## Medicare Monthly Review

**Issue No. MMR 2016-04**

**April 2016**

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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.
New, Revised, Retired LCDs and Articles: March-April 2016

March 2016 Revisions

Biologic Products for Wound Treatment and Surgical Interventions - Supplemental Instructions Article (SIA) (A52847)

Based on a conflict with CPT guidance, the following coding guideline was removed:

CPT codes 15271, 15272, 15275 and 15276 must correlate with the correct anatomical site and the site modifier (RT or LT) must be reported if the anatomical site is an extremity.

Category III CPT® Codes (L33392)

Based on CMS' final decision memorandum for Percutaneous Left Atrial Appendage Closure (LAAC) (CAG-00445N), LC, CPT code 0281T has been deleted, effective for services rendered on or after 2/8/2016.

Psychiatry and Psychology Services (L33632)

- Clarified the “ICD-10 Codes that Support Medical Necessity” section by adding CPT code 90845 Psychoanalysis to the paragraph in Group 3, and by adding CPT code 90880 Hypnotherapy to the paragraph in Group 4.
- Added ICD-10-CM diagnosis code F64.1 to the "ICD-10 Codes that Support Medical Necessity" section, Group 1, effective for services rendered on or after 10/1/2015.

Removal of Benign Skin Lesions (A54602)

The following language relating to places of service has been removed, effective for services rendered on or after 10/1/2015:

- CPT codes covered under this policy are paid under Part B when rendered in the following places of service: office (11), urgent care facility (20), inpatient hospital (21), outpatient hospital (22), emergency room (23), ambulatory surgical center (24), skilled nursing facility (31), nursing facility (32), independent clinic (49), inpatient psychiatric facility (51) and intermediate care facility/mentally retarded (54).
- CPT codes 11200, 11201, 11300, 11301, 11302, 11303, 11305, 11306, 11307, 11308, 11310, 11311, 11312, and 11313 are also payable when rendered in place of service home (12) and temporary lodging (16).
- CPT codes 17000, 17003, 17004, 17110 and 17111 are also payable in the following places of service: home (12), assisted living (13), group home (14), temporary lodging (16), and custodial care facility (33).

Routine Foot Care and Debridement of Nails (L33636)

The following explanatory note was added to the “CPT/HCPCS Codes” section:

One of the modifiers listed below must be reported with codes 11055, 11056, 11057, 11719, G0127, and with codes 11720 and 11721 when the coverage is based on the presence of a qualifying systemic condition, to indicate the class findings and site:

Modifier Q7: One (1) Class A finding
Modifier Q8: Two (2) Class B findings
Modifier Q9: One (1) Class B finding and two (2) Class C findings.

The following explanatory notes in Groups 1, 2 and 3 were revised for clarity to include the CPT/HCPCS codes:

- **Group1: Paragraph**
  Codes 11055, 11056, 11057, 11719, 11720, 11721 and G0127
  For ICD-10-CM code B35.1, L60.2 or L60.3 refer to Group 2 for the secondary ICD-10-CM codes required for coverage for codes 11719, 11720, 11721 and G0127.
• **Group 2: Paragraph**
  For treatment of mycotic nails, or onychogryphosis, or onychauxis (codes 11719, 11720, 11721 and G0127), in the absence of a systemic condition or where the patient has evidence of neuropathy, but no vascular impairment, for which class findings modifiers are not required, ICD-10-CM code B35.1, L60.2 or L60.3 respectively, must be reported as primary, with the diagnosis representing the patient’s symptom reported as the secondary ICD-10-CM code. Refer to the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD.

• **Group 3: Paragraph**
  Codes 11055, 11056, 11057, 11719, 11720, 11721 and G0127

**April 2016 Revisions and New LCDs**

**Bevacizumab (e.g., Avastin™) - Related to LCD L33394 (A52370)**

The article has been revised to add single agent treatment for persistent or recurrent ovarian cancer. ICD-10-CM code C21.2 has been added to the Group 1: Codes and ICD-10-CM codes H21.1X9, H34.819, H34.839, H35.059, and H35.359 have been added to the Group 2: Codes effective for dates of service on or after 10/01/2015. HCPC codes J3490 and J3590 have been removed from the CPT/HCPCS section of the article. Out-dated information has been removed. Lexi-Drugs compendium has been added to the “Abstract” section of the article and Lexi-Drugs Web site has been added to the “Sources of Information” section.

**Botulinum Toxins (L33646)**

FDA label update for onabotulinumtoxinA (effective 01/21/2016) has been added to the "Indications" section of the LCD under "Spasticity". ICD-10-CM codes G83.31*, G83.32*, G83.33*, G83.34*, G83.81*, G83.82*, G83.89*, I69.041*, I69.042*, I69.043*, I69.044*, I69.141*, I69.142*, I69.143*, I69.144*, I69.241*, I69.242*, I69.243*, I69.244*, I69.341*, I69.342*, I69.343*, I69.344*, I69.841*, I69.842*, I69.843*, I69.844*, I69.941*, I69.942*, I69.943* and I69.944* have been added to the Group 8: list of payable codes effective for dates of service on or after 1/21/2016. In the "Documentation Requirements" section of the LCD, "or lower limb" has been added to the following bulleted item:

Documentation of the medical necessity for this treatment. For spastic conditions other than upper or lower limb spasticity, blepharospasm, hemifacial spasm, cervical dystonia or other focal dystonias, documentation should include a statement that the spastic condition has been unresponsive to conventional treatment;

Out-dated information has been removed throughout the LCD.

**Coverage of Drugs and Biologicals for Label and Off-Label Uses (L33394)**

The LCD has been revised to add article A54862 - Nivolumab (Opdivo®) to the LCD effective for dates of service on or after 4/1/2016. Article A54863 has been added as the Comment and Response document for nivolumab.

**Nivolumab (Opdivo®) - Related to LCD L33394 (A54862)**

The indications have been revised to reflect FDA label updates. Lexi-Drugs compendium has been added to the “Abstract” section of the article and Lexi-Drugs Web site has been added to the “Sources of Information” section.

**Debridement Services (L33614)**

• The LCD was returned for comment to the J6 and JK regions from 10/29/2015 through 12/12/2015.
• CPT codes 97597 and 97598 (previously included in the Outpatient Physical and Occupational Therapy Services LCD, L33631) were added to the LCD. Indications and Documentation Requirements for these services were added to the LCD.
• Limitations were revised to clarify services which are not appropriately billed with the debridement codes covered in this LCD.

**Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy (L35936)**

ICD-10-CM code M71.38 has been added effective for dates of service on or after 10/1/2015.
Genomic Sequence Analysis Panels in the Treatment of Non-Small Cell Lung Cancer (36376)
This new LCD defines coverage for Genomic Sequential Analysis Panel (CPT 81445) in the evaluation of tumor tissue.

Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint (L36406)
This new LCD defines patient criteria for which NGS covers MIS-SI joint fusion in accordance with recently published NASS guidelines (22).

