# Medicare Monthly Review

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

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This bulletin should be shared with all health care practitioners and managerial members of the providers/suppliers staff. Bulletins issued during the last two years are available at no cost from our website at http://www.NGSMedicare.com.
Revised Local Coverage Determinations and Articles: February-March 2016

February 2016 Revisions

Botulinum Toxins (L33646)
The following paragraph in the “Indications” section under “Spasticity” has been corrected to add “upper extremity”:

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, and upper extremity.

Cataract Extraction (L33558)
Added ICD-10-CM diagnosis code H25.13 to Group I ICD-10 Codes that Support Medical Necessity section, effective for services rendered on or after 10/1/2015.

Denosumab (Prolia™, Xgeva™) - Related to LCD L33394 (A52399)
ICD-10-CM code Z48.816 has been added to the Group 7: list of codes in the “Covered ICD-10 Codes” section of the article effective 10/1/2015.

Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L33394)
Based on a reconsideration request for graft vs host disease (GVHD) for infliximab, the Infliximab article (A52423) has been revised to add sources. The Rituximab article (A52452) has also been revised to add sources for neuropathy with IgM monoclonal gammopathy based on a reconsideration request. The Denosumab article (A52399) has been revised to add ICD-10-CM codes.

Infliximab (e.g., Remicade™) – Related to LCD L33394 (A52423)
Based on a reconsideration request for graft vs host disease (GVHD), sources have been added to the “Sources of Information” section of the article. No changes were made in coverage. The following has been added to the “Indications expanded per this Article” section:

Behçet’s Disease (BD), also known as Behçet’s Syndrome, in patients without an adequate response to initial therapy, for the treatment of clinical manifestations of BD such as severe ocular involvement, major organ involvement, severe gastrointestinal or neurological involvement and resistant cases of joint or mucocutaneous involvement (i.e., painful oral and genital ulcers).

ICD-10-CM code M35.2 has been added to the Group 3: Codes effective for dates of service on or after 1/1/2016. Sources have also been added to the “Sources of Information” section of the article.

Nerve Conduction Studies and Electromyography (L35098)
ICD-10 code G62.9 was added to Group 1 diagnoses (nerve conduction and electromyography) effective for dates of service on or after 10/1/2015.

Pain Management (L33622)
ICD-10-CM codes M60.811, M60.812, M60.821, M60.822, M60.831, M60.832, M60.841, M60.842, M60.851, M60.852, M60.861, M60.862, M60.871, M60.872, M60.88, M60.89 and M79.7 have been added to the Group 1: Codes for Trigger Point injections (CPT codes 20552 and 20553) retroactive to 10/1/2015.

Reduction Mammaplasty (L35001)
Added the following ICD-10-CM diagnosis codes to the ICD-10 Codes that Support Medical Necessity section, effective for services rendered on or after 10/01/2015: D05.90, D05.91, D05.92, N65.0, and N65.1.
Rituximab (Rituxan®) - Related to LCD L33394 (A52452)
Based on a reconsideration request for neuropathy with IgM monoclonal gammopathy, sources have been added to the "Sources of Information" section of the article. No changes were made in coverage.

Routine Foot Care and Debridement of Nails (L33636)
ICD-10-CM codes E08.52, E09.52, E10.52, E11.52 and E13.52 were added to Group 1 in the “ICD-10-CM Codes that Support Medical Necessity” section.

Based on a practitioner request, ICD-10-CM code L60.3 was added to Group 1 as well as the explanatory notes in Groups 1 and 2 in the “ICD-10-CM Codes that Support Medical Necessity” section.

Routine Foot Care and Debridement of Nails - SIA (A52865)
Minor template language changes made. ICD-10-CM code L60.3 was added to the following coding guideline:

When reporting procedures for treatment of onychoagryphosis or onychauxis, the primary diagnosis representing one of these conditions must be reported (ICD-10-CM code L60.2 or L60.3), as well as one of the diagnosis codes listed in the "ICD-10-CM Codes that Support Medical Necessity" section of the LCD which indicates secondary infection or pain. A diagnosis of onychogryphosis or onychauxis alone is insufficient for payment.

March 2016 Revisions
Chiropractic Services (L33613)
In the “Utilization Guideline” section the following statement has been removed:

Utilization exceeding two courses of chiropractic treatments may be subject to medical review.

And replaced with:

Prolonged or repeated courses of treatment are more subject to medical review and may indicate maintenance therapy. Documentation to support the medical necessity of repeated courses of treatment must be present in the patient’s plan of care.

Noncovered Services (L33629)
Noncoverage provisions have been added under Indications and Limitations, CPT/HCPCS Codes, and Sources of Information and Basis for Decision for CPT codes 86152 and 86153 (Circulating Tumor Cell (CTC) Assay) and CPT code 53860 (Radiofrequency Treatment for Urinary Incontinence). The additional provisions for these procedures replace the same provisions in LCDs L33587 and L35054, respectively, that are retired effective 3/1/2016.

Noninvasive Vascular Studies (L33627)
ICD-10 code N50.9 has been added to the payable diagnoses for Group 5, Visceral Vascular Studies (93975, 93976, 93978, 93979) effective 10/1/2015.

The credentialing statement below was corrected to include information from the ICD-9 version of this LCD:

"Additionally, transcutaneous oxygen tension measurements may be performed by individuals possessing the following credentials obtained from appropriate credentialing bodies, such as, but not limited to, the National Board of Diving and Hyperbaric Medicine Technology (NBDHMT): Certified Hyperbaric Technologist (CHT), or Certified Hyperbaric Registered Nurse (CHRN)."

Rituximab (Rituxan®) - Related to LCD L33394 (A52452)
Based on a reconsideration request for membranous nephropathy, sources have been added to the "Sources of Information" section of the article. No changes were made in coverage. The first paragraph in the "Indications" section of the article has been revised to include Lexi-Drug compendium. Lexi-Drug Web site has been added to the “Sources of Information” section of the article.
Centers for Medicare & Medicaid Services
Articles for Part A&B Providers
MLN Matters® Number: MM9390  Related Change Request (CR) #: CR 9390
Related CR Release Date: February 4, 2016  Effective Date: March 4, 2016
Related CR Transmittal #: R636PI  Implementation Date: March 4, 2016

Update to Pub. 100-08, Chapter 15

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9390, from which this article was developed, makes several minor revisions to Chapter 15 of the “Medicare Program Integrity Manual.” These changes include, but are not limited to:

1. Clarifying the process for verifying correspondence telephone numbers;
2. Clarifying the process for validating the credentials of technicians of Independent Diagnostic Testing Facilities (IDTFs); and
3. Identifying the timeframe by which approval letters must be sent and to whom they must be sent.

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

Background

Chapter 15 of the “Medicare Program Integrity Manual” contains instructions regarding the processing of Form CMS-855 applications. CR9390 makes the following key changes:

1. If online verification of an IDTF technician's credentials is not available or cannot be made, the MAC will request a copy of the technician’s certification card.

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2. The MAC will not request a social security card to verify an individual’s identity or social security number.

3. Absent a CMS instruction or directive to the contrary, the MAC will send enrollment approval letters within 5 business days of approving the enrollment application.

4. For all applications other than the Form CMS-855S, the MAC will send development/approval letters/revocation letters, etc., to the contact person if one is listed; otherwise, the contractor may send the letter to the provider or supplier at the provider’s/supplier’s correspondence address or special payments address.

**Note:** CR9390 does not involve any legislative or regulatory policies and is restricted to changes in operational procedures.

Many of the other Chapter 15 revisions are small, such as inserting single words or short sentences, etc. Others are more significant and those revisions are in the revised Chapter 15, which is attached to CR9390.

**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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Screening for the Human Immunodeficiency Virus (HIV) Infection

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9403 informs MACs that the Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is adequate to conclude that screening of HIV infection for all individuals between the ages of 15-65 years is reasonable and necessary for early detection of HIV, and it is appropriate for individuals entitled to benefits under Part A or enrolled in Part B.

Background

On January 1, 2009, CMS was authorized to add coverage of "additional preventive services" through the National Coverage Determination (NCD) process if certain statutory requirements are met. One of those requirements is that the service(s) be categorized as a grade A (strongly
recommends) or grade B (recommends) rating by the United States Preventive Services Task Force (USPSTF) and meets certain other requirements. Previously, the USPSTF strongly recommended screening for all adolescents and adults at increased risk for HIV infection, as well as all pregnant women. The USPSTF made no recommendation for or against routine HIV screening in adolescents and adults not at increased risk for HIV infection. Effective December 8, 2009, CMS issued a final decision supporting the USPSTF recommendations.


In April 2013, the USPSTF updated these recommendations and recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened (Grade A recommendation). The USPSTF also recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown (Grade A recommendation).

CR 9403 instructs that effective for claims with dates of service on and after April 13, 2015, CMS will cover screening for HIV with the appropriate U.S. Food and Drug Administration (FDA)-approved laboratory tests and point-of-care tests, used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations, when ordered by the beneficiary’s physician or practitioner within the context of a healthcare setting and performed by an eligible Medicare provider for these services, for beneficiaries who meet one of the following conditions below:

1. Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual, voluntary screening for all adolescents and adults between the ages of 15 and 65, without regard to perceived risk.
2. Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual, voluntary screening for adolescents younger than 15 and adults older than 65 who are at increased risk for HIV infection. Increased risk for HIV infection is defined as follows:
   - Men who have sex with men;
   - Men and women having unprotected vaginal or anal intercourse;
   - Past or present injection drug users;
   - Men and women who exchange sex for money or drugs, or have sex partners who do;
   - Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users;
   - Persons who have acquired or request testing for other sexually transmitted infectious diseases;
   - Persons with a history of blood transfusions between 1978 and 1985;
• Persons who request an HIV test despite reporting no individual risk factors;
• Persons with new sexual partners; or
• Persons who, based on individualized physician interview and examination, are deemed to be at increased risk for HIV infection. The determination of “increased risk” for HIV infection is identified by the health care practitioner who assesses the patient’s history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical recommendation should be a reflection of the service provided.

3. A maximum of three voluntary HIV screenings of pregnant Medicare beneficiaries:
   • When the diagnosis of pregnancy is known;
   • During the third trimester; and
   • At labor, if ordered by the woman’s clinician.

**NOTE:** There is no co-insurance or deductible for tests paid under the Clinical Laboratory Fee Schedule (CLFS).

### Billing Requirements

Effective for claims with dates of service on or after April 13, 2015, MACs will recognize new HCPCS code G0475 (HIV antigen/antibody, combination assay, screening) as a new covered service for HIV screening.

**NOTE:** HCPCS G0475 will appear in the January 1, 2017, CLFS; in the January 1, 2016, Integrated Outpatient Code Editor (IOCE); in the January 2016 Outpatient Prospective Payment System (OPPS); and in the January 1, 2016, Medicare Physician Fee Schedule (MPFS). HCPCS Code G0475 will be effective retroactive to April 13, 2015, in the IOCE and OPPS.

