the statutory requirements of the Affordable Care Act, the Centers for

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Medicare & Medicaid Services (CMS) published a final rule with comment period to implement a methodology and payment rates for a PPS for FQHCs under Medicare Part B beginning on October 1, 2014.

Under the FQHC PPS, Medicare pays FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically necessary, face-to-face FQHC visit is furnished to a Medicare beneficiary. As required by 1834(o)(2)(B)(ii) of the Act, the base payment rate for the first year after implementation shall be increased in accordance with the rate of increase in the Medicare Economic Index. From January 1, 2016, through December 31, 2016, the FQHC PPS base payment rate is $160.60. The CY 2016 base payment rate reflects a 1.1 percent increase above the CY 2015 base payment rate of $158.85.

In accordance with section 1834(o)(1)(A) of the Act, the FQHC PPS base rate is adjusted for each FQHC by the FQHC geographic adjustment factor (GAF), based on the geographic practice cost indices (GPCIs) used to adjust payment under the Medicare Physician Fee Schedule (MPFS). The FQHC GAF is adapted from the work and practice expense GPCIs, and are updated when the work and practice expense GPCIs are updated for the MPFS. For CY 2016, the FQHC PPS GAFs have been updated in order to be consistent with the statutory requirements.

Additional Information


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

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- “Medicare Enrollment for Physicians and Other Part B Suppliers” Fact Sheet, ICN 903768, Downloadable

MLN Matters® Number: MM9360  Related Change Request (CR) #: CR 9360
Related CR Release Date: November 5, 2015  Effective Date: June 2, 2014
Related CR Transmittal #: R3393CP  Implementation Date: April 4, 2016

Reporting of Type of Bill (TOB) 014x for Billing Screening of Hepatitis C Virus (HCV) in Adults

Provider Types Affected

This MLN Matters® Article is intended for providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries related to screening of Hepatitis C Virus (HCV) in adults.

Provider Action Needed

This article is based on Change Request (CR) 9360, which adds Type of Bill (TOB) 014x (Hospital Other Part B) as an applicable TOB for the screening of HCV when submitted for non-patient laboratory specimen (HCPCS Code G0472). Transmittal 3215, CR 8871, titled, “Screening for Hepatitis C Virus (HCV) in Adults,” omitted TOB 014x from the list of applicable TOBs for HCV screening. Payment for these services submitted on TOB 014x will be based on the laboratory fee schedule. Make sure your billing personnel are aware of this change.
Background

As a result of CR9360, appropriate TOBs for the screening of HCV other than non-patient laboratory specimen include:

- 013x;
- 014x;
- 071x;
- 077x; and
- 085x.

Note that MACs will not search for claims with G0472, submitted under TOB 014x with dates of service on or after June 2, 2014, but received before April 4, 2016, but the MACs may adjust claims that are brought to their attention.

In addition, MACs will apply the same logic for G0472 on TOB 14x as described in MLN Matters articles MM8871 and MM9200.

Additional Information


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- “PECOS Technical Assistance Contact Information” Fact Sheet, ICN 903766, downloadable

MLN Matters® Number: MM9362 Related Change Request (CR) #: CR9362
Related CR Release Date: October 30, 2015 Effective Date: December 2, 2015
Related CR Transmittal #: R3388CP Implementation Date: December 2, 2015

Manual Updates to Clarify Inpatient Rehabilitation Facility (IRF) Claims Processing

Provider Types Affected

This MLN Matters® Article is intended for Inpatient Rehabilitation Facilities (IRFs) submitting claims to Medicare Administrative Contractors (MACs) for inpatient rehabilitation services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 9362 updates Chapter 3 of the “Medicare Claims Processing Manual” to clarify key components of IRF payment policies. These changes are intended only to clarify the existing policies and no system or processing changes are anticipated.

Background

Compliance with the regulatory requirements for the arthritis conditions specified in Chapter 3, Section 140.1.1 B-D of the “Medicare Claims Processing Manual” cannot be determined by the presence of an impairment group code or diagnosis code alone, but can only be verified through review of the IRF medical record. Thus, the Centers for Medicare

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& Medicaid Services (CMS) removed arthritis impairment group codes and diagnosis codes from the list of codes used to determine presumptive compliance for compliance review periods beginning on or after October 1, 2015. However, beginning on or after October 1, 2015, CMS also provided for an additional item on the IRF Patient Assessment Instrument (PAI) (item #24A) to enable IRFs to indicate whether the patient’s arthritis condition(s) meets all of the relevant regulatory requirements specified in Chapter 3, Section 140.1.1 B-D of the “Medicare Claims Processing Manual.”

With CR9362, CMS is adding a new subsection D to Section 140.1.3 of Chapter 3 to guide MACs in using the new item #24A on the IRF-PAI to verify that the arthritis codes meet the 60 percent rule requirements. The added provisions of Chapter 3 are attached to CR9362.

Additional Information


Additional information is also available on the IRF Classification Criteria webpage.