Molecular Pathology Procedures (L35000)
- Added the following CPT codes and indications and limitations of coverage to the TIER 1 AND TIER 2 INDICATIONS AND LIMITATIONS OF COVERAGE section: 81170, 81162, 81216, 81218, 81219, 81227, 81245, 81246, 81271, 81273, 81276, 81301, 81311, 81314, 81370-81383, 81401, 81404, 81405, 81406.
- Added the following CPT codes to the CPT HCPCS Group 1 TIER 1 COVERED MOLECULAR PATHOLOGY PROCEDURES section: 81170, 81218, 81225, 81272, 81273, 81276, 81310, 81311, 81314, 81370-81383.
- Added the following CPT codes to the CPT HCPCS Group 2 TIER 1 AND TIER 2 MOLECULAR PATHOLOGY PROCEDURES THAT REQUIRE INDIVIDUAL REVIEW section: 81162, 81216, 81301.
- Added the following CPT codes to the CPT HCPCS Group 3 TIER 1 NONCOVERED MOLECULAR PATHOLOGY PROCEDURES section: 81219, 81227, 81355.
- Added CPT code and ICD-10-CM diagnosis code groupings in ICD-10-CM Diagnosis Codes that Support Medical Necessity section for the following CPT codes: 81170, 81218, 81245-81246, 81272-81273, 81275-81276, 81311, 81314, 81401, 81404, 81405, 81406.
- Added the following language to bullet number 6 in the Indications of Coverage section: "Exceptions include clinical scenarios whereby repeat testing of somatically-acquired mutations (for example, pre- and post-therapy) may be required to inform appropriate therapeutic decision-making."
- The LCD has been revised during the notice period to remove codes 81442, 81490-81595 from Group 5 CPT Code section and to delete Group 6 CPT Code section (NONCOVERED ADMINISTRATIVE CODES FOR MULTIANALYTE ASSAYS WITH ALGORITHMIC ANALYSES (MAAA) that contained codes 0001M-0004M and 0006M-0010M.

Noninvasive Vascular Studies (L33627)
Effective 10/1/2015, ICD-10 code R60.9 has been added to payable diagnoses for Group 4, Extremity Venous Evaluation, CPT codes 93965, 93970 and 93971.

Outpatient Physical and Occupational Therapy Services (L33631)
Provisions and references related to CPT codes 97597 and 97598 were deleted from the LCD and have been added to LCD L33614, Debridement Services, effective 4/1/2016.

Outpatient Physical and Occupational Therapy Services – SIA (A52862)
CPT codes 97597 and 97598 have been deleted from the CPT code listing. These codes are included in the Debridement Services LCD, L33614, effective 4/1/2016.

Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) (L35076)
This LCD is new for JK and revised for J6:
- The LCD was submitted to J6 and JK for public and CAC comment from 10/29/2015 through 12/12/2015. The LCD was initially adopted with the J6 transition.
- Based on the comments and peer-reviewed literature received, the changes shown below were made:
  - The “Abstract” sections were merged.
- The following “Indications” for SRS/SBRT for Cranial Lesions were removed:
  - Patients with more than 4 primary or metastatic brain lesions who are enrolled in an IRB-approved clinical trial and which clinical trial meets the “standards of scientific integrity and relevance to the
Medicare population” described in CMS IOM Publication 100-03, National Coverage Determinations Manual, Chapter 1, Part 1, Section 20.32, B3a-k (with l-m desirable).

- Patients with more than 4 primary or metastatic brain lesions who are enrolled in a clinical registry compliant with the principles established in AHRQ’s “Registries for Evaluating Patient Outcomes: A User’s Guide”. (See bibliography.)

- Patients whose pretreatment imaging/work-up demonstrated 4 or fewer lesions but who are discovered to have greater than four (4) lesions at the time of treatment delivery. However, ongoing coverage after the first treatment requires enrollment in a clinical trial or registry as described in #7 and 8 "Indications".

The following “Limitation” for SRS/SBRT for Cranial Lesions was removed:

In patients with more than four (4) primary or metastatic lesions SRS is inappropriate and consideration should be given to whole brain irradiation except as described under “Indications” #7, 8, and 9. The "Indications" and "Limitations" for SBRT were consolidated to eliminate repetition.

The following "Indication" for Coverage with Evidence Development (CED) was removed as a requirement for patients with low or intermediate risk prostate cancer. Coverage will be made regardless of a patient’s enrollment status in an IRB-approved clinical trial or in a clinical registry:

- Low or intermediate risk prostate cancer may be covered when the patient is enrolled in an IRB-approved clinical trial and which clinical trial meets the “standards of scientific integrity and relevance to the Medicare population” described in CMS IOM Publication 100-03, National Coverage Determinations Manual, Chapter 1, Part 1, section 20.32, B3a-k (with l-m desirable). Similarly, enrollment in a clinical registry compliant with the principles established in AHRQ’s “Registries for Evaluating Patient Outcomes: A User’s Guide”, such as the Registry for Prostate Cancer Radiosurgery (RPCR), may qualify the treatment for coverage.

- ICD-10-CM codes G20, G21.4 and G51.0 were removed from Group 1 of the “ICD-10-CM Codes that Support Medical Necessity” section. The explanatory note designated by an asterisk (*) for ICD-10-CM code G20 was also removed.

- New peer-reviewed literature added and obsolete references removed from the “Sources of Information and Basis for Decision” section.

Vertebroplasty and Vertebral Augmentation (Percutaneous) (L33569)

- The note for Group 2 covered ICD-10 codes has been revised to remove the reference to “pathologic fracture of vertebrae” from the coding requirement.

- ICD-10 codes M85.88 and M85.89 have been added to Group 3 diagnoses, and “osteopenic” has been added to Indications where osteoporotic compression fracture was listed.

- Some explanatory provisions have been moved from Indications and Limitations to the Abstract section of the LCD. The assistant at surgery designation information has been removed.

Retired LCDs

Circulating Tumor Cell (CTC) Assay (L33587)

This LCD will no longer be in effect for services performed after 2/29/2016. The provisions in this LCD have been moved to the Noncovered Services LCD – L33629 effective for dates of service on or after 3/1/2016.

Radiofrequency Treatment for Urinary Incontinence (L35054)

This LCD will no longer be in effect for services performed after 2/29/2016. The provisions in this LCD have been moved to the Noncovered Services LCD (L33629) effective for dates of service on or after 3/1/2016.

Left Atrial Appendage Closure or Occlusion (L35956)

Based on CMS’ final decision memorandum for Percutaneous Left Atrial Appendage Closure (LAAC) (CAG-00445N), LC, this LCD has been retired, effective for services rendered on or after 2/8/2016.
### 2016 Drug Screening Code Changes

Effective 1/1/2016, CMS deleted drug screening HCPCS codes G0431, G0434, and G6030–G6058 (28 codes) and added the following new codes for drug testing.