For services from April 13 - September 30, 2015, inclusive, the diagnosis codes are:

<table>
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<tr>
<th>ICD-9 Code</th>
<th>Descriptor</th>
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<tbody>
<tr>
<td>V22.0</td>
<td>Supervision of normal first pregnancy</td>
</tr>
<tr>
<td>V22.1</td>
<td>Supervision of other normal pregnancy</td>
</tr>
<tr>
<td>V23.9</td>
<td>Supervision of unspecified high-risk pregnancy</td>
</tr>
<tr>
<td>V69.8</td>
<td>Other problems related to lifestyle</td>
</tr>
<tr>
<td>V73.89</td>
<td>Special screening examination for other specified viral diseases</td>
</tr>
<tr>
<td>V69.2</td>
<td>High risk sexual behavior</td>
</tr>
</tbody>
</table>
For dates of service on or after October 1, 2015, the diagnosis codes are:

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Long Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z34.00</td>
<td>Encounter for supervision of normal first pregnancy, unspecified trimester</td>
</tr>
<tr>
<td>Z34.01</td>
<td>Encounter for supervision of normal first pregnancy, first trimester</td>
</tr>
<tr>
<td>Z34.02</td>
<td>Encounter for supervision of normal first pregnancy, second trimester</td>
</tr>
<tr>
<td>Z34.03</td>
<td>Encounter for supervision of normal first pregnancy, third trimester</td>
</tr>
<tr>
<td>Z34.80</td>
<td>Encounter for supervision of other normal pregnancy, unspecified trimester</td>
</tr>
<tr>
<td>Z34.81</td>
<td>Encounter for supervision of other normal pregnancy, first trimester</td>
</tr>
<tr>
<td>Z34.82</td>
<td>Encounter for supervision of other normal pregnancy, second trimester</td>
</tr>
<tr>
<td>Z34.83</td>
<td>Encounter for supervision of other normal pregnancy, third trimester</td>
</tr>
<tr>
<td>Z34.90</td>
<td>Encounter for supervision of normal pregnancy, unspecified, unspecified trimester</td>
</tr>
<tr>
<td>Z34.91</td>
<td>Encounter for supervision of normal pregnancy, unspecified, first trimester</td>
</tr>
<tr>
<td>Z34.92</td>
<td>Encounter for supervision of normal pregnancy, second trimester</td>
</tr>
<tr>
<td>Z34.93</td>
<td>Encounter for supervision of normal pregnancy, third trimester</td>
</tr>
<tr>
<td>O09.90</td>
<td>Supervision of high risk pregnancy, unspecified, unspecified trimester</td>
</tr>
<tr>
<td>O09.91</td>
<td>Supervision of high risk pregnancy, unspecified, first trimester</td>
</tr>
<tr>
<td>O09.92</td>
<td>Supervision of high risk pregnancy, unspecified, second trimester</td>
</tr>
<tr>
<td>O09.93</td>
<td>Supervision of high risk pregnancy, unspecified, third trimester</td>
</tr>
<tr>
<td>Z72.89</td>
<td>Other problems related to lifestyle</td>
</tr>
<tr>
<td>Z11.4</td>
<td>Encounter for screening for human immunodeficiency virus [HIV]</td>
</tr>
<tr>
<td>Z72.51</td>
<td>High risk heterosexual behavior</td>
</tr>
<tr>
<td>Z72.52</td>
<td>High risk homosexual behavior</td>
</tr>
<tr>
<td>Z72.53</td>
<td>High risk bisexual behavior</td>
</tr>
</tbody>
</table>

On professional claims, the place of service must be either 81 (independent laboratory) or 11 (office).

If claims are received for screenings that exceed the maximum number allowed per year, the claim line item will be denied with the following remittance codes:

- Claim Adjustment Reason Code (CARC) 119: “Benefit maximum for this time period or occurrence has been reached.”
Remittance Advice Remark Code (RARC) N386: “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp) on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.” and

Group Code: CO (Contractual Obligation).

Note that the next eligible date for the service will be provided on all Common Working File (CWF) provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN).

Claims with HCPCS Code G0475 for beneficiaries between the ages of 15 and 65 without regard to risk must also be submitted with a primary diagnosis code of either V73.89 (ICD-9) or Z11.4 (ICD-10). If that primary code is not present, the line item will be denied using the following messages:

- CARC 167 – “This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N386 – “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp) on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- Group Code: CO (Contractual Obligation).

Claims with HCPCS Code G0475 for beneficiaries less than age 15 or greater than age 65 with increased risk must also be submitted with a primary diagnosis code of either V73.89 (ICD-9) or Z11.4 (ICD-10) and a secondary diagnosis code that denotes the high risk. The ICD-9 secondary codes are V69.2 or V69.8. The ICD-10 secondary diagnosis codes are Z72.51, Z72.89, Z72.52, or Z72.53. If that secondary code is not present, the line item will be denied using the following messages:

- 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.”
- RARC N129: “Not eligible due to the patient’s age.”
- Group Code: CO (Contractual Obligation).

Effective for claims with dates of service on or after April 13, 2015, MACs will deny line-items on claims for pregnant beneficiaries denoted by a secondary diagnosis code above denoting pregnancy, if HCPCS Code G0475, HIV screening, or CPT code 80081, obstetric panel, and primary diagnosis code V73.89/ Z11.4, as appropriate, are not present on the claim. Such line item denials will result in the following remittance messages:

- CARC 11: “The diagnosis is inconsistent with the procedure. 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 on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.”
• Group Code: CO (Contractual Obligation).

Institutional claims for G0475 submitted on Types of Bill (TOB) 12X, 13X, 14X, 22X, and 23X will be paid based on the CLFS with dates of service on or after January 1, 2017. MACs will apply their pricing to claims with dates of service of April 13, 2015, through December 31, 2016. Such claims submitted on TOB 85X will be paid based on reasonable cost for dates of service beginning with April 13, 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.
MLN Matters® Number: MM9434  Related Change Request (CR) #: CR 9434

Related CR Release Date: February 5, 2016  Effective Date: July 9, 2015

Implementation Date: July 5, 2016 (CWF analysis and design), October 3, 2016 (CWF Coding, Testing and Implementation, MCS and FISS implementation; January 3, 2017 (requirement 9434-04.8.2), March 7, 2016 (non-shared MAC edits)

Screening for Cervical Cancer with Human Papillomavirus (HPV) Testing—National Coverage Determination (NCD) 210.2.1

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9434 announces that the Centers for Medicare & Medicaid Services (CMS) has determined that, effective for dates of service on or after July 9, 2015, evidence is sufficient to add Human Papillomavirus (HPV) testing under specified conditions. Make sure that your billing staffs are aware of this change.

Background

Medicare covers a screening pelvic examination and Pap test for all female beneficiaries at 12- or 24-month intervals, based on specific risk factors; however, current Medicare coverage does not include the HPV testing.

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Section 1861(ddd) of the Social Security Act (the Act) (see [http://www.ssa.gov/OP_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm)) states that CMS may add coverage of "additional preventive services" through the National Coverage Determination (NCD) process. The preventive services must meet all of the following criteria:

1. Reasonable and necessary for the prevention or early detection of illness or disability;
2. Recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and,
3. Appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

CMS has reviewed the USPSTF recommendations and supporting evidence for screening for cervical cancer with HPV co-testing, and has determined that the criteria were met. Therefore, effective for claims with dates of service on or after July 9, 2015, CMS will cover screening for cervical cancer with HPV co-testing under the following conditions:

CMS has determined that the evidence is sufficient to add HPV testing once every 5 years as an additional preventive service benefit under the Medicare program, for asymptomatic beneficiaries aged 30 to 65 years in conjunction with the Pap smear test. CMS will cover screening for cervical cancer with the appropriate U.S. Food and Drug Administration (FDA)-approved/cleared laboratory tests, used consistent with FDA-approved labeling, and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations.

A new Healthcare Common Procedure Coding System (HCPCS) code, G0476 (HPV combo assay, CA screen), Type of Service (TOS) 5 (diagnostic lab), has been created for this benefit. This code will:

- Be effective retroactive back to the effective date of July 9, 2015;
- Be included in the January 2016, Integrated Outpatient Code Editor, Outpatient Prospective Payment System, and Medicare Physician Fee Schedule Database;
- Be MAC-priced from July 9, 2015, through December 31, 2016, and during this period code G0476 is paid only when it is billed by a laboratory entity; and,
- Beginning January 1, 2017, this will be priced and paid according to the Clinical Laboratory Fee Schedule (CLFS).

In addition, you should be aware of the following:

1. Your MACs will not apply beneficiary coinsurance and deductibles to claim lines containing HCPCS G0476, HPV screening;
2. Part B MACs shall only accept claims with a Place of Service Code equal to ‘81’, Independent Lab or ‘11’, Office; and
3. Effective for claims with dates of service on or after July 9, 2015, your MACs will deny line-items on claims containing HCPCS G4076, HPV screening, when reported more
than once in a 5-year period [at least 4 years and 11 months (59 months total) must elapse from the date of the last screening]. The next eligible dates for this service are shown on all Common Working File (CWF) provider query screens (HUQA, HIQA, HIQH, ELGA, ELGH, and PRVN).

When denying a line-item on a claim for this requirement they will use the following messages:

- Claim Adjustment Reason Code (CARC) 119 – “Benefit maximum for this time period or occurrence has been reached;”
- Remittance Advice Remark Code (RARC) N386 – “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.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” if the claim contains a GZ modifier to denote a signed Advance Beneficiary Notice (ABN) is not on file or with Group Code "PR” (Patient Responsibility) if the claim has a GA modifier to show a signed ABN is on file.

4. HCPCS Code G0476 will be paid only for institutional claims submitted on Type of Bill codes (TOB) 12X, 13X, 14X, 22X, 23X, and 85X. Institutional claims on other TOBs will be returned to the provider.

5. Effective for claims with dates of service on or after July 9, 2015, your MACs will deny line-items on claims containing HCPCS G4076, HPV screening, when the beneficiary is less than 30 years of age or older than 65 years of age.

When denying a line-item on claims for this requirement, they will use the following messages:

- 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;”
- RARC N129 – “Not eligible due to the patient’s age;”
- Group Code “CO” if the claim contains a GZ modifier to denote a signed Advance Beneficiary Notice (ABN) is not on file or with Group Code "PR” (Patient Responsibility) if the claim has a GA modifier to show a signed ABN is on file.

6. Effective for claims with dates of service on or after July 9, 2015, you must report the following diagnosis codes when submitting claims for HCPCS G0476:

- ICD-9 (for dates of service prior to October 1, 2015): V73.81, special screening exam, HPV (as primary), and V72.31, routine gynecological exam (as secondary)
ICD-10: Z11.51, encounter for screening for HPV, and Z01.411, encounter for gynecological exam (general)(routine) with abnormal findings, OR Z01.419, encounter for gynecological exam (general)(routine) without abnormal findings.

Effective on this date, your MACs will deny line-items on claims containing HCPCS Code G0476, HPV screening, when the claim does not contain these codes.

When denying a line-item on claim for this requirement, they will use the following messages:

- CARC 167 – “This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;”
- RARC N386 – “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD;” and
- Group Code CO.


**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.
Accredited Standards Committee (ASC) X12 Healthcare Claims Acknowledgement (277CA) Flat File Update

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9454 updates the Accredited Standards Committee (ASC) X12 Healthcare Claims Acknowledgement (277CA) flat file to allow for larger monetary amounts to meet Medicare's needs. The 277CA amount fields are currently the same size as the size used for the input files.

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: MM9461  Related Change Request (CR) #: CR 9461

Related CR Release Date: February 19, 2016  Effective Date: April 1, 2016

Related CR Transmittal #: R3467CP  Implementation Date: As soon as April 1, 2016, but no later than July 5, 2016

Healthcare Provider Taxonomy Codes (HPTCs) April 2016 Code Set Update

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9461 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference files.

Background

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

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

You should note that:

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

CR9461 implements the NUCC HPTC code set that is effective on April 1, 2016, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at [http://www.wpc-edi.com/codes](http://www.wpc-edi.com/codes) on the Internet.

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

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

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.
MLN Matters® Number: MM9474
Related Change Request (CR) #: CR 9474
Related CR Release Date: February 5, 2016
Effective Date: Claims received on or after July 1, 2016
Related CR Transmittal #: R3457CP
Implementation Date: July 5, 2016

New Condition Code for Reporting Home Health Episodes with No Skilled Visits

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9474 informs you of revisions of the Medicare billing instructions for home health claims to allow the use of a new condition code - 54. The code indicates that the HHA provided no skilled services during the billing period, but the HHA has documentation on file of an allowable circumstance. Make sure that your billing staffs are aware of these changes.

Background

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act require that, in order to be eligible to receive Medicare home health services, the beneficiary must have a skilled need (that is, require intermittent Skilled Nursing (SN) services, Physical Therapy (PT), and/or Speech Language Pathology (SLP) services or have a continuing need for Occupational Therapy (OT) services). In order to better enforce this requirement, CR9027 (see related article MM9027) revised Original Medicare systems to return to the provider any claims for episodes that are the first episode in a sequence of episodes or are the only episode of care received by a beneficiary for which patient eligibility for the Medicare home health benefit has not been established (that is, no SN, PT, or SLP visits reported on the claim).

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Enforcing this requirement on claims for subsequent episodes of HH care could not be automated using previously existing codes. There may be circumstances which prevent the HHA from delivering the skilled services planned for an episode, such as an unexpected inpatient admission. Determining whether payment is allowable requires development of the claim. **Chapter 7**, Section 40.1.3, of the “Medicare Benefits Policy Manual” states:

> “Since the need for ‘intermittent’ skilled nursing care makes the patient eligible for other covered home health services, the intermediary should evaluate each claim involving skilled nursing services furnished less frequently than once every 60 days. In such cases, payment should be made only if documentation justifies a recurring need for reasonable, necessary, and medically predictable skilled nursing services.”

Medicare requested the National Uniform Billing Committee to create a new code that would allow the HHA to indicate upon submission that such documentation exists. A new condition code 54 is effective on July 1, 2016 and is defined as “No skilled HH visits in billing period. Policy exception documented at the HHA.” Submission of this code will streamline claims processing for both the payer and provider. Claims without skilled visits that are submitted without the new condition code will be returned to the provider. This will allow the HHA to:

- Add any accidentally omitted skilled services to the claim;
- Submit the claim as noncovered, if appropriate; or
- Append the new condition code.