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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Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2016

Provider Types Affected

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

Provider Action Needed

CR 9406 informs providers about updates to the 60-day national episode rates, the national per-visit amounts, Low-Utilization Payment Adjustment (LUPA) add-on amounts, and the non-routine medical supply payment amounts under the HH PPS for CY 2016. Make sure your billing staff is aware of this update.

Background

The Affordable Care Act mandated several changes to Section 1895(b) of the Social Security Act (the Act) and hence the HH PPS Update for CY 2016.

Section 3131(a) of the Affordable Care Act mandated that starting in CY 2014, the Secretary must apply an adjustment to the national, standardized 60-day episode payment

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

Section 3401(e) of the ACA requires that the market basket percentage under the HH PPS be annually adjusted by changes in economy-wide productivity for CY 2015 and each subsequent calendar year.

In addition to the Affordable Care Act mandates, Section 421(a) of the Medicare Modernization Act (MMA), as amended by Section 210 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10), provides an increase of 3 percent of the payment amount otherwise made under Section 1895 of the Act for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2018. The statute waives budget neutrality related to this provision, as the statute specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under Section 1895 of the Act applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

**Market Basket Update**

The CY 2016 HH market basket update is 2.3 percent which is then reduced by a multi-factor productivity (MFP) adjustment of 0.4 percentage points. The resulting HH payment update is equal to 1.9 percent. HHAs that do not report the required quality data will receive a 2 percentage point reduction to the HH payment update of 1.9 percent.

**National Standardized 60-Day Episode Payment**

As described in the CY 2016 final rule, to determine the CY 2016 national, standardized 60-day episode payment rate, CMS applies a wage index budget neutrality factor of 1.0011 and a case-mix budget neutrality factor of 1.0187 to the previous calendar year's national, standardized 60-day episode rate ($2,961.38). In order to account for nominal case-mix growth from CY 2012 to CY 2013, CMS applies a payment reduction of 0.97 percent to the CY 2016 national, standardized 60-day episode payment rate. This reduction will also be applied to the CY 2017 and CY 2018 national, standardized 60-day episode payment rate. CMS then applies an $80.95 reduction (which is 3.5 percent of the CY 2010 national, standardized 60-day episode rate of $2,312.94) to the national, standardized 60-day episode rate. Lastly, the national, standardized 60-day episode payment rate is updated by the CY 2016 HH payment update percentage of 1.9 percent for HHAs that submit the required quality data and by 1.9 percent minus 2 percentage points or -0.1 percent for HHAs that do not submit quality data. These two episode payment rates are shown in Tables 1 and 2 below. These payments are further adjusted by the individual episode's case-mix weight and by the wage index.

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Table 1: For HHAs that DO Submit Quality Data – National 60-Day Episode Amounts Updated by the MFP adjusted Home Health Market Basket Update for CY 2016 Before Case-Mix Adjustment, Wage Index Adjustment Based on the Site of Service for the Beneficiary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,961.38 X 1.0011 X 1.0187 X 0.9903 -$80.95 X 1.019</td>
<td>=$2,965.12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2: For HHAs that DO NOT Submit Quality Data – National 60-Day Episode Amounts Updated by the MFP adjusted Home Health Market Basket Update for CY 2016 Before Case-Mix Adjustment, Wage Index Adjustment Based on the Site of Service for the Beneficiary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,961.38 X 1.0011 X 1.0187 X 0.9903 -$80.95 X 0.999</td>
<td>=$2,906.92</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**National Per-Visit Rates**

To calculate the CY 2016 national per-visit payment rates, CMS starts with the CY 2015 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0010 to ensure budget neutrality for LUPA per-visit payments after applying the CY 2016 wage index, and then applies the maximum rebasing adjustments to the per-visit rates for each discipline. The per-visit rates are then updated by the CY 2016 HH payment update of 1.9 percent for HHAs that submit the required quality data and by -0.1 percent for HHAs that do not submit quality data. The per-visit rates are shown in Tables 3 and 4.

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### Table 3: For HHAs that DO Submit Quality Data – CY 2016 National Per-Visit Amounts for LUPAs and Outlier Calculations Updated by the MFP adjusted HH Market Basket Update, Before Wage Index Adjustment

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2015 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>2016 Rebasing Adjustment</th>
<th>CY 2016 HH Payment Update Percentage</th>
<th>CY 2016 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$57.89</td>
<td>X 1.0010</td>
<td>+$1.79</td>
<td>X 1.019</td>
<td>$60.87</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$204.91</td>
<td>X 1.0010</td>
<td>+$6.34</td>
<td>X 1.019</td>
<td>$215.47</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$140.70</td>
<td>X 1.0010</td>
<td>+$4.35</td>
<td>X 1.019</td>
<td>$147.95</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$139.75</td>
<td>X 1.0010</td>
<td>+$4.32</td>
<td>X 1.019</td>
<td>$146.95</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$127.83</td>
<td>X 1.0010</td>
<td>+$3.96</td>
<td>X 1.019</td>
<td>$134.42</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$151.88</td>
<td>X 1.0010</td>
<td>+$4.70</td>
<td>X 1.019</td>
<td>$159.71</td>
</tr>
</tbody>
</table>