#### Table: Laboratory Drug Testing HCPCS Codes G0477-G0483

**Note:** The following codes may be included in the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) and/or Medically Unlikely Edit (MUE) files that are available on the CMS website. The edits are updated annually with quarterly updates. To review the published NCCI PTP and MUE information go to [https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html](https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html)

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<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>OPPS Status Indicator (SI)</th>
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<tr>
<td>G0477</td>
<td>Drug test presum optical</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service</td>
<td>Q4</td>
</tr>
<tr>
<td>G0478</td>
<td>Drug test presum opt inst</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument-assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service</td>
<td>Q4</td>
</tr>
<tr>
<td>G0479</td>
<td>Drug test presum not opt</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service</td>
<td>Q4</td>
</tr>
<tr>
<td>G0480</td>
<td>Drug test def 1-7 classes</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed</td>
<td>Q4</td>
</tr>
<tr>
<td>G0481</td>
<td>Drug test def 8-14 classes</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed</td>
<td>Q4</td>
</tr>
<tr>
<td>G0482</td>
<td>Drug test def 15-21 classes</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed</td>
<td>Q4</td>
</tr>
<tr>
<td>G0483</td>
<td>Drug test def 22+ classes</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not</td>
<td>Q4</td>
</tr>
<tr>
<td>HCPCS Code</td>
<td>Short Descriptor</td>
<td>Long Descriptor</td>
<td>OPPS Status Indicator (SI)</td>
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<td>limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed.</td>
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**NGS Local Coverage Determination and Supplemental Instructions Article**

- The LCD for Qualitative Drug Screening (L33581) was retired and replaced by LCD L36037, “Urine Drug Testing”, effective for services rendered on or after 12/1/2015.
- The SIA (A48395) was retired and replaced by SIA A54681, “Response to Comments: Urine Drug Testing”, effective for services rendered on or after 12/1/2015.

**Note:** The current LCD L36037 includes the following changes:

- Effective for services rendered on or after 1/1/2016, CPT codes 80159, 80171, 80173, 80183, 80184, 83789, 83992, and 84999 have been deleted from the LCD.
- Effective for services rendered on or after 1/1/2016: HCPCS codes G0431, G0434, and G6030-G6058 are no longer valid and have been replaced by the HCPCS codes listed in the above table.

Providers are encouraged to review the LCD and SIA in detail.

**Documentation Tips**

Documentation should include:

- Diagnosis and/or clinical findings
- Physician order for the laboratory services rendered
- Relevant medical history, physical examination and results of pertinent diagnostic tests with lab results
- Physician progress notes and/or clinical documentation to support the medical necessity of the services rendered
- Complete documentation of the laboratory services including test results
  - Documentation should include the medical necessity for ordering the test(s) as well as how the results were used in management of the beneficiary’s condition
- Any additional documentation that supports coverage of the lab services
- When an ABN was issued, include a copy of the signed and dated ABN
  - Ensure the claim reflects that an ABN was issued
- When presumptive testing is performed in a clinician’s office lab, and definitive testing is performed either by a physician’s lab or reference lab, it is expected that the physician is directly involved in determining the clinical appropriateness for all subsequent definitive testing, and documents the necessity in the patient’s medical record.

**Medical Review**

The NGS Medical Review Department has been conducting prepayment targeted medical review of drug screening services. Denials are typical due to:

- Documentation does not support the medical necessity of the billed services
- Billed services were not documented in the medical records
- Missing/incomplete documentation

**Related Content**

- [Local Coverage Determination L36037: Urine Drug Testing](#)
- [SIA - Local Coverage Article A54681: Response to Comments: Urine Drug Testing](#)
- [CMS MLN Matters article MM9549: April 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS)](#)
Centers for Medicare & Medicaid Services
Articles for Part A&B Providers
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9424
Related Change Request (CR) #: CR 9424
Related CR Release Date: March 4, 2016
Effective Date: June 6, 2016
Related CR Transmittal #: R3475CP
Implementation Date: June 6, 2016

Updates to the “Medicare Claims Processing Manual,” Pub. 100-04, Chapters 4 and 5 to Correct Remittance Advice Messages

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) 9424 revises chapters 4 and 5 of the “Medicare Claims Processing Manual” to ensure that all remittance advice coding is consistent with nationally standard operating rules. It also provides a format for consistently showing remittance advice coding throughout this manual.

CR9424 directs MACs to use remittance coding that is compliant with nationally standard Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE) operating rules.

Background
Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry’s use of Electronic Data Interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs regulates the way in which group codes, Claims Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) may be used. The rule requires specific codes, which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the CAQH CORE.

Disclaimer
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Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages.

With CR9424, the Centers for Medicare & Medicaid Services (CMS) makes the following adjustments to CARC/RARC usage:

- MACs will use CARC 54 without an associated RARC when denying assistant at surgery services.
- MACs will use CARC 54 without an associated RARC when denying co-surgery services.
- MACs will use CARC 16 with RARCs MA66 and N56 when returning as unprocessable claims for Outpatient Intravenous Insulin Therapy (OIVIT) billed with HCPCS code 99199.
- MACs will use CARC 16 with RARCs MA66 and N56 when returning as unprocessable claims for OIVIT billed with the incorrect diagnosis code.
- MACs will also apply reformatted, but not changed, remittance advice coding as described in the revised Chapters 4 and 5 of the “Medicare Claims Processing Manual.”

**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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Telehealth Services

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9428:

- Informs MACs that the list of telehealth services that were once available through the manual updates will now be displayed at [http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth](http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth) on the Centers for Medicare & Medicaid Services (CMS) website.
- Adds Certified Registered Nurse Anesthetists (CRNAs) to the list of Medicare practitioners who may bill for covered telehealth services.
- Removes the telehealth language from Chapter 15, Section 270 of the “Medicare Benefit Policy Manual” and puts a reference in the text to see Chapter 12, Section 190 of the “Medicare Claims Processing Manual” for further information regarding telehealth service.

The text added to Chapter 12 of the “Medicare Claims Processing Manual” addresses the following topics:

- Payment for ESRD-Related Services as a Telehealth Service;

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• Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services;
• Payment for Diabetes Self-Management Training (DSMT) as a Telehealth Service;
• Originating Site Facility Fee Payment Methodology; and
• Payment Methodology for Physician/Practitioner at the Distant Site.

Several conditions must be met for Medicare to make payments for telehealth services under the Medicare Physician Fee Schedule (MPFS). The service must be on the list of Medicare telehealth services and meet all of the following additional requirements:

• The service must be furnished via an interactive telecommunications system;
• The service must be furnished by a physician or authorized practitioner;
• The service must be furnished to an eligible telehealth individual; and
• The individual receiving the service must be located in a telehealth originating site.

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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April Quarterly Update for 2016 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9554 provides the April quarterly update for the Medicare DMEPOS fee schedule. The instructions include information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. Because there are no updates from the previous quarter (January through March 2016), an April update to the 2016 DMEPOS and Parenteral and Enteral Nutrition (PEN) fee schedule files is not scheduled for release. However, an April 2016 DMEPOS Rural ZIP code file containing Quarter Two, 2016 rural ZIP Code changes is being provided to the MACs.

The April 2016 DMEPOS Rural ZIP code Public Use File (PUF), containing the rural ZIP codes effective for Quarter 2, 2016, will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the above file.

Background

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedule on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the “Medicare Claims Processing Manual,” Chapter 23, Section 60.

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

Additionally, Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from Competitive Bidding Programs (CBPs) for DME. Section 1842(s)(3)(B) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs. CMS issued a final rule on November 6, 2014 (79 FR 66223), on the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs.

CMS issued a final rule on November 6, 2014 (79 FR 66223), on the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs. The CBP product categories, HCPCS codes and Single Payment Amounts (SPAs) included in each Round of the CBP are available on the Competitive Bidding Implementation Contractor (CBIC) website.

The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjusted payment amount methodologies discussed above as well as codes that are not subject to the fee schedule CBP adjustments. To apply the adjusted fees rural payment rule for areas within the contiguous United States, the DMEPOS and PEN fee schedule files have been updated, effective January 1, 2016, to include rural payment amounts for certain HCPCS codes.