These actions will prevent unnecessary reviews and denials for the HHA and allow Medicare to better target medical review resources.

Also, CR9474 address unintended consequences of the implementation of new Healthcare Common Procedure Coding System (HCPCS) codes for skilled nursing visits. CR9369 (see related article MM9369) terminated HCPCS code G0154, replacing it with two new codes, G0299 and G0300. During the implementation of CR9369, CMS discovered several other processes are affected by this coding change:

- G0299 and G0300 were previously used to describe defibrillator services. An edit in Medicare systems requires certain diagnosis codes appropriate to support the need for dates of service on or after January 1, 2016.
- Another edit in Medicare systems currently requires that revenue code 055x is always reported with HCPCS G0154 on hospice claims. This edit would set inappropriately on all hospice claims with dates of service on or after January 1, 2016.

The Centers for Medicare & Medicaid Services (CMS) directed the MACs to temporarily deactivate these two edits to prevent Medicare from returning claims in error. CR9474 revises these edits so MACs can reactivate them without any adverse impact.

Medicare systems also use HCPCS code G0154 in the criteria for identifying the earliest date when calculating Low Utilization Payment Adjustment (LUPA) add on amounts. When...
home health agencies can no longer report G0154, the earliest visit date for skilled nursing visits reported with G0299 or G0300 will not be used in the calculation. This will result in some claims not receiving LUPA add on amounts or receiving a payment based on the wrong service discipline. CR9474 corrects this error and instruct MACs to adjust home health claims to correct payments within 60 days of the implementation date of CR9474.

Finally, CR9474 contains a number of routine maintenance revisions to home health billing contained in the “Medicare Claims Processing Manual,” Pub. 100-04, Chapter 10, Home Health Agency Billing. The revisions include reformatting the presentation of remittance advice codes and ensuring code pairs are compliant with CAQH/CORE requirements. They include an update to the Pricer logic section to reflect case-mix scoring changes for calendar year 2016 and to correctly reflect LUPA add-on calculations which were effective January 1, 2014.

Additional Information

The official instruction, CR9474, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3457CP.pdf on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

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Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April Calendar Year (CY) 2016 Update

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) 9531 amends payment files that were issued to your MAC based upon the CY 2016 Medicare Physician Fee Schedule (MPFS) Final Rule published in the Federal Register on November 16, 2015. These payment files are to be effective for services furnished between January 1, 2016, and December 31, 2016. Please make sure your billing staff is aware of these changes.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians’ services.

MACs will not search their files to either retract payment for claims already paid or to retroactively pay claims, however, they will adjust claims that you bring to their attention.

The key changes for the April update that are effective as of January 1, 2016 are as follows:

- CPT/HCPCS code G0464 is assigned a procedure status of I;
- Code 10030 is assigned Global period days of 000;
- Code 77014 is assigned a PC/TC Indicator of 1; and
- Code 80055 is assigned a procedure status of X.

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Other changes that are effective for services performed on or after April 1, 2016 are as follows:

- Code G9678 is assigned a procedure status of X;
- G9481 (Remote E/M new pt 10mins) has a PE RVU = 0, all other MPFS indicators/values = code 99201;
- G9482 (Remote E/M new pt 20mins) has a PE RVU = 0, all other MPFS indicators/values = 99202;
- G9483 (Remote E/M new pt 30mins) has a PE RVU = 0, all other MPFS indicators/values = 99203;
- G9484 (Remote E/M new pt 45mins) has a PE RVU = 0, all other MPFS indicators/values = 99204;
- G9485 (Remote E/M new pt 60mins) has a PE RVU = 0, all other MPFS indicators/values = 99205;
- G9486 (Remote E/M est. pt 10mins) has a PE RVU = 0, all other MPFS indicators/values = 99212;
- G9487 (Remote E/M est. pt 15mins) has a PE RVU = 0, all other MPFS indicators/values = 99213;
- G9488 (Remote E/M est. pt 25mins) has a PE RVU = 0, all other MPFS indicators/values = 99214;
- G9489 (Remote E/M est. pt 40mins) has a PE RVU = 0, all other MPFS indicators/values = 99215; and
- G9490 (Joint replac mod home visit) with all MPFS indicators & RVUs = those of G9187.

Codes G9481-G9490 are new and are assigned Type of Service of 1. See the MLN Matters article MM9533 at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9533.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9533.pdf) for further details of these new codes.

### 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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Comprehensive Care for Joint Replacement Model (CJR) Provider Education

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9533 supplies information to providers about the CJR model. The intent of the CJR model is to promote quality and financial accountability for episodes of care surrounding a Lower-Extremity Joint Replacement (LEJR) or reattachment of a lower extremity procedure. CJR will test whether bundled payments to certain acute care hospitals for LEJR episodes of care will reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. Make sure that your billing staffs are aware of these changes.

Background

Section 1115A of the Social Security Act (the Act) authorizes the Centers for Medicare & Medicaid Services (CMS) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. Under this authority, CMS published a rule to implement a new five year payment model called the Comprehensive Care for Joint Replacement (CJR) model on April 1, 2016.
Under the CJR model, acute care hospitals in certain selected geographic areas will take on quality and payment accountability for retrospectively calculated bundled payments for LEJR episodes. Episodes will begin with admission to an acute care hospital for an LEJR procedure that is paid under the Inpatient Prospective Payment System (IPPS) through Medical Severity Diagnosis-Related Group (MS-DRG) 469 (Major joint replacement or reattachment of lower extremity with MCC) or 470 (Major joint replacement or reattachment of lower extremity without MCC) and end 90 days after the date of discharge from the hospital.

**Key Points of CR9533**

**CJR Episodes of Care**

LEJR procedures are currently paid under the IPPS through: MS-DRG 469 or MS-DRG 470. The episode will include the LEJR procedure, inpatient stay, and all related care covered under Medicare Parts A and B within the 90 days after discharge. The day of discharge is counted as the first day of the 90-day bundle.

**CJR Participant Hospitals**

The model requires all hospitals paid under the IPPS in selected geographic areas to participate in the CJR model, with limited exceptions. A list of the selected geographic areas and participant hospitals is available at [https://innovation.cms.gov/initiatives/cjr](https://innovation.cms.gov/initiatives/cjr) on the Internet. Participant hospitals initiate episodes when an LEJR procedure is performed within the hospital and will be at financial risk for the cost of the services included in the bundle. Eligible beneficiaries who elect to receive care at these hospitals will automatically be included in the model.

**CJR Model Beneficiary Inclusion Criteria**

Medicare beneficiaries whose care will be included in the CJR model must meet the following criteria upon admission to the anchor hospitalization:

- The beneficiary is enrolled in Medicare Part A and Part B;
- The beneficiary's eligibility for Medicare is not on the basis of the End-Stage Renal Disease benefit;
- The beneficiary is not enrolled in any managed care plan;
- The beneficiary is not covered under a United Mine Workers of America health plan; and
- Medicare is the primary payer.

If at any time during the episode the beneficiary no longer meets all of these criteria, the episode is canceled.

**CJR Performance Years**

CMS will implement the CJR model for 5 performance years, as detailed in the table below. Performance years for the model correlate to calendar years with the exception of performance year 1, which is April 1, 2016, through December 31, 2016.
## CJR Model: 5 Performance Years

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Date for Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Year 1 (calendar year 2016)</td>
<td>Episodes that start on or after April 1, 2016, and end on or before December 31, 2016</td>
</tr>
<tr>
<td>Performance Year 2 (calendar year 2017)</td>
<td>Episodes that end between January 1, 2017, and December 31, 2017, inclusive</td>
</tr>
<tr>
<td>Performance Year 3 (calendar year 2018):</td>
<td>Episodes that end between January 1, 2018, and December 31, 2018, inclusive</td>
</tr>
<tr>
<td>Performance Year 4 (calendar year 2019):</td>
<td>Episodes that end between January 1, 2019, and December 31, 2019, inclusive</td>
</tr>
<tr>
<td>Performance Year 5 (calendar year 2020):</td>
<td>Episodes that end between January 1, 2020, and December 31, 2020, inclusive</td>
</tr>
</tbody>
</table>

### CJR Episode Reconciliation Activities

CMS will continue paying hospitals and other providers and suppliers according to the usual Medicare fee-for-service payment systems during all performance years. After completion of a performance year, Medicare will compare or “reconcile” actual claims paid for a beneficiary during the 90 day episode to an established target price. The target price is an expected amount for the total cost of care of the episode. Hospitals will receive separate target prices to reflect expected spending for episodes assigned to MS-DRGs 469 and 470, as well as hip fracture status. If the actual spending is lower than the target price, the difference will be paid to the hospital, subject to certain adjustments, such as for quality. This payment will be called a reconciliation payment. If actual spending is higher than the target price, hospitals will be responsible for repayment of the difference to Medicare, subject to certain adjustments, such as for quality.

### Identifying CJR Claims

To validate the retroactive identification of CJR episodes, CMS is associating the Demonstration Code 75 with the CJR initiative. This code will also be utilized in future CRs to operationalize a waiver of the three-day stay requirement for covered Skilled Nursing Facility (SNF) services, effective for CJR episodes beginning on or after January 1, 2017.

Medicare will automatically apply the CJR demonstration code to claims meeting the criteria for inclusion in the demonstration. **Participant hospitals need not include demonstration code 75 on their claims.** Instructions for submission of claims for SNF services rendered to beneficiaries in a CJR episode of care will be communicated once the waiver of the three-day stay requirement is operationalized.

### Waivers and Amendments of Medicare Program Rules

The CJR model waives certain existing payment system requirements to provide additional flexibilities to hospitals participating in CJR, as well as other providers that furnish services to beneficiaries in CJR episodes. The purpose of such flexibilities would be to increase LEJR episode quality and decrease episode spending or provider and supplier internal costs,
or both, and to provide better, more coordinated care for beneficiaries and improved financial efficiencies for Medicare, providers, and beneficiaries.

Post-Discharge Home Visits

In order for Medicare to pay for home health services, a beneficiary must be determined to be "home bound." A beneficiary is considered to be confined to the home if the beneficiary has a condition, due to an illness or injury, that restricts his or her ability to leave home except with the assistance of another individual or the aid of a supportive device (that is, crutches, a cane, a wheelchair or a walker) or if the beneficiary has a condition such that leaving his or her home is medically contraindicated. Additional information regarding the homebound requirement is available in the “Medicare Benefit Policy Manual;” Chapter 7, Home Health Services, Section 30.1.1, Patient Confined to the Home.

Medicare policy allows physicians and Non-Physician Practitioners (NPPs) to furnish and bill for visits to any beneficiary’s home or place of residence under the Medicare Physician Fee Schedule (MPFS). Medicare policy also allows such physicians and practitioners to bill Medicare for services furnished incident to their services by licensed clinical staff. Additional information regarding the “incident to” requirements is available in 42 CFR 410.26.

For those CJR beneficiaries who could benefit from home visits by licensed clinical staff for purposes of assessment and monitoring of their clinical condition, care coordination, and improving adherence with treatment, CMS will waive the “incident to” direct physician supervision requirement to allow a beneficiary who does not qualify for Medicare home health services to receive post-discharge visits in his or her home or place of residence any time during the episode, subject to the following conditions:

- Licensed clinical staff will provide the service under the general supervision of a physician or NPP. These staff can come from a private physician office or may be either an employee or a contractor of the participant hospital.
- Services will be billed under the MPFS by the supervising physician or NPP or by the hospital or other party to which the supervising physician has reassigned his or her billing rights.
- Up to 9 post discharge home visits can be billed and paid per beneficiary during each CJR episode, defined as the 90-day period following the anchor hospitalization.
- The service cannot be furnished to a CJR beneficiary who has qualified, or would qualify, for home health services when the visit was furnished.
- All other Medicare rules for coverage and payment of services incident to a physician's service continue to apply.

As described in the “Medicare Claims Processing Manual”, Chapter 12, Sections 40-40.4, Medicare policy generally does not allow for separate billing and payment for a postoperative visit furnished during the global period of a surgery when it is related to recovery from the surgery. However, for CJR, CMS will allow the surgeon or other practitioners to bill and be paid separately for a post-discharge home visit that was furnished...
in accordance with these conditions. All other Medicare rules for global surgery billing during the 90 day post-operative period continue to apply.