### Table 4: For HHAs that DO NOT Submit Quality Data – CY 2016 National Per-Visit Amounts for LUPAs and Outlier Calculations Updated by the MFP adjusted HH Market Basket Update, Before Wage Index Adjustment

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2015 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>2016 Rebasing Adjustment</th>
<th>CY 2016 HH Payment Update Percentage</th>
<th>CY 2016 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$57.89</td>
<td>X 1.0010</td>
<td>+$1.79</td>
<td>X 0.999</td>
<td>$59.68</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$204.91</td>
<td>X 1.0010</td>
<td>+$6.34</td>
<td>X 0.999</td>
<td>$211.24</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$140.70</td>
<td>X 1.0010</td>
<td>+$4.35</td>
<td>X 0.999</td>
<td>$145.05</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$139.75</td>
<td>X 1.0010</td>
<td>+$4.32</td>
<td>X 0.999</td>
<td>$144.07</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$127.83</td>
<td>X 1.0010</td>
<td>+$3.96</td>
<td>X 0.999</td>
<td>$131.79</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$151.88</td>
<td>X 1.0010</td>
<td>+$4.70</td>
<td>X 0.999</td>
<td>$156.58</td>
</tr>
</tbody>
</table>

**LUPA Add-On Payments**

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. Beginning in CY 2014, CMS calculates the payment for the first visit in a LUPA episode by multiplying the per-visit rate by a LUPA add-on factor specific to

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the type of visit (skilled nursing, physical therapy, speech-language pathology). The specific requirements for the new LUPA add-on calculation are described in CR 8380, Transmittal 2828 dated November 27, 2013. The LUPA add-on adjustment factors are displayed in Table 5.

Table 5: CY 2016 LUPA Add-On Factors

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

Non-Routine Supply Payments

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by an NRS conversion factor. To determine the CY 2016 NRS conversion factors, CMS starts with the CY 2015 NRS conversion factor ($53.23) and applies a 2.82 percent rebasing adjustment as described in the CY 2016 final rule. CMS then updates the conversion factor by the CY 2016 HH payment update of 1.9 percent for HHAs that submit the required quality data and by -0.1 percent for HHAs that do not submit quality data. CMS does not apply a standardization factor as the NRS payment amount calculated from the conversion factor is not wage or case-mix adjusted when the final payment amount is computed. The NRS conversion factor for CY 2016 payments for HHAs that do submit the required quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b.

Table 6a: CY 2016 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2015 NRS Conversion Factor</th>
<th>2016 Rebasing Adjustment</th>
<th>CY 2016 HH Payment Update Percentage</th>
<th>CY 2016 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$53.23</td>
<td>X 0.9718</td>
<td>X 1.019</td>
<td>$52.71</td>
</tr>
</tbody>
</table>

Table 6b: CY 2016 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2016 NRS Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.22</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$51.35</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$140.80</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$209.18</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$322.57</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$554.79</td>
</tr>
</tbody>
</table>

The NRS conversion factor for CY 2016 payments for HHAs that do not submit quality data is shown in Table 7a and the payment amounts for the various NRS severity levels are shown in Table 7b.

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Table 7a: CY 2016 NRS Conversion Factor for HHAs that DO NOT Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2015 NRS Conversion Factor</th>
<th>2016 Rebasing Adjustment</th>
<th>CY 2016 HH Payment Update Percentage</th>
<th>CY 2016 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$53.23</td>
<td>X 0.9718</td>
<td>X 0.999</td>
<td>$51.68</td>
</tr>
</tbody>
</table>

Table 7b: CY 2016 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2016 NRS Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$13.94</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$50.35</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$138.05</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$205.10</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$316.27</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$543.95</td>
</tr>
</tbody>
</table>

Rural Add-On

As stipulated in section 421(a) of the MMA, the 3 percent rural add-on is applied to the national standardized 60-day episode rate, national per-visit payment rates, LUPA add-on payments, and the NRS conversion factor when home health services are provided in rural (non-CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2018. Refer to Tables 8 through 10b for the CY 2016 rural payment rates.

Table 8a: CY 2016 Payment Amounts for 60-Day Episodes for Services Provided in a Rural Area Before Case-Mix and Wage Index Adjustment for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>CY 2016 National, Standardized 60-Day Episode Payment Rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2016 Rural National Standardized 60-Day Episode Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,965.12</td>
<td>X 1.03</td>
<td>$3,054.07</td>
</tr>
</tbody>
</table>