Beginning January 1, 2016, the ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts based on information from the competitive bidding program. ZIP codes for non-continental Metropolitan Statistical Areas (MSA) are not included in the DMEPOS Rural ZIP code file.

The DMEPOS Rural ZIP code file is updated on a quarterly basis as necessary. Program instructions on these changes are available in MLN® Matters 9431 (MM9431) entitled “Calendar Year (CY) 2016 Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule” based on Transmittal 3416, Change Request (CR) 9431, dated November 23, 2015.

Additional Information

The official instruction, CR9554, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3472CP.pdf on the CMS website. If you have any questions, please contact your MAC at their toll-free number. That number is 1-800-778-6892.

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MLN Matters® Number: MM9562 Related Change Request (CR) #: CR 9562
Related CR Release Date: March 18, 2016 Effective Date: June 20, 2016
Related CR Transmittal #: R3481CP Implementation Date: June 20, 2016

Updates to Pub. 100-04, Chapters 3, 6, 7 and 15 to Correct Remittance Advice Messages

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9562 informs MACs about revisions to Chapters 3, 6, 7 and 15 of the “Medicare Claims Processing Manual” to ensure that all remittance advice coding is consistent with nationally standard operating rules. It also provides a format for consistently showing remittance advice coding throughout the manual. CR9562 does not reflect any change in Medicare policy.

Background

Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry’s use of Electronic Data Interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs, regulates the way in which group codes, Claims Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) may be used. The rule requires specific codes which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

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Medicare and all other payers must comply with the CAQH CORE-developed code combinations. CR8424 established a standard format for presenting these code combinations in the “Medicare Claims Processing Manual.” CR9562 updates Chapters 3, 6, 7 and 15 of the manual to reflect the standard format and to correct any non-compliant code combinations. CR9562 does not reflect any change in Medicare policy.

**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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Centers for Medicare & Medicaid Services
Articles for Part A Providers
Discretion

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

MLN Matters® Number: MM8822 Revised
Related Change Request (CR) #: CR 8822

Related CR Release Date: March 23, 2016
Effective Date: July 1, 2016 - except in Round 1 Re-compete CBP areas where effective date is January 1, 2017

Related CR Transmittal #: R1638OTN
Implementation Date: July 5, 2016 - except for A/B and HHH MACs where implementation is 10/3/2016

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

Note: This article was revised on March 24, 2016, due to a revised Change Request. The revised CR adds business requirements 8822.6.2, 8822.6.3 and 8822.7 (bottom of page 7 and top of page 8 of this article), which provides instructions to the MACs for calculating the lump sum purchases. In the article, the transmittal number, CR issue date, and the Web address for accessing CR8822 are revised. All other information is unchanged.

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

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.

**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 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 (HHHs) providers 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). Note that for this requirement, MACs will calculate the fee for the lump sum purchase basis (NU modifier - Purchase of new equipment) for these items as the rental price times ten. The fee for a used
item lump sum purchase basis (UE modifier - Purchase of used equipment) will be 75 percent of the purchase fee.

**Note:** Contractors will not search their files but will adjust claims brought to their attention between July 1, 2016, and October 3, 2016, for previously processed claims that meet the requirements stated in 6 and 7 above.

**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.

**Document History**

<table>
<thead>
<tr>
<th>Date of Change</th>
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<tr>
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</tr>
</tbody>
</table>
Required Billing Updates for Rural Health Clinics

Note: This article was revised on March 24, 2016, due to a revised Change Request (CR). In the article, the transmittal number, CR issue date, and the Web address for accessing CR9269 are revised. 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

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 the “RHC Preventive Services Chart” on the [CMS RHC center webpage](https://www.cms.gov).

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. Services furnished through March 31, 2016, should be billed without a HCPCS code under the previous guidelines.

A RHC visit must include one of the services listed on the [RHC Qualifying Visit List](https://www.cms.gov), which is shown below. 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. Updates to the qualifying visit list are generally made on a quarterly basis and posted on the [CMS RHC center webpage](https://www.cms.gov). 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 using revenue code 052X.
- Qualifying mental health services are billed using revenue code 0900.
- Telehealth originating site facility fees are billed using revenue code 0780.

**Billing Qualifying Visits under the HCPCS Reporting Requirement**

An encounter must include one of the services listed under the [RHC Qualifying Visit List](https://www.cms.gov). The total charges for the encounter must be included on the qualifying visit line minus any charge for an approved preventive service. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying visit line. All other RHC services furnished during the encounter are also reported with a charge and payment for these lines is included in the AIR.

**NOTE:** The examples listed below include form locators (FL) from the UB-04.

**Example 1: 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](https://www.cms.gov). Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line. All other RHC services furnished during the encounter are also reported with the charge for the service.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied</th>
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</thead>
<tbody>
<tr>
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<td>99213</td>
<td>04/01/2016</td>
<td>1</td>
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<td>Yes</td>
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<tr>
<td>0300</td>
<td>36415</td>
<td>04/1/2016</td>
<td>1</td>
<td>$3.00</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

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Example 2: 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. The qualifying medical visit line should include the total charges for the visit and payment and coinsurance will be based upon this line. All other RHC services furnished during the encounter are also reported with the charge for the service. Preventive services furnished with a medical visit are ineligible to receive an additional encounter payment at the AIR, except for the IPPE.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
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<th>Coinsurance/Deductible Applied</th>
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<td>$38.67</td>
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<td>36415</td>
<td>04/01/2016</td>
<td>1</td>
<td>$3.00</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

Example 3: Preventive Service Only Encounter

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.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
<th>Payment</th>
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<td>G0101</td>
<td>04/01/2016</td>
<td>1</td>
<td>$38.67</td>
<td>AIR</td>
<td>No^3</td>
</tr>
</tbody>
</table>

1HCPCS code from the RHC Qualifying Visit List
2Total charges minus charge for approved preventive service
3Charge for the service

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

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Example 4: 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. The qualifying mental health visit line should include the total charges for the visit and payment and coinsurance will be based upon this line. All other RHC services furnished during the encounter are also reported with the charge for the service.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance/ Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>0900</td>
<td>90834¹</td>
<td>04/01/2016</td>
<td>1</td>
<td>$110.63²</td>
<td>AIR</td>
<td>Yes</td>
</tr>
<tr>
<td>0900</td>
<td>90863</td>
<td>04/01/2016</td>
<td>1</td>
<td>$25.42³</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

¹HCPCS code from the RHC Qualifying Visit List  
²Total charge for the encounter  
³Charge for the service

Example 5: 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. Each additional medical service furnished should be reported with revenue code 052X. The qualifying medical visit line should include the total charges for the visit and payment and coinsurance will be based upon this line.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 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>$183.32²</td>
<td>AIR</td>
<td>Yes</td>
</tr>
<tr>
<td>052X</td>
<td>12002</td>
<td>04/01/2016</td>
<td>1</td>
<td>$109.92³</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

¹HCPCS code from the RHC Qualifying Visit List  
²Total charges for the encounter  
³Charge for the service

Example 6: 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 payable as standalone services. 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

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revenue codes except 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x. RHCs should report the most appropriate revenue code for the services being performed.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 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>$139.11</td>
<td>AIR</td>
<td>Yes</td>
</tr>
<tr>
<td>0300</td>
<td>36415</td>
<td>04/01/2016</td>
<td>1</td>
<td>$3.00</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
<tr>
<td>0636</td>
<td>90746</td>
<td>04/01/2016</td>
<td>1</td>
<td>$59.71</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
<tr>
<td>0771</td>
<td>G0010</td>
<td>04/01/2016</td>
<td>1</td>
<td>$5.00</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

1HCPCS code from the RHC Qualifying Visit List
2Total charge for the encounter
3Charge for the service

For any service line included in the AIR payment, the following remittance codes will be received:

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

**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 qualifying medical visit line should include the total charges for the medical services and the qualifying mental health visit line should include the total charges for the mental health services.