CMS expects that the post-discharge home visits by licensed clinical staff could include patient assessment, monitoring, assessment of functional status and fall risk, review of medications, assessment of adherence with treatment recommendations, patient education, communication and coordination with other treating clinicians, and care management to improve beneficiary connections to community and other services.

The service will be billed under the MPFS with a HCPCS G-code (G9490) specific to the CJR post-discharge home visit, as listed in Attachment A. The post-discharge home visit HCPCS code will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for post-discharge home visits for the CJR model will be accepted only when the claim contains the CJR specific HCPCS G-Code. Although CMS is associating the Demonstration Code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-Code.

Additional information on billing and payment for the post-discharge home visit HCPCS G-Code will be available in the April 2016 release of the MPFS Recurring Update. Future updates to the relative value units (RVUs) and payment for this HCPCS code will be included in the MPFS final rules and recurring updates each year.

**Billing and Payment for Telehealth Services**

Medicare policy covers and pays for telehealth services when beneficiaries are located in specific geographic areas. Within those geographic areas, beneficiaries must be located in one of the health care settings that are specified in the statute as eligible originating sites. The service must be on the list of approved Medicare telehealth services. Medicare pays a facility fee to the originating site and provides separate payment to the distant site practitioner for the service. Additional information regarding Medicare telehealth services is available in the “Medicare Benefit Policy Manual,” Chapter 15, Section 270 and the “Medicare Claims Processing Manual,” Chapter 12, Section 190.

Under CJR, CMS will allow a beneficiary in a CJR episode in any geographic area to receive services via telehealth. CMS also will allow a home or place of residence to be an originating site for beneficiaries in a CJR episode. This will allow payment of claims for telehealth services delivered to beneficiaries at eligible originating sites or at their residence, regardless of the geographic location of the beneficiary. CMS will waive these telehealth requirements, subject to the following conditions:

- Telehealth services cannot substitute for in-person home health visits for patients under a home health episode of care.
- Telehealth services performed by social workers for patients under a home health episode of care will not be covered under the CJR model.
- The telehealth geographic area waiver and the allowance of home as an originating site under the CJR model does not apply for instances where a physician or allowed
NPP is performing a face-to-face encounter for the purposes of certifying patient eligibility for the Medicare home health benefit.

- The principal diagnosis code reported on the telehealth claim cannot be one that is specifically excluded from the CJR episode definition.

- If the beneficiary is at home, the physician cannot furnish any telehealth service with a descriptor that precludes delivering the service in the home (for example, a hospital visit code).

- If the physician is furnishing an evaluation and management visit via telehealth to a beneficiary at home, the visit must be billed by one of nine unique HCPCS G-codes developed for the CJR model that reflect the home setting.

- For CJR telehealth home visits billed with HCPCS codes G9484, G9485, G9488, and G9489, the physician must document in the medical record that auxiliary licensed clinical staff were available on site in the patient's home during the visit or document the reason that such a high-level visit would not require such personnel.

- Physicians billing distant site telehealth services under these waivers must include the GT modifier on the claim, which attests that the service was furnished in accordance with all relevant coverage and payment requirements.

- The facility fee paid by Medicare to an originating site for a telehealth service will be waived if the service was originated in the beneficiary's home.

The telehealth home visits will be billed under the MPFS with one of nine HCPCS G-code specific to the CJR telehealth home visits. Those codes are G9481, G9482, G9483, G9484, G9485, G9586, G9487, G9488, and G9499. Attachment A of CR9533 provides the long descriptors of these codes. The telehealth home visit HCPCS codes will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for telehealth home visits for the CJR model will be accepted only when the claim contains one of nine of the CJR specific HCPCS G-Code. Although CMS is associating the Demonstration Code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-Code. Additional information on billing and payment for the telehealth home visit HCPCS G-Codes will be available in the April 2016 release of the MPFS Recurring Update. Future updates to the RVUs and payment for these HCPCS codes will be included in the MPFS final rules and recurring updates each year.

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.
April 2016 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

Provider Types Affected

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

Provider Action Needed

Medicare will use the April 2016 quarterly Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 4, 2016, with dates of services from April 1, 2016, through June 30, 2016.

Change Request (CR) 9536 instructs MACs to implement the April 2016 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised January 2016, October 2015, July 2015, and April 2015 files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are established using the ASP and NOC pricing files.

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System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in the “Medicare Claims Processing Manual,” Chapter 4, Section 50.

The following table shows how the files will be applied.

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<thead>
<tr>
<th>Files</th>
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<tr>
<td>April 2016 ASP and ASP NOC</td>
<td>April 1, 2016, through June 30, 2016</td>
</tr>
<tr>
<td>January 2016 ASP and ASP NOC</td>
<td>January 1, 2016, through March 31, 2016</td>
</tr>
<tr>
<td>October 2015 ASP and ASP NOC</td>
<td>October 1, 2015, through December 31, 2015</td>
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<tr>
<td>July 2015 ASP and ASP NOC</td>
<td>July 1, 2015, through September 30, 2015</td>
</tr>
<tr>
<td>April 2015 ASP and ASP NOC</td>
<td>April 1, 2015, through June 30, 2015</td>
</tr>
</tbody>
</table>

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.
Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program

Note: This article was revised on February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under Important Clarifications Concerning QMB Balance Billing Law on page 3. All other information is the same.

Provider Types Affected

This article pertains to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in original Medicare or a Medicare Advantage plan.

What you Need to Know

STOP – Impact to You

This Special Edition MLN Matters® Article from the Centers for Medicare & Medicaid Services (CMS) reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing (such charges are known as “balance billing”). QMB is a Medicare Savings Program that exempts Medicare beneficiaries from Medicare cost-sharing liability.

CAUTION – What You Need to Know

The QMB program is a State Medicaid benefit that covers Medicare deductibles, coinsurance, and copayments, subject to State payment limits. (States may limit their liability to providers for Medicare deductibles, coinsurance and copayments under certain

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Medicare providers may not balance bill QMB individuals for Medicare cost-sharing, regardless of whether the State reimburses providers for the full Medicare cost-sharing amounts. Further, all original Medicare and MA providers --not only those that accept Medicaid--must refrain from charging QMB individuals for Medicare cost-sharing. Providers who inappropriately balance bill QMB individuals are subject to sanctions.

GO – What You Need to Do
Refer to the Background and Additional Information Sections of this article for further details and resources about this guidance. Please ensure that you and your staffs are aware of the federal balance billing law and policies regarding QMB individuals. Contact the Medicaid Agency in the States in which you practice to learn about ways to identify QMB patients in your State and procedures applicable to Medicaid reimbursement for their Medicare cost-sharing. If you are a Medicare Advantage provider, you may also contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

Background
This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductibles, coinsurance, and copayments. This practice is known as “balance billing.”

Balance Billing of QMBs Is Prohibited by Federal Law
Federal law bars Medicare providers from balance billing a QMB beneficiary under any circumstances. See **Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997.** (Please note, this section of the Act is available at [http://www.ssa.gov/OP_Home/ssact/title19/1902.htm](http://www.ssa.gov/OP_Home/ssact/title19/1902.htm) on the Internet.)

QMB is a Medicaid program for Medicare beneficiaries that exempts them from liability for Medicare cost-sharing. State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments. However, as permitted by federal law, States can limit provider reimbursement for Medicare cost-sharing under certain circumstances. See the chart at the end of this article for more information about the QMB benefit.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.)

Inappropriate Balance Billing Persists
Despite federal law, erroneous balance billing of QMB individuals persists. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining
provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. See Access to Care Issues Among Qualified Medicare Beneficiaries (QMB), Centers for Medicare & Medicaid Services July 2015 at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf on the CMS website.

**Important Clarifications Concerning QMB Balance Billing Law**

Be aware of the following policy clarifications to ensure compliance with QMB balance billing requirements. First, know that all original Medicare and MA providers—not only those that accept Medicaid—must abide by the balance billing prohibitions.

In addition, QMB individuals retain their protection from balance billing when they cross state lines to receive care. Providers cannot charge QMB individuals even if the patient’s QMB benefit is provided by a different State than the State in which care is rendered.

Finally, note that QMBs cannot choose to “waive” their QMB status and pay Medicare cost-sharing. The federal statute referenced above supersedes Section 3490.14 of the “State Medicaid Manual,” which is no longer in effect.

**Ways to Improve Processes Related to QMBs**

Proactive steps to identify QMB individuals you serve and to communicate with State Medicaid Agencies (and Medicare Advantage plans if applicable), can promote compliance with QMB balance billing prohibitions.

1. Determine effective means to identify QMB individuals among your patients. Find out what cards are issued to QMB individuals so you can in turn ask all your patients if they have them. Learn if you can query state systems to verify QMB enrollment among your patients. If you are a Medicare Advantage provider contact the plan to determine how to identify the plan’s QMB enrollees.

2. Discern what billing processes apply to seek reimbursement for Medicare cost-sharing from the States in which you operate. Different processes may apply to original Medicare and MA services provided to QMB beneficiaries. For original Medicare claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.

- If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare Remittance Advice.
- Understand the processes you need to follow to request reimbursement for Medicare cost-sharing amounts if they are owed by your State. You may need to complete a State Provider Registration Process and be entered into the State payment system to bill the State.

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3. Make sure that your billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

**QMB Eligibility and Benefits**

<table>
<thead>
<tr>
<th>Dual Eligibility</th>
<th>Eligibility Criteria</th>
<th>Benefits</th>
</tr>
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</table>
| Qualified Medicare Beneficiary (QMB only) | - Resources cannot exceed $7,280 for a single individual or $10,930 in 2015 for an individual living with a spouse and no other dependents.  
- Income cannot exceed 100% of the Federal Poverty Level (FPL) +$20 ($1,001/month – Individual $1,348/month – Couple in 2015).  
**Note:** These guidelines are a federal floor. Under Section 1902 (r)(2) of the Social Security Act, states can effectively raise these limits above these baseline federal standards. | Medicaid Pays Medicare Part A and B premiums, deductibles, co-insurance and co-pays to the extent required by the State Medicaid Plan.  
- Exempts beneficiaries from Medicare cost-sharing charges  
- The State may choose to pay the Medicare Advantage (Part C) premium. |
| QMB Plus                               | - Meets all of the standards for QMB eligibility as described above, but also meets the financial criteria for full Medicaid coverage | Provides all benefits available to QMBs, as well as all benefits available under the State Plan to a fully eligible Medicaid recipient |

**Additional Information**

For more information about dual eligible categories and benefits, please visit [http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf](http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf) on the Internet. Also, for more information about QMBs and other individuals who are dually eligible to receive Medicare and Medicaid benefits, please refer to the Medicare Learning Network® publication titled “Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles),” which is available on the CMS website.

For general Medicaid information, please visit the Medicaid webpage at [http://www.medicaid.gov/index.html](http://www.medicaid.gov/index.html) on the CMS website.

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### Document History

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<td>February 4, 2016</td>
<td>The article was revised on February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under <em>Important Clarifications Concerning QMB Balance Billing Law</em> on page 3.</td>
</tr>
<tr>
<td>February 1, 2016</td>
<td>The article was revised to include updated information for 2016 and a clarifying note regarding eligibility criteria in the table on page 4.</td>
</tr>
<tr>
<td>March 28, 2014</td>
<td>The article was revised on to change the name of the Coordination of Benefits Contractor (COBC) to Benefits Coordination &amp; Recovery Center (BCRC).</td>
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Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers

Note: This article was revised on February 2, 2016, to reflect an extension of the temporary moratoria for an additional 6 months, as noted in the article. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You
Effective January 29, 2016, the temporary moratoria on new home health agencies, home health agency sub-units, and part B ground ambulance suppliers are being extended for an additional 6 months in certain geographic locations.
CAUTION – What You Need to Know

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

GO – What You Need to Do

Effective January 29, 2016, home health agencies, home health agency sub-units, and part B ground ambulance suppliers should not submit initial enrollment applications or change of information applications to add additional practice locations until the 6-month moratoria has expired. CMS will announce in the Federal Register when the moratorium has been lifted, extended, or changed.

Background

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

On January 29, 2016, CMS announced, in a Federal Register notice (http://federalregister.gov/a/2016-01835), the extension of temporary moratoria on the enrollment of new home health agencies, home health agency sub-units and part B ambulance suppliers in designated geographic locations.