Table 8b: CY 2016 Payment Amounts for 60-Day Episodes for Services Provided in a Rural Area Before Case-Mix and Wage Index Adjustment for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>CY 2016 National, Standardized 60-Day Episode Payment Rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2016 Rural National Standardized 60-Day Episode Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,906.92</td>
<td>X 1.03</td>
<td>$2,994.13</td>
</tr>
</tbody>
</table>
Table 9a: CY 2016 Per-Visit Amounts for Services Provided in Rural Area, Before Wage Index Adjustment for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>Home Health Discipline Type</th>
<th>CY 2016 Per-Visit Rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2016 Rural Per-Visit Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH Aide</td>
<td>$60.87</td>
<td>X 1.03</td>
<td>$62.70</td>
</tr>
<tr>
<td>MSS</td>
<td>$215.47</td>
<td>X 1.03</td>
<td>$221.93</td>
</tr>
<tr>
<td>OT</td>
<td>$147.95</td>
<td>X 1.03</td>
<td>$152.39</td>
</tr>
<tr>
<td>PT</td>
<td>$146.95</td>
<td>X 1.03</td>
<td>$151.36</td>
</tr>
<tr>
<td>SN</td>
<td>$134.42</td>
<td>X 1.03</td>
<td>$138.45</td>
</tr>
<tr>
<td>SLP</td>
<td>$159.71</td>
<td>X 1.03</td>
<td>$164.50</td>
</tr>
</tbody>
</table>

Table 9b: CY 2016 Per-Visit Amounts for Services Provided in Rural Area, Before Wage Index Adjustment for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>Home Health Discipline Type</th>
<th>CY 2016 Per-Visit Rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2016 Rural Per-Visit Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH Aide</td>
<td>$59.68</td>
<td>X 1.03</td>
<td>$61.47</td>
</tr>
<tr>
<td>MSS</td>
<td>$211.24</td>
<td>X 1.03</td>
<td>$217.58</td>
</tr>
<tr>
<td>OT</td>
<td>$145.05</td>
<td>X 1.03</td>
<td>$149.40</td>
</tr>
<tr>
<td>PT</td>
<td>$144.07</td>
<td>X 1.03</td>
<td>$148.39</td>
</tr>
<tr>
<td>SN</td>
<td>$131.79</td>
<td>X 1.03</td>
<td>$135.74</td>
</tr>
<tr>
<td>SLP</td>
<td>$156.58</td>
<td>X 1.03</td>
<td>$161.28</td>
</tr>
</tbody>
</table>

Table 10a: CY 2016 Conversion Factor for Services Provided in Rural Areas

<table>
<thead>
<tr>
<th>For HHAs that DO Submit Quality Data</th>
<th>For HHAs that DO NOT Submit Quality Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2016 Conversion Rates</td>
<td>CY 2016 Conversion Factor</td>
</tr>
<tr>
<td>Multiply by the 3 Percent Rural Add-On</td>
<td>CY 2016 Rural Conversion Factor</td>
</tr>
<tr>
<td>$52.71</td>
<td>$51.68</td>
</tr>
<tr>
<td>X 1.03</td>
<td>X 1.03</td>
</tr>
</tbody>
</table>

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### Table 10b: CY 2016 Relative Weights and Payment Amounts for the 6-Severity NRS System for Services Provided in Rural Areas

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>For HHAs that DO Submit Quality Data</th>
<th>For HHAs that DO NOT Submit Quality Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Relative Weight</td>
<td>Total CY 2016 NRS Payment Amount for Rural Areas</td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.65</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$52.89</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$145.02</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$215.46</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$332.24</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$571.42</td>
</tr>
</tbody>
</table>

**Clarification Regarding the Use of the “Initial Encounter” Seventh Character, Applicable to Certain ICD-10-CM Code Categories, under the HH PPS**

The ICD-10-CM coding guidelines regarding the use of the seventh character assignment for diagnosis codes in Chapter 19, “Injury, Poisoning, and Certain Other Consequences of External Causes (S00–T88)” were revised. Based upon the revised guidance, coding certain diagnosis codes as “initial encounters” would be appropriate when the patient is receiving active treatment during a home health episode. Initial encounters are not based on chronology of care or whether the patient is seeing the same or a new provider for the same condition.

A revised translation list effective January 1, 2016, will be posted on the CMS website. Also effective, January 1, 2016, the Home Health Prospective Payment System Grouper logic will be revised to award points for certain initial encounter codes based upon the revised ICD-10-CM coding guidelines for M0090 dates on or after October 1, 2015. HHAs should review their OASIS records and claims submitted between October 1, 2015 and December 31, 2015, to determine if they should submit a modification of their assessment and adjust their claim with a revised HIPPS code that was assigned to the OASIS record based upon the revised grouper logic.

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

**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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**Clarification of Patient Discharge Status Codes and Hospital Transfer Policies**

*Note: This article was reissued on November 17, 2015 to clarify language on pages 2 and 3. All other information remains the same.*

**Provider Types Affected**

This MLN Matters® Special Edition (SE) Article is intended for hospitals that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

**What You Need to Know**

The Office of Inspector General (OIG) conducted several reviews identifying Medicare overpayments to hospitals that did not comply with the post-acute care transfer policy. Hospitals transferred inpatients to certain post-acute care settings but coded the patient discharge status as a discharge to home. To assure proper payment under the Medicare Severity-Diagnosis Related Group (MS-DRG) payment system, hospitals must be sure to code the discharge/transfer status of patients accurately to reflect the level of post-discharge care to be received by the patient.
Background

Hospitals are responsible for coding the discharge bill based on the discharge plan for the patient, and if the hospital subsequently learns that post-acute care was provided, the hospital should submit an adjustment bill to correct the discharge status code following Medicare’s claim adjustment criteria located in the “Medicare Claims Processing Manual,” (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending) Chapter 1, Section 130.1.1 and Chapter 34.