- 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.

**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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## Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 24, 2016</td>
<td>The article was revised due to a revised CR. The transmittal number, CR release date and link to the CR were changed. All other information is unchanged.</td>
</tr>
<tr>
<td>February 29, 2016</td>
<td>Revised to provide clarifying information, especially in the billing examples provided.</td>
</tr>
<tr>
<td>February 10, 2016</td>
<td>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>
<tr>
<td>February 1, 2016</td>
<td>Initial issuance</td>
</tr>
</tbody>
</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 establish 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>
<td>Nursing fac care subseq</td>
</tr>
<tr>
<td>99315</td>
<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 Medicare Physician Fee Schedule (MPFS) national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC claim.
Fiscal Year 2017 and After Payments to Long-Term Care Hospitals That Do Not Submit Required Quality Data - This Change Request (CR) Rescinds and Fully Replaces CR9105

Provider Types Affected

This MLN Matters® Article is intended for Long-Term Care Hospitals (LTCHs) submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9544 revises Chapter 3, Section 60 of the “Medicare Quality Reporting Incentive Programs Manual” to reflect changes to the payment reduction reconsideration process. It also includes general clarifications to the section. Make sure your billing staffs are aware of these revisions and clarifications.

Background

Section 3004 of the Affordable Care Act amended the Social Security Act (the Act) to authorize a quality reporting program for LTCHs. Section 1886(m)(5)(A)(i) of the Act requires application of a 2 percent reduction of the applicable market basket increase factor for LTCHs that fail to comply with the quality data submission requirements. Fiscal Year (FY) 2014 was the first year that the mandated reduction was applied for LTCHs that failed to comply with the data submission requirements during the data collection period of October 1, 2012, though December 31, 2012.
Beginning with FY 2014, and each subsequent year, if an LTCH 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-percent 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.

Every year, in late Spring/Summer, the Centers for Medicare & Medicaid Services (CMS) will provide MACs with a list of those LTCHs not meeting the quality data reporting requirements. The MAC will then notify the LTCHs that they have been identified as not complying with the requirements of submitting quality data and are scheduled to have Medicare payments to their facility reduced by 2 percentage points. The notification letter will inform the LTCH that they were identified as not complying with the LTCH quality reporting requirements. The notification letter will also inform the LTCH regarding the process to request a reconsideration of their payment reduction if they disagree with the determination. The reconsideration process will be outlined within that initial notification letter.

There is a 30-day period from the date of the notification letter for the LTCH to submit a letter requesting reconsideration and documentation to support a finding of compliance. CMS will then review all reconsideration requests received and provide a determination to the MAC typically within a period of 2 to 3 months. In its review of the LTCH documentation, CMS will determine whether evidence to support a finding of compliance has been provided by the LTCH. The determination will be made based solely on the documentation provided. If clear evidence to support a finding of compliance is not present, the 2 percentage point reduction will be upheld. If clear evidence of compliance is present, the reduction will be reversed.

After the reconsideration process has occurred and prior to October 1 of each FY, CMS will provide the MACs with a final list of LTCHs that failed to comply with the data submission requirements. The MACs will then be responsible for notifying each LTCH that failed to comply with the quality data submission requirements that it will receive a 2 percentage point reduction in the annual payment update. The MACs will send this second letter only to LTCHs that requested reconsideration. Additionally, the MACs will include information regarding the LTCHs right to further appeal the 2 percentage point reduction via the Provider Reimbursement Review board (PRRB) appeals process.

**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 under - How Does It Work.
April 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice (HH&H) MACs, for services provided to Medicare beneficiaries paid under the Outpatient Prospective Payment System (OPPS).

Provider Action Needed

Change Request (CR) 9549 describes changes to and billing instructions for various payment policies implemented in the April 2016 OPPS update.

The April 2016 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR9549. The I/OCE update is in CR9553. Upon release of that CR, an MLN Matters article (MM9553) related to the updated I/OCE will be posted on the Centers for Medicare & Medicaid Services (CMS) website. Make sure your billing staffs are aware of these changes.

Key Points of CR9549

Key changes to and billing instructions for various payment policies implemented in the April 2016 OPPS updates are as follows:

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Neurostimulator HCPCS Codes C1822 and C1820

HCPCS Code C1822

As described in the January 2016 Update of the OPPS (see MM 9486, January 2016 OPPS Update), HCPCS code C1822 (Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system) was added to the OPPS pass-through list as a new pass-through device effective January 1, 2016. HCPCS code C1822 is based on a clinical trial that demonstrated that a high frequency spinal cord stimulator operated at 10,000 Hz and paresthesia-free provides a substantial clinical improvement in pain management versus a low-frequency spinal cord stimulator.

HCPCS Code C1820

In the January 2016 OPPS Update, CMS added the words “non-high-frequency” to the descriptor of C1820. CMS is revising the descriptor for C1820 back to its original language and deleting “non-high-frequency” from the descriptor such that the descriptor again states the following: Generator, neurostimulator (implantable), with rechargeable battery and charging system. Neurostimulator generators that are not high frequency should be reported with C1820.


Billing Instructions for Intensity Modulated Radiation Therapy (IMRT) Planning

Payment for the services identified by CPT codes 77014, 77280, 77285, 77290, 77295, 77305 through 77321, 77331, and 77370 are included in the Ambulatory Payment Classification (APC) payment for CPT code 77301 (IMRT planning). These codes should not be reported in addition to CPT code 77301 when provided prior to or as part of the development of the IMRT plan.

Laboratory Drug Testing HCPCS Codes G0477-G0483 Effective January 1, 2016

HCPCS codes G0477-G0483 were published on the CMS website after the release of the January 2016 I/OCE. Consequently, CMS was unable to include them in the January 2016 I/OCE release. These codes are being added to the April 2016 I/OCE release with an effective date of January 1, 2016, and are assigned to Status Indicator (SI) of “Q4” (Conditionally packaged laboratory tests) under the hospital OPPS. The descriptors for Codes G0477-G0483 are listed in Table 1.
### Table 1 – Laboratory Drug Testing HCPCS Codes G0477-G0483

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0477</td>
<td>Drug test presumptive optical</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service</td>
<td>Q4</td>
</tr>
<tr>
<td>G0478</td>
<td>Drug test presumptive opt inst</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument-assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service</td>
<td>Q4</td>
</tr>
<tr>
<td>G0479</td>
<td>Drug test presumptive not opt</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service.</td>
<td>Q4</td>
</tr>
<tr>
<td>G0480</td>
<td>Drug test def 1-7 classes</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed.</td>
<td>Q4</td>
</tr>
<tr>
<td>G0481</td>
<td>Drug test def 8-14 classes</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed.</td>
<td>Q4</td>
</tr>
<tr>
<td>HCPCS Code</td>
<td>Short Descriptor</td>
<td>Long Descriptor</td>
<td>OPPS SI</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>---------</td>
</tr>
<tr>
<td>G0482</td>
<td>Drug test def 15-21 classes</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed.</td>
<td>Q4</td>
</tr>
<tr>
<td>G0483</td>
<td>Drug test def 22+ classes</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed.</td>
<td>Q4</td>
</tr>
</tbody>
</table>

**Drugs, Biologics, and Radiopharmaceuticals**

**Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2016**

For Calendar Year (CY) 2016, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2016, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a

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quarterly basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2016, and drug price restatements are available in the April 2016 update of the OPPS Addendum A and Addendum B at [http://www.cms.gov/HospitalOutpatientPPS/](http://www.cms.gov/HospitalOutpatientPPS/) on the CMS website.

**Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2016**

Ten drugs and biologicals have been granted OPPS pass-through status effective April 1, 2016. See codes listed in Table 2.

**Table 2 – Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2016**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9137</td>
<td>Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 I.U.</td>
<td>1844</td>
<td>G</td>
</tr>
<tr>
<td>C9138</td>
<td>Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwiq), 1 I.U.</td>
<td>1846</td>
<td>G</td>
</tr>
<tr>
<td>C9461</td>
<td>Choline C 11, diagnostic, per study dose</td>
<td>9461</td>
<td>G</td>
</tr>
<tr>
<td>C9470</td>
<td>Injection, aripiprazole lauroxil, 1 mg</td>
<td>9470</td>
<td>G</td>
</tr>
<tr>
<td>C9471</td>
<td>Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg</td>
<td>9471</td>
<td>G</td>
</tr>
<tr>
<td>C9472</td>
<td>Injection, talimogene laherparepvec, 1 million plaque forming units (PFU)</td>
<td>9472</td>
<td>G</td>
</tr>
<tr>
<td>C9473</td>
<td>Injection, mepolizumab, 1 mg</td>
<td>9473</td>
<td>G</td>
</tr>
<tr>
<td>C9474</td>
<td>Injection, irinotecan liposome, 1 mg</td>
<td>9474</td>
<td>G</td>
</tr>
<tr>
<td>C9475</td>
<td>Injection, necitumumab, 1 mg</td>
<td>9475</td>
<td>G</td>
</tr>
<tr>
<td>J7503</td>
<td>Tacrolimus, extended release, (envarsus xr), oral, 0.25 mg</td>
<td>1845</td>
<td>G</td>
</tr>
</tbody>
</table>

**Revised Status Indicator for HCPCS Codes**

The status indicator for CPT code 90653 (Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use) will change from SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=L (Not paid under OPPS paid at reasonable cost, not subject to deductible or coinsurance).

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The status indicator for HCPCS code J0130 (Injection abciximab, 10 mg) will change from SI=K (Paid under OPPS; separate APC payment) to SI=N (Paid under OPPS; payment is packaged into payment for other services).

The status indicator for HCPCS code J0583 (Injection, bivalirudin, 1 mg) will change from SI K (Paid under OPPS; separate APC payment) to SI=N (Paid under OPPS; payment is packaged into payment for other services).

The status indicator for HCPCS code J1443 (Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron) will change from SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=N (Paid under OPPS; payment is packaged into payment for other services).

The status indicator for HCPCS code J2704 (Injection, Propofol, 10mg) will change from SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=N (Paid under OPPS; payment is packaged into payment for other services).

These codes and the effective dates for the status indicator changes are listed in Table 3.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>90653</td>
<td>Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use</td>
<td>L</td>
<td>11/24/2015</td>
</tr>
<tr>
<td>J0130</td>
<td>Injection abciximab, 10 mg</td>
<td>N</td>
<td>1/1/2016</td>
</tr>
<tr>
<td>J0583</td>
<td>Injection, bivalirudin, 1 mg</td>
<td>N</td>
<td>1/1/2016</td>
</tr>
<tr>
<td>J1443</td>
<td>Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron</td>
<td>N</td>
<td>1/1/2016</td>
</tr>
<tr>
<td>J2704</td>
<td>Injection, Propofol, 10mg</td>
<td>N</td>
<td>1/1/2016</td>
</tr>
</tbody>
</table>

Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html) on the CMS website.

Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

**Revised Billing Instruction for Stereotactic Radiosurgery (SRS) Planning and Delivery**

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Effective for cranial single session stereotactic radiosurgery procedures (CPT code 77371 or 77372) furnished on or after January 1, 2016, until December 31, 2017, costs for certain adjunctive services (for example, planning and preparation) are not factored into the APC payment rate for APC 5627 (Level 7 Radiation Therapy). Rather, the ten planning and preparation codes listed in Table 4, will be paid according to their assigned status indicator when furnished 30 days prior or 30 days post SRS treatment delivery.

In addition, hospitals must report modifier “CP” (Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification [C-APC] procedure) on Type of Bill (TOB) 13X claims for any other services (excluding the ten codes in table 4) that are adjunctive or related to SRS treatment but billed on a different claim and within either 30 days prior or 30 days after the date of service for either CPT code 77371 (Radiation treatment delivery, stereotactic radiosurgery, complete course of treatment cranial lesion(s) consisting of 1 session; multi-source Cobalt 60-based) or CPT code 77372 (Linear accelerator based). The “CP” modifier need not be reported with the ten planning and preparation CPT codes listed in table 4. Adjunctive/related services include but are not necessarily limited to imaging, clinical treatment planning/preparation, and consultations. Any service related to the SRS delivery should have the CP modifier appended. CMS does not expect the “CP” modifier to be reported with services such as chemotherapy administration as this is considered to be a distinct service that is not directly adjunctive, integral, or dependent on delivery of SRS treatment.

Table 4 – Excluded Planning and Preparation CPT Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CY 2016 Short Descriptor</th>
<th>CY 2016 Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>70551</td>
<td>Mri brain stem w/o dye</td>
<td>Q3</td>
</tr>
<tr>
<td>70552</td>
<td>Mri brain stem w/dye</td>
<td>Q3</td>
</tr>
<tr>
<td>70553</td>
<td>Mri brain stem w/o &amp; w/dye</td>
<td>Q3</td>
</tr>
<tr>
<td>77011</td>
<td>Ct scan for localization</td>
<td>N</td>
</tr>
<tr>
<td>77014</td>
<td>Ct scan for therapy guide</td>
<td>N</td>
</tr>
<tr>
<td>77280</td>
<td>Set radiation therapy field</td>
<td>S</td>
</tr>
<tr>
<td>77285</td>
<td>Set radiation therapy field</td>
<td>S</td>
</tr>
<tr>
<td>77290</td>
<td>Set radiation therapy field</td>
<td>S</td>
</tr>
<tr>
<td>77295</td>
<td>3-d radiotherapy plan</td>
<td>S</td>
</tr>
<tr>
<td>77336</td>
<td>Radiation physics consult</td>
<td>S</td>
</tr>
</tbody>
</table>

Changes to OPPS Pricer Logic

Effective April 1, 2016, there will be four diagnostic radiopharmaceuticals (1 newly approved) and one contrast agent receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical or contrast agent payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical or contrast agent with pass-through appears on a claim with a nuclear procedure. The offset

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will cease to apply when the diagnostic radiopharmaceutical or contrast agent expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals and contrast agents are the “policy-packaged” portions of the CY 2016 APC payments for nuclear medicine procedures and are available on the CMS website. MACs will adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of the April 2016 OPPS Pricer.