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

Moratoria Extension

Effective January 29, 2016, the temporary moratorium on new home health agencies and home health agency sub-units is being extended for an additional 6 months in the areas stated in Table 1, below.
Table 1: Home Health Agencies and Home Health Agency Sub-units under Temporary Moratorium

<table>
<thead>
<tr>
<th>City and State</th>
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In addition, the temporary moratorium on new part B ground ambulance suppliers is being extended for an additional 6 months in the areas stated in Table 2, below.
Table 2: Part B Ambulance Suppliers Under 6-month Temporary Moratorium

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

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

Additional Information


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

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Provider Enrollment Revalidation - Cycle 2

Provider Types Affected

This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers who are enrolled in Medicare and required to revalidate through their Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs), Medicare Carriers, Fiscal Intermediaries, and the National Supplier Clearinghouse (NSC). These contractors are collectively referred to as MACs in this article.

Provider Action Needed

STOP – Impact to You

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. The Centers for Medicare & Medicaid Services (CMS) has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. In an effort to streamline the revalidation process and reduce provider/supplier burden, CMS has implemented several revalidation processing improvements that are captured within this article.

CAUTION – What You Need to Know

Special Note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers/suppliers should continue to submit changes (for example, changes of ownership, change in practice location or reassignments, final adverse action, changes in authorized or delegated officials or, any other changes) as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

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GO – What You Need to Do

1. Check [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) for the provider/suppliers due for revalidation;

2. If the provider/supplier has a due date listed, CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate. When either of these occur:
   - Submit a revalidation application through Internet-based PECOS located at [https://pecos.cms.hhs.gov/pecos/login.do](https://pecos.cms.hhs.gov/pecos/login.do), the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or
   - Complete the appropriate CMS-855 application available at [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html);
   - If applicable, pay your fee by going to [https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do](https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do); and
   - Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

Background

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. This cycle of revalidation applies to those providers/suppliers that are currently and actively enrolled.

What’s ahead for your next Medicare enrollment revalidation?

Established Due Dates for Revalidation

CMS has established due dates by which the provider/supplier’s revalidation application must reach the MAC in order for them to remain in compliance with Medicare’s provider enrollment requirements. The due dates will generally be on the last day of a month (for example, June 30, July 31 or August 31). Submit your revalidation application to your MAC within 6 months of your due date to avoid a hold on your Medicare payments and possible
deactivation of your Medicare billing privileges. Generally, this due date will remain with the provider/supplier throughout subsequent revalidation cycles.

- The list will be available at [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) and will include all enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a “TBD” (To Be Determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) on the CMS website.

**IMPORTANT:** The list identifies **billing providers/suppliers only that are required to revalidate. If you are enrolled solely to order, certify, and/or prescribe via the CMS-855O application or have opted out of Medicare, you will not be asked to revalidate and will not be reflected on the list.**

- Due dates are established based on your last successful revalidation or initial enrollment (approximately 3 years for DME suppliers and 5 years for all other providers/suppliers).

- In addition, the MAC will send a revalidation notice within 2-3 months prior to your revalidation due date either by email (to email addresses reported on your prior applications) or regular mail (at least two of your reported addresses: correspondence, special payments and/or your primary practice address) indicating the provider/supplier’s due date.

Revalidation notices sent via email will indicate **“URGENT: Medicare Provider Enrollment Revalidation Request”** in the subject line to differentiate from other emails. If all of the emails addresses on file are returned as undeliverable, your MAC will send a paper revalidation notice to at least two of your reported addresses: correspondence, special payments and/or primary practice address.

**NOTE:** Providers/suppliers who are within 2 months of their listed due dates on [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) but have not received a notice from their MAC to revalidate, are encouraged to submit their revalidation application.

- To assist with submitting complete revalidation applications, revalidation notices for individual group members, will list the identifying information of the organizations that the individual reassigns benefits.

**Large Group Coordination**

Large groups (200+ members) accepting reassigned benefits from providers/suppliers identified on the CMS list will receive a letter from their MACs listing the providers linked
to their group that are required to revalidate for the upcoming 6 month period. A spreadsheet detailing the applicable provider’s Name, National Provider Identifier (NPI) and Specialty will also be provided. CMS encourages the groups to work with their practicing practitioners to ensure that the revalidation application is submitted prior to the due date. We encourage all groups to work together as only one application from each provider/supplier is required, but the provider must list all groups they are reassigning to on the revalidation application submitted for processing. MACs will have dedicated provider enrollment staff to assist in the large group revalidations.

Groups with less than 200 reassignments will not receive a letter or spreadsheet from their MAC, but can utilize PECOS or the CMS list available on http://go.cms.gov/MedicareRevalidation to determine their provider/supplier’s revalidation due dates.

Unsolicited Revalidation Submissions

All unsolicited revalidation applications submitted more than 6 months in advance of the provider/supplier’s due date will be returned.

• What is an unsolicited revalidation?
  o If you are not due for revalidation in the current 6 month period, your due date will be listed as “TBD” (To Be Determined). This means that you do not yet have a due date for revalidation. **Please do not submit a revalidation application if there is NOT a listed due date.**
  o Any off-cycle or ad hoc revalidations specifically requested by CMS or the MAC are not considered unsolicited revalidations.

• If your intention is to submit a change to your provider enrollment record, you must submit a ‘change of information’ application using the appropriate CMS-855 form.

Submitting Your Revalidation Application

**IMPORTANT:** Each provider/supplier is required to revalidate their entire Medicare enrollment record.

A provider/supplier’s enrollment record includes information such as the provider’s individual practice locations and every group that benefits are reassigned (that is, the group submits claims and receives payments directly for services provided). This means the provider/supplier is recertifying and revalidating all of the information in the enrollment record, including all assigned NPIs and Provider Transaction Access Numbers (PTANs).

If you are an individual who reassigns benefits to more than one group or entity, you must include all organizations to which you reassign your benefits on one revalidation application. If you have someone else completing your revalidation application for you, encourage coordination with all entities to which you reassign benefits to ensure your reassignments remain intact.

**The fastest and most efficient way to submit your revalidation information is by using the Internet-based PECOS.**
To revalidate via the Internet-based PECOS, go to https://pecos.cms.hhs.gov/pecos/login.do. PECOS allows you to review information currently on file and update and submit your revalidation via the Internet. Once completed, YOU MUST electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper certification statement along with all required supporting documentation to your appropriate MAC IMMEDIATELY.

PECOS ensures accurate and timelier processing of all types of enrollment applications, including revalidation applications. It provides a far superior alternative to the antiquated paper application process.

To locate the paper enrollment applications, refer to https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html on the CMS website.

Getting Access to PECOS:

To use PECOS, you must get approved to access the system with the proper credentials which are obtained through the Identity and Access Management System, commonly referred to as “I&A”. The I&A system ensures you are properly set up to submit PECOS applications. Once you have established an I&A account you can then use PECOS to submit your revalidation application as well as other enrollment application submissions.

To learn more about establishing an I&A account or to verify your ability to submit applications using PECOS, please refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf on the CMS website.

If you have questions regarding filling out your application via PECOS, please contact the MAC that sent you the revalidation notice. You may also find a list of MAC’s at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf on the CMS website.

For questions about accessing PECOS (such as login, forgot username/password) or I&A, contact the External User Services (EUS) help desk at 1-866-484-8049 or at EUSSupport@cgi.com .

Deactivations Due to Non-Response to Revalidation or Development Requests

It is important that you submit a complete revalidation application by your requested due date and you respond to all development requests from your MACs timely. Failure to submit a complete revalidation application or respond timely to development requests will result in possible deactivation of your Medicare enrollment.

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If your application is received substantially after the due date, or if you provide additional requested information substantially after the due date (including an allotted time period for US or other mail receipt) your provider enrollment record may be deactivated. Providers/suppliers deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

**NOTE:** The reactivation date after a period of deactivation will be based on the receipt date of the new full and complete application. Retroactive billing privileges back to the period of deactivation will not be granted. Services provided to Medicare patients during the period between deactivation and reactivation are the provider’s liability.

**Revalidation Timeline and Example**

Providers/suppliers may use the following table /chart as a guide for the sequence of events through the revalidation progression.

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeframe</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revalidation list posted</td>
<td>Approximately 6 months prior to due date</td>
<td>March 30, 2016</td>
</tr>
<tr>
<td>Issue large group notifications</td>
<td>Approximately 6 months prior to due date</td>
<td>March 30, 2016</td>
</tr>
<tr>
<td>MAC sends email/letter notification</td>
<td>75 – 90 days prior to due date</td>
<td>July 2 - 17, 2016</td>
</tr>
<tr>
<td>MAC sends letter for undeliverable emails</td>
<td>75 – 90 days prior to due date</td>
<td>July 2 - 17, 2016</td>
</tr>
<tr>
<td>Revalidation due date</td>
<td></td>
<td>September 30, 2016</td>
</tr>
<tr>
<td>Apply payment hold/issue reminder letter (group members)</td>
<td>Within 25 days after due date</td>
<td>October 25, 2016</td>
</tr>
<tr>
<td>Deactivate</td>
<td>60 – 75 days after due date</td>
<td>November 29 – December 14, 2016</td>
</tr>
</tbody>
</table>

**Application Fees**

Institutional providers of medical or other items or services and suppliers are required to submit an application fee for revalidations. The application fee is $554.00 for Calendar Year (CY) 2016. CMS has defined “institutional provider” to mean any provider or supplier that submits an application via PECOS or a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms.

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All institutional providers (that is, all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit the 2016 enrollment fee (reference 42 CFR 424.514) with their revalidation application. You may submit your fee by ACH debit, or credit card. To pay your application fee, go to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you include this receipt with your uploaded documents on PECOS or mail it to the MAC along with the Certification Statement for the enrollment application. CMS will notify the MAC that the application fee has been paid. Revalidations are processed only when fees have cleared.

**SUMMARY:**

- CMS will post the revalidation due dates for the upcoming revalidation cycle on http://go.cms.gov/MedicareRevalidation for all providers/suppliers. This list will be refreshed periodically. Check this list regularly for updates.

- MACs will continue to send revalidation notices (either by email or mail) within 2-3 months prior to your revalidation due date. When responding to revalidation requests, be sure to revalidate your entire Medicare enrollment record, including all reassignment and practice locations. If you have multiple reassignments/billing structures, you must coordinate the revalidation application submission with all parties.

- If a revalidation application is received but incomplete, the MACs will develop for the missing information. If the missing information is not received within 30 days of the request, the MACs will deactivate the provider/supplier’s billing privileges.

- If a revalidation application is not received by the due date, the MAC may place a hold on your Medicare payments and deactivate your Medicare billing privileges.

- If billing privileges are deactivated, a reactivation will result in the same PTAN but an interruption in billing during the period of deactivation. This will result in a gap in coverage.

- If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.

**Additional Information**

To find out whether a provider/supplier has been mailed a revalidation notice go to http://go.cms.gov/MedicareRevalidation on the CMS website.

A sample revalidation letter is available at http://www.cms.gov/Medicare/Provider-Enrollment-and-

For more information about the enrollment process and required fees, refer to MLN Matters® Article MM7350, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf on the CMS website.

For more information about the application fee payment process, refer to MLN Matters Article SE1130, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1130.pdf on the CMS website.

The MLN fact sheet titled “The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations” is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf on the CMS website.

To access PECOS, your Authorized Official must register with the PECOS Identification and Authentication system. To register for the first time go to https://pecos.cms.hhs.gov/pecos/PecosIAConfirm.do?transferReason=CreateLogin to create an account.

For additional information about the enrollment process and Internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment webpage at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html on the CMS website.

If you have questions, contact your MAC. Medicare provider enrollment contact information for each State can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf on the CMS website.

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Guidance on the Physician Quality Reporting System (PQRS) 2014 Reporting Year and 2016 Payment Adjustment for Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and Critical Access Hospitals (CAHs)

Provider Types Affected

This article is intended for Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and Critical Access Hospitals (CAHs) who submit claims to Medicare Administrative Contractors (MACs) for services furnished to Medicare beneficiaries.

What You Need to Know

In this informational article the Centers for Medicare & Medicaid Services (CMS) provides answers to some frequently asked questions raised by staff at RHCs, FQHCs, and CAHs.

Frequently Asked Questions - RHCs and FQHCs

Question:
If I furnish professional Medicare Part B services only at an RHC or an FQHC, are the services eligible for PQRS?

Answer:
If you bill professional services paid under or based on the Part B Medicare Physician Fee Schedule (PFS) submitted via CMS-1500 or CMS-1450 claim form or the electronic equivalents 837P and 837I, you are considered a PQRS Eligible Professional (EP) and you are subject to PQRS analysis. Technical services, which are covered under Part B Medicare PFS, are not eligible for PQRS.
Additionally, services rendered under billing methodologies other than Part B Medicare PFS will not be included in PQRS analysis (that is, an EP who bills under an organization that is registered as a Federally Qualified Health Center [FQHC], yet he or she renders services that are not covered by the FQHC methodology).