Patient discharge status codes are part of the Official UB-04 Data Specifications Manual and are used nationwide by institutional, private, and public providers, and payers of health care claims. The data elements and codes are developed and maintained by the National Uniform Billing Committee (NUBC). To assist in the proper coding of patient discharge status code, providers may access data elements, codes, and frequently asked questions by referring to the UB-04 Data Specifications Manual. Information on obtaining a manual is located at http://www.nubc.org on the Internet.

For the purpose of discussing transfers the following terms describe when a patient leaves the hospital. Discharges and transfers under the inpatient hospital prospective payment system (IPPS) are defined in 42 CFR 412.4(a) and (b).

A “discharge” occurs when a Medicare beneficiary:

1. Leaves a Medicare IPPS acute care hospital after receiving complete acute care treatment; or
2. Dies in the hospital.

Medicare makes full MS-DRG payments to Inpatient Prospective Payment system (IPPS) hospitals when the patient is discharged to their home (Patient Discharge Status Code 01) or certain types of health care institutions (such as Patient Discharge Status Code 04 to an Intermediate Care Facility).

An “acute care transfer” occurs when a Medicare beneficiary in an IPPS hospital (with any MS-DRG) is:

1. Transferred to another acute care IPPS hospital or unit for related care - Patient Discharge Status Code 02 (or 82 when an Acute Care Hospital Inpatient Readmission is planned); or
2. Leaves against medical advice - Patient Discharge Status Code 07 but is admitted to another PPS hospital on the same day; or
3. Transferred to a hospital that would ordinarily be paid under prospective payment, but is excluded because of participation in a state or area wide cost control program - Patient Discharge Status Code 02 (or 82 when an Acute Care Hospital Inpatient Readmission is planned); or
4. Transferred to a hospital or hospital unit that has not been officially determined as being excluded from PPS such as:
a. An acute care hospital that would otherwise be eligible to be paid under the IPPS, but does not have an agreement to participate in the Medicare program (Patient Discharge Status Code 02 or 82 when an Acute Care Hospital Inpatient Readmission is planned);

b. A Critical Access Hospital (Patient Discharge Status Code 66 or 94 when an Acute Care Hospital Inpatient Readmission is planned).

5. Discharged but then readmitted the same day to another IPPS hospital (unless the readmission is unrelated to the initial discharge). This may occur when a hospital discharges the patient to home (01), the patient goes to a doctor’s appointment the same day and is then admitted to another hospital. If the first hospital was unaware of the planned admission at the second hospital, it is likely the first hospital will have to adjust the previously submitted claim to correct the patient discharge status code to indicate a transfer (02), which reflects where the patient was later admitted on the same date.

The transferring hospital is paid a per diem payment (when the patient transfers to an IPPS hospital) up to and including the full DRG payment. The transferring hospital may be paid a cost outlier payment. For more detailed information regarding payment, please refer to the “Medicare Claims Processing Manual,” Chapter 3, Section 20. The receiving hospital is paid based on the full prospective payment rate which may include a cost outlier payment if applicable or based on the rate of its respective payment system (if not IPPS).

For unrelated admissions, where a transfer case results in treatment in the second hospital under a MS-DRG different than the MS-DRG in the transferring hospital, payment to each hospital is based upon the MS-DRG under which the patient was treated.

For transfers from an IPPS hospital to a hospital or unit excluded from IPPS with a DRG that is not subject to the post acute care transfer policy, the transferring hospital is paid the full IPPS rate including an outlier payment if applicable. The outlier threshold and payment are calculated the same as any other discharge without a transfer. The payment to the final discharging hospital or unit is made at the rate of its respective payment system.

A “post-acute care transfer” occurs when a Medicare beneficiary in an IPPS hospital stay is grouped to one of the MS-DRGs listed in Table 5 of the applicable Fiscal Year IPPS Final Rule Home Page (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html) and the transfer occurs to:

1. A hospital or distinct part hospital unit excluded from IPPS:
   - Inpatient rehabilitation facilities and units - Patient Discharge Status Code 62 (or 90 when an Acute Care Hospital Inpatient Readmission is planned.),
   - Long term care hospitals - Patient Discharge Status Code 63 (or 91 when an Acute Care Hospital Inpatient Readmission is planned ),
   - Psychiatric hospitals and units - Patient Discharge Status Code 65 (or 93 when an Acute Care Hospital Inpatient Readmission is planned ),
   - Cancer hospitals - Patient Discharge Status Code 05 (or 85 when an Acute Care Hospital Inpatient Readmission is planned),
• Children’s hospitals - Patient Discharge Status Code 05 (or 85 when an Acute Care Hospital Inpatient Readmission is planned); or

2. A skilled nursing facility - Patient Discharge Status Code 03 (or 83 when an Acute Care Hospital Inpatient Readmission is planned); or

3. Home under a written plan of care for the provision of home health services from a home health agency and those services occur within 3 days after the date of discharge - Patient Discharge Status Code 06 (or 86 when an Acute Care Hospital Inpatient Readmission is planned).