Coverage Determinations

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

These HCPCS codes will be included with the April 2016 I/OCE update. Status and payment indicators for these HCPCS codes will be listed in the April 2016 update of the OPPS Addendum A and Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html on the CMS website.

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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April 2016 Integrated Outpatient Code Editor (I/OCE) Specifications
Version 17.1

Note: This article was revised on March 23, 2016, to reflect the revised CR9553, issued on March 22. In the article, the transmittal number, CR issue date, and the Web address for accessing CR9553 are revised. In addition, a row was added to the table at the top of page 6 to show added editing for NCD effective date for code G0475. All other information remains the same.

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9553 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications that will be used under the Outpatient Prospective Payment System (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes. The I/OCE specifications will be posted at http://www.cms.gov/OutpatientCodeEdit/ on the Centers for Medicare & Medicaid Services (CMS) website. These specifications contain the appendices mentioned in the table below.
The modifications of the IOCE for the April 2016 v17.1 release are summarized in the following table. Note that some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the 'Effective Date' column.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2015</td>
<td>2, 3, 86</td>
<td>Update diagnosis editing for ICD-10 diagnosis codes (see quarterly data files, Dx10Map): - Removes age restrictions for specific newborn and pediatric diagnosis codes that are to be used throughout the patient’s lifetime; - Additions and removal of age edits for specific maternity diagnosis codes; - Removes sex restriction for specific diagnosis codes currently restricted for female patients; and - Additional codes added to the list of manifestation diagnosis codes.</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Implement new logic to identify pass-through drugs and biologicals present for payment offset; output each offset amount condition present with Payer Value codes QR, QS, QT and identify the pass-through drug or biological procedures for payment offset with new payment adjustment flag values (see OPPS special processing logic, Table 5, Table 7 and Appendix G).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Implement new logic to identify terminated device intensive procedures reported with modifier 73; output the device portion amount with Payer Value code QQ and identify the device intensive procedure reported with modifier 73 with a payment adjustment flag (see OPPS special processing logic, Table 5, Table 7 and Appendix G).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Implement new logic to identify device credit conditions for device intensive Ambulatory Payment Classifications (APCs) when Condition Code 49, 50 or 53 is present; output the device credit amount with Payer Value code QQ and identify the device intensive procedure with a payment adjustment flag (see OPPS special processing logic, Table 5, Table 7 and Appendix G).</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/1/2016</td>
<td>6, 91</td>
<td>Implement edit 91 for Rural Health Clinic (RHC) claims with bill type 71x to be returned if non-covered services are reported (see special processing logic for FQHC PPS claims, Appendix F (a) and Appendix M); update the description for edit 91 to include RHC. Implement edit 6 for RHC (see Appendix F (a)).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the program logic for CT scan payment reduction when not meeting National Electrical Manufacturers Association (NEMA) standards to assign payment adjustment flag 14 to the multiple imaging composite APC line if CT modifier is not present but there are composite constituent codes present that do not report modifier CT (see OPPS special processing logic and Appendix K).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td>45</td>
<td>Update the logic for edit 45 to include criteria for inpatient separate procedures reported on the same claim as a comprehensive APC procedure with a Status Indicator (SI) = J1.</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update Appendix L to include procedure codes with SI = C in the list of non-allowed procedures by SI for OPPS claims.</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the program logic for pass-through device payment offset to not provide the offset if the primary comprehensive APC procedure (SI = J1) is not paired with a pass-through device code present on the claim (see OPPS special processing logic and Appendix L).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update Appendix E with a note for setting the Payment Method Flag to 2 for laboratory codes with SI = Q4 that result in final assignment of SI = A.</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the program logic for comprehensive APC 5881 (inpatient procedure where patient expired) to correctly exclude services designated as comprehensive APC exclusions when reported on the same day when APC 5881 is assigned.</td>
</tr>
<tr>
<td>1/1/2015</td>
<td></td>
<td>Update program logic for comprehensive APC processing to recognize modifier 50 for comprehensive APC procedures that may be eligible for complexity adjustment (see Appendix L).</td>
</tr>
<tr>
<td>Effective Date</td>
<td>Edits Affected</td>
<td>Modification</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the program logic for Grandfathered Tribal Federally Qualified Health Center (FQHC) claims to identify the single payable visit (payment indicator 14) for each day if the claim contains multiple days (see Appendix M).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the program logic for Grandfathered Tribal FQHC claims to assign the composite adjustment flag only for the single payable visit for the day (see Appendix M).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Modify the output of the Payer Value Code and Amount field to pass blanks for the Value Code label (QN-QW) and zero-fill the Amount portion of the field if conditions for payment offset are not present on the claim (see Table 5 of the I/OCE specifications). Note: If conditions for edit 24 (Date out of OCE range) are present, Payer Value Code and Amount is blank (no zero-fill).</td>
</tr>
</tbody>
</table>
| 1/1/2016       |                | Add the following new Payer Value Codes to the field output (see Table 5):  
- QP: Placeholder reserved for future use  
- QQ: Terminated procedure with pass-through device OR condition for device credit present  
- QR: First APC pass-through drug or biological offset  
- QS: Second APC pass-through drug or biological offset  
- QT: Third APC pass-through drug or biological offset  
Revise the following Payer Value Code descriptions:  
- QN: First APC device offset  
- QO: Second APC device offset |
<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
</table>
| 1/1/2016       |                | Add the following new Payment Adjustment Flag values (see Table 7 and Appendix G):  
- 15: Placeholder reserved for future use  
- 16: Terminated procedure with pass-through device  
- 17: Condition for device credit present  
- 18: Offset for first pass-through drug or biological  
- 19: Offset for second pass-through drug or biological  
- 20: Offset for third pass-through drug or biological  
Revise the following Payment Adjustment Flag descriptions:  
- 12: Offset for first device pass-through  
- 13: Offset for second device pass-through |
| 1/1/2016       |                | Correction of the issue with the interactive PC IOCE product that caused claims to not complete processing to the output report when the pass-through device offset amount was greater than $999.99. |
| 1/1/2016       |                | The following clarifying information is added (no change to software program logic):  
- Direct Referral logic to include J1 procedures (page 46) with the SI = T criteria  
- Critical Care packaged ancillary codes (page 11): update SI values for codes subject to modifier 59 exception.  
- Conditionally packaged laboratory codes (page 12): laboratory codes that are always packaged with SI = N, and removal of SI J1 and J2 (comprehensive APCs) from list of OPPS services by SI under which laboratory codes with SI = Q4 are changed to SI = A for claims with bill type 13x. |
<p>| 11/24/2015     | 67             | Add mid-quarter editing for Food and Drug Administration (FDA) approval of code 90653 (SI changed to L). |</p>
<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/13/2015</td>
<td>68</td>
<td>Add mid-quarter editing for NCD effective date for code G0475.</td>
</tr>
<tr>
<td>4/1/2016</td>
<td></td>
<td>Update the following procedure lists for the release (see quarterly data files):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Procedures not recognized under OPPS (SI=B)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Conditionally packaged laboratory services (SI=Q4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- FQHC non-covered services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Device offset pairs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Device list (edit 92)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Comprehensive APC exclusions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- New pass-through drug and biological/APC offset</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- New device intensive procedures for terminated procedure and device credit (Value Code QQ)</td>
</tr>
<tr>
<td>4/1/2016</td>
<td></td>
<td>Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).</td>
</tr>
<tr>
<td>4/1/2016</td>
<td>20, 40</td>
<td>Implement version <strong>22.1</strong> of the NCCI (as modified for applicable outpatient institutional providers).</td>
</tr>
</tbody>
</table>

Note: Readers should also read through the entire document and note the highlighted sections, which also indicate changes from the prior release of the software.