The “2015 Physician Quality Reporting System List of Eligible Professionals” is available on the CMS website.

Question:
I’m an EP and I furnish professional Medicare Part B services at an RHC/FQHC and also furnish services at a non-RHC/FQHC setting. Are the non-RHC/FQHC services eligible for the 2016 PQRS negative payment adjustment?

Answer:
If an eligible PQRS EP renders services under the Medicare PFS in addition to services under other billing schedules or methodologies, he or she must meet the PQRS reporting requirements for those services that fall under the Medicare PFS to avoid future payment adjustments regardless of the organization’s participation in other fee schedules or methodologies.

Question:
Under what circumstances are professional Part B Medicare PFS services furnished by an EP at a setting outside an RHC/FQHC subject to the 2016 PQRS 2.0 percent negative payment adjustment?

Answer:
An EP is subject to the 2016 PQRS 2.0 percent negative payment adjustment if he or she has not satisfactorily reported 2014 PQRS quality measures as required by the EP’s selected reporting mechanism (that is, as an individual EP or as an EP who is a part of a PQRS group practice).

For more information about the 2016 PQRS 2.0 percent negative payment adjustment, visit Physician Quality Reporting System Payment Adjustment Information on the CMS website.

To find timeline information, refer to the “2015 – 2017 Physician Quality Reporting System (PQRS) Timeline” on the CMS website.

To find general PQRS information, including information about payment adjustments, visit Physician Quality Reporting System on the CMS website.

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Frequently Asked Questions - CAHs

Question:
I’m an EP who furnishes professional Medicare Part B services at a CAH and the CAH is paid under the Optional Payment Method (Method II). Are my services eligible for PQRS?

Answer:
Yes, beginning in 2014, EPs at CAHs who bill Medicare Part B using Method II can participate in PQRS (and the Electronic Health Record [EHR] Incentive Program) if they add their Individual National Provider Identifier (NPI) on the CMS-1450 Institutional Claim form (not the CMS-1500 form). For the 5010 version of the 837 I, Fiscal Intermediary Shared System (FISS) shall accept rendering physician/practitioner information at the line level (loop 2420A) or at the claim level if the rendering physician/practitioner is different from the attending physician/practitioner (loop 2310D).

For the 2014 PQRS program year, EPs who bill using CAH Method II will not be able to report via the claims-based reporting mechanism as the claims system needed to be updated to pull PQRS Quality-Data Codes (QDCs) off the 1450 claim form and only pulled off of the CMS 1500 claim form in 2014. However, EPs who bill using CAH Method II will be able to report PQRS via Registry, EHR, Qualified Clinical Data Registry (QCDR), and Group Practice Reporting Option (GPRO).

If you need assistance determining whether or not your provided services are included in PQRS measures, please contact the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) or via qnetsupport@hcqis.org. The QualityNet Help Desk is available from 7:00 a.m. to 7:00 p.m. Central Time, Monday through Friday.

Question:
I’m a CAH provider paid under Method II. Am I required to report line-item rendering NPI information?

Answer:
Yes, a CAH provider paid under Method II is required to report the rendering NPI at the line level if it is different from the rendering NPI at the claim level. For more information about this billing standard requirement, refer to “Fiscal Intermediary Shared System (FISS) and Common Working File (CWF) System Enhancement for Storing Line Level Rendering Physicians/Practitioners National Provider Identifier (NPI) Information” on the CMS website.
**Additional Information**

For additional information about PQRS, visit [Physician Quality Reporting System](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/EducationalResources.html) on the CMS website.


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

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Centers for Medicare & Medicaid Services
Articles for Part A Providers
Reclassification of Certain Durable Medical Equipment HCPCS Codes Included in Competitive Bidding Programs (CBP) from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category

Provider Types Affected

This MLN Matters® Article is intended for suppliers and Home Health Agencies (HHAs) submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Home Health & Hospice MACs for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provided to Medicare beneficiaries.

What You Need to Know

Change request (CR)8822 provides instructions for the upcoming reclassification of certain Durable Medical Equipment (DME) Healthcare Common Procedure Coding System (HCPCS) codes, that are included in Round 2 and Round 1 Re-compete DMEPOS CBPs, from the inexpensive and routinely purchased DME payment category to the capped rental DME payment category.

CR 8822 follows CR 8566, Rescind and Replace of CR 8409: Reclassification of Certain Durable Medical Equipment from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category, which was released on March 25, 2014. You can find the associated MLN Matters® article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8566.pdf on the CMS website. Make sure your billing staffs are aware of these changes.

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Background

Medicare defines routinely purchased DME (set forth at 42 CFR §414.220(a)(2)) as equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987. A review of expensive items that have been classified as routinely purchased equipment since 1989 (that is, new codes added to the HCPCS after 1989 for items costing more than $150) showed inconsistencies in applying the definition.

As a result, a review of the definition of routinely purchased DME was published in the Federal Register (CMS-1526-F) along with notice of DME items (codes) requiring a revised payment category. Also in that rule, the Centers for Medicare & Medicaid Services (CMS) established that DME wheelchair accessories that are capped rental items furnished for use as part of a complex rehabilitative power wheelchair (wheelchair base codes K0835 – K0864), will be paid under the associated lump sum purchase option set forth at 42 CFR § 414.229(a)(5) and section 1834(a)(7)(A)(iii) of the Social Security Act. If the beneficiary declines the purchase option, the supplier must furnish the items on a capped rental basis and payment will be made on a monthly rental basis in accordance with the capped rental payment rules.

In order to align the payment category with the required regulatory definition, the HCPCS codes in the table below will reclassify to the capped rental payment category effective:

- July 1, 2016: Items furnished in all areas except the nine Round 1 Re-compete CBAs; and
- January 1, 2017: Items furnished in the nine Round 1 Re-compete CBAs.

### HCPCS Codes for Items Reclassified to Capped Rental DME Category

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0197</td>
<td>Support Surfaces</td>
</tr>
<tr>
<td>E0140, E0149</td>
<td>Walkers</td>
</tr>
<tr>
<td>E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070</td>
<td>Wheelchairs Options/Accessories</td>
</tr>
<tr>
<td>E0955</td>
<td>Wheelchair Seating</td>
</tr>
</tbody>
</table>

### Further Details from CR8822:

1. In Round 1 Re-compete CBAs, payment for HCPCS codes shown in the above table will be made under the inexpensive and routinely purchased (IN) payment category for dates of service July 1, 2016 through December 31, 2016. Your MAC will recognize that the capped payment category requires payment of 10 percent of the purchase price for the first three months and 7.5 percent for each of the remaining rental months 4 through 13. You should also be aware that payment amounts will be based on the lower of the supplier’s actual charge and the fee schedule amount. Your MAC will return as

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unprocessable claims for the inexpensive and routinely purchased codes described above that are billed with the KH, KI and KJ modifiers. Such unprocessable claims will be returned with Claim Adjustment Reason Code (CARC) 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.), Remittance Advice Remark Code (RARC) N519 (Invalid combination of HCPCS modifiers) and Group Code CO (Contractual Obligation).

2. Effective for claims with dates of service on or after July 1, 2016, for items furnished in Round 2 CBAs, your MAC will cease any IN category rental payments for the codes in the above table and start payment under the Capped Rental (CR) payment category; applying a determination of the number of rental months paid (which cannot exceed 13 rental months combined from dates of service before and after the effective date (July 1, 2016)).

3. Effective for claims with dates of service on or after January 1, 2017, for items furnished in Round 1 Re-compete CBAs, your MAC will cease any IN rental payments for these codes, and start payment under the Capped Rental (CR) payment category; applying a determination of the number of rental months paid (which cannot exceed 13 rental months combined from dates of service before and after the effective date (January 1, 2017)).

4. Effective July 1, 2016, in all areas except the nine Round 1 CBAs, your MACs will process and pay claims for wheelchair base codes K0835 – K0864): E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955 (when applicable) on a lump sum purchase basis when used with complex rehabilitative power wheelchairs.

5. Effective January 1, 2017 in all areas including the Round 1 Re-compete CBAs, your MACs will process and pay claims for the codes K0835 – K0864): E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955 (when applicable) on a lump sum purchase basis when used with complex rehabilitative power wheelchairs.

6. When Home Health/Hospice providers (HHHs) bill codes E0197, E0140, E0149, E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070 and E0955 for services outside a competitive bid area on or after July 1, 2016, payment will be made on a capped rental basis.

7. When HHHs bill E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955 for services outside a competitive bid area on or after July 1, 2016, MACs will process such claims on a lump sum purchase basis, where applicable, when used with a complex rehabilitative wheelchair base (K0835-K0864).
**Additional Information**


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

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Required Billing Updates for Rural Health Clinics

Note: This article was revised on February 10, 2016, to add examples 5 and 6 on page 5 and to correct the language regarding the coinsurance amount in the text under “Coinsurance” on page 6. All other information is unchanged

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

Change Request (CR) 9269 provides instructions to the MACs to accept Healthcare Common Procedure Coding System (HCPCS) coding on RHC claims.

CAUTION – What You Need to Know

Effective April 1, 2016, RHCs, including RHCs exempt from electronic reporting under Section 424.32(d)(3), are required to report the appropriate HCPCS code for each service line along with the revenue code, and other required billing codes. Payment for RHC services will continue to be made under the All-Inclusive Rate (AIR) system when all of the program requirements are met. There is no change to the AIR system and payment...
methodology, including the “carve out” methodology for coinsurance calculation, due to this reporting requirement.

GO – What You Need to Do

Make sure that your billing staffs are aware of these RHC-related changes for 2016.

Background

Beginning on April 1, 2005, through December 31, 2010, RHCs billing under the AIR system were not required to report HCPCS coding when billing for RHC services, absent a few exceptions. Generally, it has not been necessary to require reporting of HCPCS since the AIR system was designed to provide payment for all of the costs associated with an encounter for a single day.

Provisions of the Affordable Care Act of 2010 further modified the billing requirements for RHCs. Effective January 1, 2011, Section 4104 of the Affordable Care Act waived the coinsurance and deductible for the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and other Medicare covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. In accordance with this provision, RHCs have been required to report HCPCS codes when furnishing certain preventive services since January 1, 2011.

CMS regulations require covered entities to report standard medical code sets for electronic health care transactions, although CMS program instructions have directed RHCs to submit HCPCS codes only for preventive services. Such standard medical code sets are defined as Level I and Level II of the HCPCS. In the CY 2016 Physician Fee Schedule (PFS) proposed rule (80 FR 41943), CMS proposed that all RHCs, including RHCs exempt from electronic reporting under Section 424.32(d)(3), be required to submit HCPCS and other codes as required on claims for services furnished. The requirements for RHCs to submit HCPCS codes were finalized in the CY 2016 PFS final rule with comment period (80 FR 71088).

CR9269 Changes

Basic Guidelines on RHC Visits and Billing for 71X Types of Bills (TOBs)

An RHC visit is defined as a medically necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and an RHC practitioner during which time one or more RHC services are furnished. A Transitional Care Management (TCM) service can also be an RHC visit. Additional information on what constitutes a RHC visit can be found in the “Medicare Benefit Policy Manual,” Chapter 13.

Qualified preventive health services include the IPPE, the AWV, and other Medicare covered preventive services recommended by the USPSTF with a grade of A or B. For a complete list of preventive services and their coinsurance and deductible requirements, see

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the “RHC Preventive Services Chart” on the CMS RHC webpage at: https://www.cms.gov/center/provider-type/rural-health-clinics-center.html on the CMS website.

Beginning on April 1, 2016, RHCs are required to report the appropriate HCPCS code for each service line along with a revenue code on their Medicare claims. RHC qualifying medical visits are typically Evaluation and Management (E/M) type of services or screenings for certain preventive services. RHC qualifying mental health visits are typically psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis. Refer to the RHC Qualifying Visit List below for a list of HCPCS codes that are defined as qualifying visits, which corresponds with the following guidance on service level information. Updates to the qualifying visit list are generally made on a quarterly basis and posted on the CMS RHC webpage. RHCs can subscribe to the center page for email updates.

Service Level Information:

- The professional component of qualifying medical services and approved preventive health services are billed under revenue code 052X.
- Qualifying mental health services are billed under revenue code 0900.
- Telehealth originating site facility fees are billed under revenue code 0780.

Billing Qualifying Visits under the HCPCS Reporting Requirement

Medical Services

RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the RHC Qualifying Visit List. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line.