Note: Condition Code 42 may be used to indicate that the care provided by the Home Care Agency is not related to the Hospital Care and therefore, will result in payment based on the MS-DRG and not a per diem payment. Condition Code 43 may be used to indicate that Home Care was started more than three days after discharge from the Hospital and therefore payment will be based on the MS-DRG and not a per diem payment.

The transferring hospital is paid based upon a per diem rate up to and including the full DRG payment which may include a cost outlier payment if applicable. The final discharging hospital is paid based on the full prospective payment rate which may include a cost outlier payment if applicable.

A ‘special payment post-acute care transfer” occurs when a Medicare beneficiary in an IPPS hospital stay is grouped to one of the MS-DRGs in the column titled, “Special Pay DRG” in Table 5 of the applicable Fiscal Year IPPS Final Rule Home Page on the CMS website (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html). For these cases, the transferring hospital is paid 50 percent of the appropriate inpatient prospective payment rate and 50 percent of the appropriate transfer payment.

Additional Information

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

Document History

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<tr>
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<th>Description</th>
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<tr>
<td>November 17, 2015</td>
<td>The article was changed to clarify language on page 2 and 3.</td>
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## REVISED product from the Medicare Learning Network® (MLN)
- “837P and Form CMS-1500” Web-Based Training (WBT) has been revised and is now available.

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<tr>
<td>Related CR Release Date: NA</td>
<td>Effective Date: Episodes beginning on or after August 1, 2015</td>
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<tr>
<td>Related CR Transmittal #: NA</td>
<td>Implementation Date: N/A</td>
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**Selecting Home Health Claims for Probe and Educate Review: Episodes that Begin on or After August 1, 2015**

### Provider Types Affected

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

### Provider Action Needed

**STOP – Impact to You**

MACs, in conjunction with the Centers for Medicare & Medicaid Services (CMS), will be conducting medical review and reporting under the Home Health Probe & Educate medical review strategy. These reviews relate to claims submitted by HHAs related to Medicare home health services and patient eligibility (certification/re-certification), as outlined in CMS-1611-F.

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CAUTION – What You Need to Know

Final rule CMS-1611-F eliminates the requirement of a face-to-face encounter narrative as part of the certification of patient eligibility for home health services.

GO – What You Need to Do

Make sure that your billing staff is aware of these revised policies.

Background

On November 6, 2014, CMS issued CMS-1611-F, Calendar Year (CY) 2015 Home Health Prospective Payment System (HH PPS) Final Rule. The changes, discussed below, were effective beginning January 1, 2015.

- Final rule CMS-1611-F eliminates the requirement of a face-to-face encounter narrative as part of the certification of patient eligibility for home health services.

- In determining whether the patient is or was eligible to receive services under the Medicare home health benefit at the start of care, 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) is to be used as the basis for certification of home health eligibility.

- The certifying physician can incorporate information obtained from or generated by the HHA into his or her medical record, to support the patient’s homebound status and need for skilled care, by including it in his or her documentation and signing and dating to demonstrate review and concurrence.

CMS is implementing a Probe and Educate medical review strategy to assess and promote provider understanding and compliance with the Medicare home health eligibility requirements. CMS is issuing guidance to MACs about how to select home health claims for review during the “Probe and Educate” program for home health episodes that began on or after August 1, 2015.

CMS anticipates MACs will begin sending Additional Documentation Requests (ADRs) after October 1, 2015, and that the first round of claim reviews and provider education will conclude in approximately one year. This document contains a summary of the technical direction that CMS will issue to the MACs.

Claims Subject to Review as Part of the Probe and Educate Process

CMS will direct Home Health MACs to select a sample of 5 claims for pre-payment review from each HHA within their jurisdiction. As they are completing the Probe and Educate reviews, MACs will focus on the HHA’s compliance with the policy outlined in CMS-1611-F, as well as to make sure all other coverage and payment requirements are met.

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Based on the results of these initial reviews, MACs will conduct provider specific educational outreach. CMS will instruct MACs to deny each non-compliant claim and to outline the reasons for denial in a letter to the HHA, which will be sent at the conclusion of the probe review. We will also instruct the MACs to offer individualized telephone calls/education to all providers with errors in their claim sample. During such calls, the MAC will discuss the reasons for denials, provide pertinent education and reference materials, and answer questions.

In addition to these educational outreach efforts, for those providers that are identified as having moderate or major concerns, the MACs will repeat the Probe and Educate process for dates of services occurring after education has been provided. The following table outlines MAC actions following HHA probe reviews.