Example 1:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS</th>
<th>Service Date</th>
<th>Service Units</th>
<th>Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>992131</td>
<td>04/01/2016</td>
<td>1</td>
<td>$XX.XX</td>
<td>AIR</td>
<td>Yes</td>
</tr>
</tbody>
</table>

1HCPCS code from the RHC Qualifying Visit List
2Any date of service on or after 04/01/2016
3Enter charge amount

Medical Services and Preventive Services

If an approved preventive service is furnished with a medical visit, the RHC shall report the preventive service on an additional 052X service line with the associated charges.

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Preventive services furnished with a medical visit are ineligible to receive an additional encounter payment at the AIR, except for the IPPE.

**Example 2:**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS</th>
<th>Service Date</th>
<th>Service Units</th>
<th>Total Charges</th>
<th>Payment</th>
<th>Coinsurance/ Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>99213</td>
<td>04/01/2016</td>
<td>1</td>
<td>$XX.XX</td>
<td>AIR</td>
<td>Yes</td>
</tr>
<tr>
<td>052X</td>
<td>G0101</td>
<td>04/01/2016</td>
<td>1</td>
<td>$XX.XX</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

1. HCPCS code from the RHC Qualifying Visit List  
2. Any date of service on or after 04/01/2016  
3. Enter charge amount

See the *Coinsurance* section below for information applicable to Example 2.

**Preventive Services**

When a preventive health service is the only qualifying visit reported for the encounter, the payment and applicable coinsurance and/or deductible will be based upon the associated charges for this service line. Frequency edits will apply.

**Example 3:**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS</th>
<th>Service Date</th>
<th>Service Units</th>
<th>Total Charges</th>
<th>Payment</th>
<th>Coinsurance/ Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>G0101</td>
<td>04/01/2016</td>
<td>1</td>
<td>$XX.XX</td>
<td>AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

1. Any date of service on or after 04/01/2016  
2. Enter charge amount  
3. Coinsurance and deductible are waived when appropriate

**Mental Health Services**

RHCs shall report one service line per mental health encounter/visit with revenue code 0900 and a qualifying mental health visit from the RHC Qualifying Visit List.

**Example 4:**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS</th>
<th>Service Date</th>
<th>Service Units</th>
<th>Total Charges</th>
<th>Payment</th>
<th>Coinsurance/ Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>0900</td>
<td>90834</td>
<td>04/01/2016</td>
<td>1</td>
<td>$XX.XX</td>
<td>AIR</td>
<td>Yes</td>
</tr>
</tbody>
</table>

1. HCPCS code from the RHC Qualifying Visit List  
2. Any date of service on or after 04/01/2016  
3. Enter charge amount

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**Multiple Medical Services**

RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the RHC Qualifying Visit List, and one service line for each additional medical service.

**Example 5:**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS</th>
<th>Service Date</th>
<th>Service Units</th>
<th>Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>99213</td>
<td>04/01/2016</td>
<td>1</td>
<td>$XX.XX</td>
<td>AIR</td>
<td>Yes</td>
</tr>
<tr>
<td>052X</td>
<td>12002</td>
<td>04/01/2016</td>
<td>1</td>
<td>$XX.XX</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

1. HCPCS code from the RHC Qualifying Visit List  
2. Any date of service on or after 04/01/2016  
3. Enter charge amount

**Medical Services and Incident to Services**

Services and supplies furnished incident to a RHC visit are considered RHC services. They are included in the payment of a qualifying visit and are not separately billable. The qualifying visit line must include the total charges for all the services provided during the encounter/visit. RHCs can report incident to services using all valid revenue codes except 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x. Payment for these service lines is included in the AIR and the service lines will receive CARC 97 for the covered lines not receiving the AIR payment on RHC claims.

**Example 6:**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS</th>
<th>Service Date</th>
<th>Service Units</th>
<th>Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>99213</td>
<td>04/01/2016</td>
<td>1</td>
<td>$XX.XX</td>
<td>AIR</td>
<td>Yes</td>
</tr>
<tr>
<td>0300</td>
<td>36415</td>
<td>04/01/2016</td>
<td>1</td>
<td>$XX.XX</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

1. HCPCS code from the RHC Qualifying Visit List  
2. Any date of service on or after 04/01/2016  
3. Enter charge amount

**Billing for Multiple Visits on the Same Day**

Encounters with more than one RHC practitioner on the same day, or multiple encounters with the same RHC practitioner on the same day, constitute a single RHC visit and is payable as one visit, except for the following circumstances:
• The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC for treatment). The subsequent medical service should be billed using a qualifying visit, revenue code 052X, and modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day and that the condition being treated was not present during the visit earlier in the day. This is the only circumstance in which modifier 59 should be used.

• The patient has a qualifying medical visit and a qualifying mental health visit on the same day. The RHC shall follow the guidelines in the Billing Qualifying Visits under the HCPCS Reporting Requirement section of this article to bill for a medical and mental health visit.

• The patient has an IPPE and a separate medical and/or mental health visit on the same day. IPPE is a once in a lifetime benefit and is billed using HCPCS code G0402 and revenue code 052X. The beneficiary coinsurance and deductible are waived.

Coinsurance

When reporting a qualifying medical visit and an approved preventive service, the 052X revenue line with the qualifying medical visit must include the total charges for all of the services provided during the encounter, minus any charges for the approved preventive service.

The charges for the approved preventive service must be deducted from the qualifying medical visit line for the purposes of calculating beneficiary coinsurance correctly. For example, if the total charge for the visit is $150.00, and $50.00 of that is for a qualified preventive service, the beneficiary coinsurance is based on $100.00 of the total charge.

Returned Claims

MACs will return to the RHC all claims with service lines that do not contain a valid HCPCS code. MACs will also return to the RHC all claims that contain more than one qualifying visit HCPCS code (from the RHC Qualifying Visit List) billed under revenue code 052X for medical service lines (excluding approved preventive services and modifier 59) and mental health services billed under revenue code 0900 with the same date of service.

For any service lines not receiving the AIR payment on RHC claims, the following remittance codes will be used:

• Group code CO- Contractual obligation;
• 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; and

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• RARC M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

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

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 10, 2016</td>
<td>The article was revised to add examples 5 and 6 on page 5 and to correct the language regarding the coinsurance amount in the text under “Coinsurance” on page 6.</td>
</tr>
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</table>

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RHC Qualifying Visit List

**Medical Services**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>92002</td>
<td>Eye exam new patient</td>
</tr>
<tr>
<td>92004</td>
<td>Eye exam new patient</td>
</tr>
<tr>
<td>92012</td>
<td>Eye exam establish patient</td>
</tr>
<tr>
<td>92014</td>
<td>Eye exam&amp;tx estab pt 1/&gt;vst</td>
</tr>
<tr>
<td>99201</td>
<td>Office/outpatient visit new</td>
</tr>
<tr>
<td>99202</td>
<td>Office/outpatient visit new</td>
</tr>
<tr>
<td>99203</td>
<td>Office/outpatient visit new</td>
</tr>
<tr>
<td>99204</td>
<td>Office/outpatient visit new</td>
</tr>
<tr>
<td>99205</td>
<td>Office/outpatient visit new</td>
</tr>
<tr>
<td>99212</td>
<td>Office/outpatient visit est</td>
</tr>
<tr>
<td>99213</td>
<td>Office/outpatient visit est</td>
</tr>
<tr>
<td>99214</td>
<td>Office/outpatient visit est</td>
</tr>
<tr>
<td>99215</td>
<td>Office/outpatient visit est</td>
</tr>
<tr>
<td>99304</td>
<td>Nursing facility care init</td>
</tr>
<tr>
<td>99305</td>
<td>Nursing facility care init</td>
</tr>
<tr>
<td>99306</td>
<td>Nursing facility care init</td>
</tr>
<tr>
<td>99307</td>
<td>Nursing fac care subseq</td>
</tr>
<tr>
<td>99308</td>
<td>Nursing fac care subseq</td>
</tr>
<tr>
<td>99309</td>
<td>Nursing fac care subseq</td>
</tr>
<tr>
<td>99310</td>
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</tr>
<tr>
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<td>Nursing fac discharge day</td>
</tr>
<tr>
<td>99316</td>
<td>Nursing fac discharge day</td>
</tr>
<tr>
<td>99318</td>
<td>Annual nursing fac assessmnt</td>
</tr>
<tr>
<td>99324</td>
<td>Domicil/r-home visit new pat</td>
</tr>
<tr>
<td>99325</td>
<td>Domicil/r-home visit new pat</td>
</tr>
<tr>
<td>99326</td>
<td>Domicil/r-home visit new pat</td>
</tr>
<tr>
<td>99327</td>
<td>Domicil/r-home visit new pat</td>
</tr>
<tr>
<td>99328</td>
<td>Domicil/r-home visit new pat</td>
</tr>
<tr>
<td>99334</td>
<td>Domicil/r-home visit est pat</td>
</tr>
<tr>
<td>99335</td>
<td>Domicil/r-home visit est pat</td>
</tr>
<tr>
<td>99336</td>
<td>Domicil/r-home visit est pat</td>
</tr>
<tr>
<td>99337</td>
<td>Domicil/r-home visit est pat</td>
</tr>
<tr>
<td>99341</td>
<td>Home visit new patient</td>
</tr>
</tbody>
</table>

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### Approved Preventive Health Services

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0101</td>
<td>Ca screen; pelvic/breast exam</td>
</tr>
<tr>
<td>G0102*</td>
<td>Prostate ca screening; dre</td>
</tr>
<tr>
<td>G0117*</td>
<td>Glaucoma scrn hgh risk direc</td>
</tr>
<tr>
<td>G0118*</td>
<td>Glaucoma scrn hgh risk direc</td>
</tr>
<tr>
<td>G0296</td>
<td>Visit to determ LDCT elig</td>
</tr>
<tr>
<td>G0402</td>
<td>Initial preventive exam</td>
</tr>
<tr>
<td>G0436</td>
<td>Tobacco-use counsel 3-10 min</td>
</tr>
<tr>
<td>G0437</td>
<td>Tobacco-use counsel &gt;10</td>
</tr>
<tr>
<td>G0438</td>
<td>Ppps, initial visit</td>
</tr>
<tr>
<td>G0439</td>
<td>Ppps, subseq visit</td>
</tr>
<tr>
<td>G0442</td>
<td>Annual alcohol screen 15 min</td>
</tr>
<tr>
<td>G0443</td>
<td>Brief alcohol misuse counsel</td>
</tr>
<tr>
<td>G0444</td>
<td>Depression screen annual</td>
</tr>
<tr>
<td>G0445</td>
<td>High inten beh couns std 30 min</td>
</tr>
<tr>
<td>G0446</td>
<td>Intens behave ther cardio dx</td>
</tr>
<tr>
<td>G0447</td>
<td>Behavior counsel obesity 15 min</td>
</tr>
<tr>
<td>Q0091</td>
<td>Obtaining screen pap smear</td>
</tr>
</tbody>
</table>

*Coinsurance and deductible are not waived*
**Mental Health Services**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>Psych diagnostic evaluation</td>
</tr>
<tr>
<td>90792</td>
<td>Psych diag eval w/med srvcs</td>
</tr>
<tr>
<td>90832</td>
<td>Psytx pt&amp;/family 30 minutes</td>
</tr>
<tr>
<td>90834</td>
<td>Psytx pt&amp;/family 45 minutes</td>
</tr>
<tr>
<td>90837</td>
<td>Psytx pt&amp;/family 60 minutes</td>
</tr>
<tr>
<td>90839</td>
<td>Psytx crisis initial 60 min</td>
</tr>
<tr>
<td>90845</td>
<td>Psychoanalysis</td>
</tr>
</tbody>
</table>

Effective January 1, 2016, CPT code 99490 (chronic care management) is paid based on the PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC claim.
Revision to Fiscal Intermediary Shared System (FISS) Lab Travel Allowance Editing to Include New Specimen Collection Code G0471

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9471, from which this article was developed, updates Fiscal Intermediary Shared System (FISS) reason code 32436 to include HCPCS code G0471 in the list of specimen collection fee codes that will allow the travel allowance to be paid on outpatient claims. Notify your MAC if your claims for lab travel allowance (HCPCS codes P9603 or P9604), for dates of service on or after April 1, 2014, were returned or rejected when billed with specimen collection fee HCPCS code G0471.

Background

Medicare covers a specimen collection fee and travel allowance for laboratories that collect samples from nursing home or homebound patients (see detail in Chapter 16, Section 60.2 of the “Medicare Claims Processing Manual”). FISS reason code 34236 requires a specimen collection fee Healthcare Common Procedure coding System (HCPCS) code to be present on all outpatient claims when a lab travel allowance HCPCS (P9603 or P9604) is also present.