<table>
<thead>
<tr>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No or Minor Concerns</strong></td>
</tr>
<tr>
<td>5 claim sample</td>
</tr>
<tr>
<td><strong>Action</strong></td>
</tr>
<tr>
<td>1. Deny non-compliant claims; and</td>
</tr>
<tr>
<td>2. Send detailed review results letters explaining each denial.</td>
</tr>
<tr>
<td>3. Send summary letter that:</td>
</tr>
<tr>
<td>• Offers the provider a 1:1 phone call to discuss claim denials if any; and</td>
</tr>
<tr>
<td>• Indicates that no more reviews will be conducted under the Probe &amp; Educate process.</td>
</tr>
<tr>
<td>4. <strong>Await further instruction from CMS</strong></td>
</tr>
</tbody>
</table>

| **Action** | For each provider with major to moderate concerns CMS will direct the MAC to: |
| 1. Deny non-compliant claims; and |
| 2. Send detailed review results letters explaining each denial. |
| 3. Send summary letter that: |
| • Offers the provider a one-to-one phone call to discuss; |
| • Indicates the review contractor will REPEAT Probe & Educate process with an additional five claim sample; and |
| 4. **Repeat Probe & Educate of five claims with dates of after the implementation of education.** |

*Note: If the HHA fails to submit five claims, the provider will be considered of moderate concern (unless four claims were reviewed and the MAC approved all four).
**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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**Each Office Visit is an Opportunity to Recommend Influenza Vaccination.**

Protect your patients, your staff, and yourself. Medicare Part B covers one influenza vaccination and its administration each influenza season for Medicare beneficiaries. If medically necessary, Medicare may cover additional seasonal influenza vaccinations.

- **Preventive Services** Educational Tool
- **Influenza Vaccine Payment Allowances** MLN Matters Article
- **Influenza Resources for Health Care Professionals** MLN Matters Article
- **CDC Influenza** website

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Centers for Medicare & Medicaid Services
Articles for Part B Providers
**MLN Matters® Number: MM9291**

**Change Request (CR) #: CR 9291**

**Related CR Release Date: November 5, 2015**

**Implementation Date: April 4, 2016**

**Related Transmittal #: R1552OTN**

**Effective Date: April 1, 2016**

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**Medicare Remit Easy Print (MREP) Upgrade**

**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) 9291 contains upgrades to Medicare Remit Easy Print (MREP) software based on enhancement requests received through the Medicare Administrative Contractors (MACs) and/or the Centers for Medicare & Medicaid Services (CMS) website. This software is available free of charge from the CMS website and now offers a number of special reports that users can view and download in addition to the remittance advice. Make sure that your billing staffs are aware of these changes.

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Background

MREP software was developed by CMS to help providers to transition to Electronic Remittance Advice (ERA) by offering to translate the ERA into a humanly readable format. CMS introduced the software in October 2005, and has continuously enhanced the software based on feedback from the end users.

CMS offers free software - MREP - to view and print Health Insurance Portability and Accountability Act (HIPAA) compliant ERA, transaction 835 - Health Care Claim Payment/Advice. The software gets enhanced on a regular basis to meet the changing needs of providers/suppliers to help them transition to ERA.

A key change in this version of the MREP application is an upgrade so that when a user prints the Claim Detail with the Glossary option selected, the Glossary will begin on the same page of the last claim if there are available print lines on the page, rather than always printing on a new page.

Another upgrade to the MREP application is that the Claim Adjustment Reason Code (CARC) is added as a new criteria option for the existing search functionality. The search scope will be limited to a single selected remit, as it is today.

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 Waived Tests

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 9416 which informs your MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its contractors of the new tests so that MACs can accurately process claims. CR 9416 informs MACs of the newly added waived complexity tests. See the Background and Additional Information Sections of this article for further details, and make sure that your billing staff is aware of these changes.

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Background

CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that CMS only pays for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Note: CR 8871 mentioned that effective for services performed on or after June 2, 2014, the HCPCS G0472, HCV screening, will be recognized as a covered service. The HCPCS code G0472QW describes the hepatitis C antibody test performed using the OraQuick HCV Rapid Antibody Test and OraQuick Visual Reference. The OraQuick HCV Rapid Antibody Test and OraQuick Visual Reference test was mentioned as a new waived test in CR 8054. The related MLN Matters® articles for CR8871 and CR 8054 may be viewed at MM8871 and MM8054.

CR9416 Updates

The latest tests approved by the FDA as waived tests under CLIA are listed in the tables that follows. The Current Procedural Terminology (CPT) codes for these new tests in Table 1 must have the modifier ‘QW’ to be recognized as a waived test.