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CR8837, issued August 29, 2014, provided instructions for adjusting payment for a sample collected from an individual in a Skilled Nursing Facility (SNF) or by a laboratory on behalf of a Home Health Agency (HHA). CR9471 implements a new HCPCS code for specimen collection, G0471 – “Collection of venous blood by Venipuncture or urine sample by catheterization from an individual in a Skilled Nursing Facility (SNF) or by a laboratory on behalf of a Home Health Agency (HHA).” It has come to CMS’ attention that claims for lab travel allowance codes P9603 and P9604 are being Returned to Providers (RTP) when billed with G0471.

CR9471 updates FISS reason code 32436 to include HCPCS code G0471 in the list of specimen collection fee codes that will allow the lab travel allowance to be paid on outpatient claims.

**Note:** Upon implementation of CR9471, your MAC will:

- Reprocess claims that are brought to their attention for dates of service on and after April 1, 2014, which were previously returned to you in error.
- Override timely filing, if necessary, to reprocess claims previously returned to you in error.

**Additional Information**


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

MLN Matters® Number: MM9489
Related Change Request (CR) #: CR 9489

Related CR Release Date: February 4, 2016
Effective Date: Dates of service on or after January 1, 2016 for Maryland hospitals; Dates of service on or after July 1, 2016, for rehabilitation agencies and CORFs

Related CR Transmittal #: R3454CP
Implementation Date: July 5, 2016

Correction to Applying Therapy Caps to Maryland Hospitals and Billing Requirement for Rehabilitation Agencies and Comprehensive Outpatient Rehabilitation Facilities (CORFs)

Provider Types Affected
This MLN Matters® Article is intended for Rehabilitation Agencies and Comprehensive Outpatient Rehabilitation Facilities (CORFs) and to Maryland hospitals that provide therapy services and submit claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9489 contains no new policy. It corrects the implementation of the policy established in CR9223.

- Modifies the requirements of CR9223 to ensure therapy caps are applied correctly to claims from certain Maryland hospitals. This does not constitute a change in policy for Maryland hospitals.
- Adds instructions to the “Medicare Claims Processing Manual” to clarify billing requirements for rehabilitation agencies and CORFs when these providers operate multiple sites in differing payment localities.

Make sure your billing staffs are aware of these changes and clarifications.

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**Background**

CR9223 applied the therapy caps and related policies to Maryland outpatient hospital claims (Types of Bill (TOB) 012x and 013x submitted with CMS Certification Numbers (CCNs) beginning with 21). The CR applied cap amounts based on the submitted charge amount on covered outpatient therapy service lines, before applying coinsurance or deductible. This is the correct application of the cap amounts for the majority of Maryland hospitals.

Certain specialty hospitals in Maryland are not paid under the Maryland All-Payer Model. These hospitals are paid for therapy services using the Medicare Physician Fee Schedule (MPFS) amounts. The therapy cap amounts for these claims should be the MPFS amount, before applying coinsurance or deductible, not the submitted charge. Since these hospitals also have CCNs beginning with 21, the implementation of CR9223 caused Medicare systems to begin using the submitted charge amount instead.

As a result of this error, the therapy cap and threshold total for beneficiaries served by these specialty hospitals is incorrect. In many cases the totals may be overstated. The requirements in CR9489 correct the error in Medicare systems and instruct the MACs to adjust claims to correct the therapy cap totals for affected beneficiaries. These adjustments will be made within 30 days of the implementation date of CR9489.

In addition, CR9489 adds instructions to the “Medicare Claims Processing Manual” to add a new billing requirement for rehabilitation agencies and CORFs when these providers operate multiple sites in differing payment localities as determined by the MPFS. These MPFS payment localities are determined by the 9-digit ZIP code where services are provided. Specifically, when rehabilitation agencies and CORFs furnish a service in an off-site location that is in a different 9-digit ZIP code from that of the primary or parent location, the off-site location ZIP code must be reported on the claim. Since these providers are paid subject to the MPFS, the new billing requirement ensures that payments are adjusted based on the applicable payment locality. Until now, rehabilitation agencies and CORFs did not have a mechanism to accurately report the 9-digit ZIP code for the services they provide in off-site locations with differing payment localities. Where a rehabilitation agency or CORF has only one service location, the ZIP code of the primary site of record is used as the MPFS payment locality.

**Additional Information**


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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.
MLN Matters® Number: MM9523  
Related Change Request (CR) #: CR 9523
Related CR Release Date: February 4, 2016  
Effective Date: January 1, 2016
Related CR Transmittal #: R3449CP  
Implementation Date: April 4, 2016

Off-Cycle Update to the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2016 Pricer

Provider Types Affected

This MLN Matters® Article is intended for hospitals submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries and which are paid using the Fiscal Year (FY) 2016 Inpatient Prospective Payment System (IPPS) Pricer.

Provider Action Needed

Change Request (CR) 9523 implements changes to the FY 2016 IPPS Pricer in compliance with Section 601 of the Consolidated Appropriations Act 2016. Make sure that your billing staff are aware of these changes.

Background

On December 18, 2015, the Consolidated Appropriations Act, 2016 was signed into law. As part of that act, Section 601 - Modification of Medicare Inpatient Hospital Payment Rate for Puerto Rico Hospitals modifies the payment calculation with respect to operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for discharges on or after January 1, 2016.

The amount of the payment (with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges on or after January 1, 2016) will be based on 100 percent of the national standardized amount. Puerto Rico hospitals will no longer be paid with a Puerto Rico specific standardized amount.

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At this time, there are no changes to the IPPS payment calculation for capital-related costs of inpatient hospital services of Puerto Rico hospitals, and the capital IPPS payment for Puerto Rico hospitals for all discharges occurring during FY 2016 continue to be based on a blend of 25 percent of the capital IPPS Puerto Rico rate and 75 percent of the capital IPPS Federal rate.

The IPPS FY 2016 Pricer will include conforming changes to certain FY 2016 IPPS operating rates and factors that result from the application of the new Puerto Rico hospital operating IPPS payment calculation requirement. These changes are applicable to all IPPS hospital discharges on or after January 1, 2016. MACs will reprocess all IPPS claims with a discharge date on or after 01/01/16 through the implementation of the revised Pricer by May 31, 2016.

In addition, new state code '84' for Puerto Rico (assigned in CR 9300 will be added to the IPPS Pricer.

Also, In the Calendar Year (CY) 2016 Outpatient PPS Final Rule (and implemented in CR 9408, Transmittal 3390, issued November 2, 2015), the Centers for Medicare & Medicaid Services (CMS) provided for a transition period for certain former Medicare-Dependent, Small Rural Hospitals (MDHs) to mitigate the financial impact of losing MDH status in FY 2015 as a result of the loss of their rural status under the new OMB delineations. Under this transitional payment, for FY 2016 discharges occurring on or after January 1, 2016, through September 30, 2016, qualifying former MDHs receive an add-on payment equal to two-thirds of “the MDH add-on” (that is, two-thirds of 75 percent of the amount by which the Federal rate payment is exceeded by the hospital’s hospital-specific rate payment). The Pricer logic for hospitals that CMS identified as qualifying for this add-on payment for FY 2016 has been revised to correct an inadvertent technical error in the calculation of certain payment amounts for such hospitals.

MACs will reprocess all inpatient claims from the former MDHs that CMS identified as eligible for the transition payment (as described in CR 9408) with a discharge date on or after 10/1/2015 through the implementation of the revised FY 2016 IPPS Pricer in CR9523 by May 31, 2016.

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.
Off-Cycle Update to the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Fiscal Year (FY) 2016 Pricer

Provider Types Affected

This MLN Matters® Article is intended for hospitals that submit claims to Medicare Administrative Contractors (MACs) for inpatient hospital services provided to Medicare beneficiaries and paid for under the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) using the LTCH PPS Fiscal Year (FY) 2016 Pricer.

Provider Action Needed

Change Request (CR) 9527 updates certain rates and factors used in the Inpatient Prospective Payment System (IPPS) Comparable Amount calculation in the LTCH PPS FY 2016 Pricer applicable to discharges occurring on or after January 1, 2016. It also updates the LTCH PPS FY 2016 high-cost outlier fixed-loss amount for site-neutral rate discharges, and modifies the IPPS Comparable Amount calculation for Puerto Rico hospitals consistent with the new IPPS payment requirement. Please make sure your billing staffs are aware of these updates.

Background

Section 601 of Public Law 114-113, The Consolidated Appropriations Act of 2016, modified the IPPS payment calculation with respect to operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges on or after January 1, 2016, to use 100 percent of the applicable Federal payment rate. Certain payment adjustments under the LTCH PPS are calculated using IPPS payment rates and factors, which are updated as a result of this new IPPS payment calculation requirement.
In addition, new state code “84” for Puerto Rico (assigned in CR 9300) will be added to the LTCH Pricer.

CR9527:

- Updates certain rates and factors in the LTCH PPS FY 2016 Pricer used in the calculation of the IPPS Comparable Amount under Section 412.529(d)(4), which is used to determine Short-Stay Outlier (SSO)-adjusted standard Federal rate payment amounts and site neutral payment rate amounts;
- Updates the LTCH PPS FY 2016 high-cost outlier fixed-loss amount for site-neutral rate discharges to $22,538, which is the same as the updated IPPS outlier fixed-loss cost threshold for FY 2016; and
- Modifies the IPPS Comparable Amount calculation for Puerto Rico hospitals consistent with the new IPPS payment requirement.

The updated LTCH PPS payment rate and factor changes are applicable to discharges occurring on or after January 1, 2016. Your MAC will reprocess all LTCH inpatient claims with a discharge date on or after January 1, 2016, through the implementation of the Pricer revised by CR9527 by May 31, 2016.

The Centers for Medicare & Medicaid Services (CMS) reminds providers that fiscal year changes to the LTCH PPS system occur annually in October. Specific instructions will be published shortly after the publication of the LTCH Final Rule each year. In addition, other changes to the LTCH PPS system may occur in January, April, or July, as necessary.

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.
MLN Matters® Number: MM9543  Related Change Request (CR) #: CR 9543
Related CR Release Date: February 19, 2016  Effective Date: January 1, 2016
Related CR Transmittal #: R54QRI  Implementation Date: April 1, 2016

Fiscal Year 2017 and After Payments to Inpatient Rehabilitation Facilities (IRFs) That Do Not Submit Required Quality Data - This CR Rescinds and Fully Replaces CR9106

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9543 advises IRFs of changes and clarifications to the payment reduction reconsideration process for Fiscal Year (FY) 2017 and after. Make sure that your billing staffs are aware of these changes.

Background

Section 1886 (j)(7)(A)(i) of the Social Security Act requires application of a 2 percentage reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. FY 2014 was the first year that the mandated reduction was applied for IRFs that failed to comply with the data submission requirements during the data collection period October 1, 2012, through December 31, 2012.

Beginning with FY 2014 and each subsequent year, if an IRF agency does not submit required quality data, their payment rates for the year are reduced by 2 percentage points for that fiscal year. Application of the 2 percentage reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment.
rates for the preceding fiscal year. In addition, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the fiscal year involved.

Information about the **Inpatient Rehabilitation Facilities (IRF) Quality Reporting Program** (QRP) and the **IRF Quality Reporting Reconsideration and Exception & Extension** process is available on the Centers for Medicare & Medicaid Services (CMS) website.

CMS will provide the MACs with a list of IRFs potentially subject to the reductions. If your facility is on that list, your MAC will, send you a letter advising you about that potential reduction. You will have the opportunity to request a reconsideration by CMS of your reduction. Once CMS makes a decision on your request for reconsideration, your MAC will notify you of such decision.

**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) on the CMS website under - How Does It Work.
Centers for Medicare & Medicaid Services
Articles for Part B Providers
New Non-Physician Specialty Code for Dentist

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9355 announces that the Centers for Medicare & Medicaid Services (CMS) has created a new non-physician specialty code (C5) for Dentist.

Background

Physicians self-designate their Medicare physician specialty on the Medicare enrollment application ((CMS-855B, CMS-855I or CMS-855O) or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) when they enroll in the Medicare program. Non-physician practitioners are assigned a Medicare specialty code when they enroll.

The specialty code becomes associated with the claims that the physician or non-physician practitioner submits, and describes the specific/unique types of medicine that they (and certain other suppliers) practice. CMS uses specialty codes for programmatic and claims processing purposes.

Additional Information

The official instruction, CR9355, issued to your MAC regarding this change consists of two transmittals. The first revises the “Medicare Claims Processing Manual” and it is available

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.