Table 1: TESTS GRANTED WAIVED STATUS UNDER CLIA
(Requires QW Modifier)

<table>
<thead>
<tr>
<th>CPT Code(s)</th>
<th>Effective Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>86308QW</td>
<td>January 21, 2015</td>
<td>Medline Mono Test Cassette {Whole Blood}</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 5, 2015</td>
<td>AssureTech Co. LTD, AssureTech Oxycodone Strip {OTC}</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 5, 2015</td>
<td>AssureTech Co. Ltd, AssureTech Secobarbital Strip {OTC};</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 5, 2015</td>
<td>AssureTech Co. Ltd, AssureTech Secobarbital/Oxycodone Panel Dip {OTC}</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 5, 2015</td>
<td>AssureTech Co. Ltd, AssureTech Secobarbital/Oxycodone Quick Cup {OTC}</td>
</tr>
<tr>
<td>G0434QW</td>
<td>June 5, 2015</td>
<td>AssureTech Co. Ltd, AssureTech Secobarbital/Oxycodone Turn Key-Split Cup {OTC}</td>
</tr>
<tr>
<td>82274QW, G0328QW</td>
<td>June 26, 2015</td>
<td>Medline iFOB Test</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>CPT Code(s)</th>
<th>Effective Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0434QW</td>
<td>July 16, 2015</td>
<td>Noble Medical Inc. Noble 1 Step + Cup</td>
</tr>
<tr>
<td>82274QW, G0328QW</td>
<td>July 28, 2015</td>
<td>Sekisui Diagnostics, LLC OSOM iFOB Test</td>
</tr>
<tr>
<td>86318QW</td>
<td>August 19, 2015</td>
<td>Alere Clearview H. pylori Whole Blood Only {Whole Blood};</td>
</tr>
<tr>
<td>86318QW</td>
<td>August 19, 2015</td>
<td>Alere Signify H. pylori Whole Blood Only {Whole Blood}</td>
</tr>
<tr>
<td>87880QW</td>
<td>August 21, 2015</td>
<td>LABSCO Advantage Strep A</td>
</tr>
<tr>
<td>G0434QW</td>
<td>August 31, 2015</td>
<td>UCP Biosciences, Inc. UCP Drug Test Mini Cups</td>
</tr>
<tr>
<td>G0434QW</td>
<td>Sept. 22, 2015</td>
<td>American Screening Corporation, Reveal Mini Drug Test Cups</td>
</tr>
<tr>
<td>G0434QW</td>
<td>October 13, 2015</td>
<td>,Assure Tech Co., Ltd AssureTech Buprenorphine Strip;</td>
</tr>
<tr>
<td>G0434QW</td>
<td>October 13, 2015</td>
<td>Assure Tech Co., Ltd AssureTech Methadone Strip;</td>
</tr>
<tr>
<td>G0434QW</td>
<td>October 13, 2015</td>
<td>Assure Tech Co., Ltd AssureTech Buprenorphine/Methadone Panel Dip;</td>
</tr>
<tr>
<td>G0434QW</td>
<td>October 13, 2015</td>
<td>Assure Tech Co., Ltd AssureTech Buprenorphine/Methadone Quick Cup; and</td>
</tr>
<tr>
<td>G0434QW</td>
<td>October 13, 2015</td>
<td>Assure Tech Co., Ltd AssureTech Buprenorphine/Methadone Turn Key-Split Cup.</td>
</tr>
</tbody>
</table>

However, the tests referenced in the attachment of CR9416 titled, “TESTS GRANTED WAIVED STATUS UNDER CLIA”, do not require a ‘QW’ modifier to be recognized as a waived test. These tests have been extracted from that document and are listed in Table 2.

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Table 2: TESTS GRANTED WAIVED STATUS UNDER CLIA  
(Do not require QW Modifier)

<table>
<thead>
<tr>
<th>CPT Code(s)</th>
<th>Test Name</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>81002</td>
<td>Dipstick or tablet reagent urinalysis – non-automated for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen</td>
<td>Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections</td>
</tr>
<tr>
<td>81025</td>
<td>Urine pregnancy tests by visual color comparison</td>
<td>Diagnosis of pregnancy</td>
</tr>
<tr>
<td>82270, 82272</td>
<td>Fecal occult blood</td>
<td>Detection of blood in feces from whatever cause, benign or malignant (colorectal cancer screening)</td>
</tr>
<tr>
<td>82962</td>
<td>Blood glucose by glucose monitoring devices cleared by the FDA for home use</td>
<td>Monitoring of blood glucose levels</td>
</tr>
<tr>
<td>83026</td>
<td>Hemoglobin by copper sulfate – non-automated</td>
<td>Monitors hemoglobin level in blood</td>
</tr>
<tr>
<td>84830</td>
<td>Ovulation tests by visual color comparison for human luteinizing hormone</td>
<td>Detection of ovulation (optimal for conception)</td>
</tr>
<tr>
<td>85013</td>
<td>Blood count; spun microhematocrit</td>
<td>Screen for anemia</td>
</tr>
<tr>
<td>85651</td>
<td>Erythrocyte sedimentation rate – non-automated</td>
<td>Nonspecific screening test for inflammatory activity, increased for majority of infections, and most cases of carcinoma and leukemia</td>
</tr>
</tbody>
</table>

Note: MACs will not search their files to either retract payment or retroactively pay claims processed prior to the implementation of CR 9416. However, your MAC should adjust claims if you bring such claims to their attention.

Additional Information


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