**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.
## Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 23</td>
<td>The article was revised to reflect the revised CR9553, issued on March 22. In the article, the transmittal number, issue date, and the Web address for accessing CR9553 are revised. In addition, a row was added to the table at the top of page 6 to show added editing for NCD effective date for code G0475.</td>
</tr>
<tr>
<td>March 14</td>
<td>Initial Issuance</td>
</tr>
</tbody>
</table>

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July Quarterly Update to 2016 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

Provider Types Affected

This MLN Matters® Article is intended for providers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries during a Skilled Nursing Facility (SNF) stay.

Provider Action Needed

Change Request (CR) 9561 provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing (CB) provision of the SNF Prospective Payment System (PPS), effective January 1, 2016. Make sure your billing staffs are aware of these HCPCS code updates.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are excluded from the CB provision of the SNF PPS.

You should be aware that providers other than SNFs may be paid for services that are excluded from SNF PPS and CB, even for those provided to beneficiaries in a SNF stay. However, Medicare will only pay SNFs for claims for services that do not appear on the exclusion lists.

Additionally, SNF CB applies to non-therapy services only when furnished to a SNF resident during a covered Part A stay; however, it applies to physical and occupational therapies, and speech-language pathology services whenever they are furnished to a SNF.
resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare systems edit for services provided to SNF beneficiaries, both those that are included and those excluded from SNF CB.


CR 9561 adds HCPCS Codes 93600, 93602, 93609, 93610, 93612, 93613, 93615, 93616, 93618-93624, 93631, 93640 - 93642, 93644, 93650, 93653, 93654, 93655, 93656, 93657, 93660, and 93662 to the Major Category 1.B Coding List for SNF Consolidated Billing, effective for dates of service on or after January 1, 2016.

**Note:** If you have claims with dates of service on or after January 1, 2016, that are impacted by these changes and that were denied/rejected prior to the implementation of CR9561, your MAC will re-open and re-process those claims that you bring to your MAC's attention.

**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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Centers for Medicare & Medicaid Services

Articles for Part B Providers
Quarterly Update to the Correct Coding Initiative (CCI) Edits, Version 22.2, Effective July 1, 2016

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.

Provider Action Needed

Change Request (CR) 9516 informs MACs about the release of the latest package of National Correct Coding Initiative (NCCI) edits, Version 22.2, which will be effective July 1, 2016. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the NCCI edits to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The latest package of CCI edits, Version 22.2, effective July 1, 2016, will be available via the CMS Data Center (CDC). A test file will be available on or about May 2, 2016, and a final file will be available on or about May 17, 2016.

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Version 22.2 will include all previous versions and updates from January 1, 1996, to the present. In the past, CCI was organized in two tables: Column 1/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits.

In order to simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two Correct Coding edit file. Separate consolidations have occurred for the two practitioner NCCI edit files and the two NCCI edit files used for OCE. It will only be necessary to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits.

CMS no longer publishes a Mutually Exclusive edit file on its website for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single Column One/Column Two Correct Coding edit file on each website. The edits previously contained in the Mutually Exclusive edit file are NOT being deleted but are being moved to the Column One/Column Two Correct Coding edit file.

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

Note: The coding policies developed are based on coding conventions defined in the American Medical Association’s Current Procedural Terminology manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

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 on the CMS website under - How Does It Work.

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April 2016 Update of the Ambulatory Surgical Center (ASC) Payment System

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9557 informs MACs about changes to billing instructions for various payment policies implemented in the April 2016 ASC payment system update. As appropriate, CR9557 also includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure that your billing staffs are aware of these changes that are effective on April 1, 2016.

Background

This article notifies MACs about updates to the ASC payment system, payment rates for separately payable drugs and biologicals, including descriptors for newly created Level II HCPCS codes for drugs and biologicals (ASC DRUG files), and the CY 2016 ASC payment rates for covered surgical and ancillary services (ASCFS file).

Many ASC payment rates under the ASC payment system are established using payment rate information in the Medicare Physician Fee Schedule (MPFS). The payment files associated with CR9557 reflect the most recent changes to CY 2016 MPFS payment.

The changes effective with CR9557 are as follows:

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1. HCPCS Code C1822 and C1820

As described in the January 2016 Update of the ASC Payment System (See article MM9484), HCPCS code C1822 (Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system) was added to the ASC list as a new pass-through device effective January 1, 2016.

- HCPCS code C1822 is based on a clinical trial that demonstrated that a high frequency spinal cord stimulator operated at 10,000 Hz and paresthesia-free provides a substantial clinical improvement in pain management versus a low-frequency spinal cord stimulator.
- No changes are being introduced to C1822, but this information is being announced as the descriptor is closely related to C1820.

In the January 2016 ASC Update (See article MM9484), the Centers for Medicare & Medicaid Services (CMS) added the words “non-high-frequency” to the descriptor of C1820. CMS is revising the descriptor for C1820 back to its original language and deleting “non-high-frequency” from the descriptor such that the descriptor again states the following: *Generator, neurostimulator (implantable), with rechargeable battery and charging system.*

- Neurostimulator generators that are not high frequency are to be reported with C1820.
- Note also that C1820, in the ASC payment system, is a packaged code.
- ASCs do not report packaged codes, but with the change in the descriptor for HCPCS code C1820, it is important to announce the differentiation between HCPCS code C1822 and C1820.


2. Drugs, Biologicals, and Radiopharmaceuticals

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2016

For CY 2016, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2016, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly...
basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2016, are available in the April 2016 ASC Addendum BB at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html on the CMS website.

b. New Separately Payable CY 2016 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective April 1, 2016

For April 2016, nine new HCPCS codes have been created for reporting drugs and biologicals in the ASC setting. Additionally, one existing code, J7503, is now separately payable. These new codes, their descriptors, and payment indicators (PI) are listed in the following table.

New CY 2016 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals, and Radiopharmaceuticals, Effective April 1, 2016

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>ASC PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9137</td>
<td>Adynovate Factor VIII recom</td>
<td>Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 I.U.</td>
<td>K2</td>
</tr>
<tr>
<td>C9138</td>
<td>Nuwiq Factor VIII recom</td>
<td>Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwiq), 1 I.U.</td>
<td>K2</td>
</tr>
<tr>
<td>C9461</td>
<td>Choline C 11, diagnostic</td>
<td>Choline C 11, diagnostic, per study dose</td>
<td>K2</td>
</tr>
<tr>
<td>C9470</td>
<td>Aripiprazole lauroxil im</td>
<td>Injection, aripiprazole lauroxil, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9471</td>
<td>Hymovis, 1 mg</td>
<td>Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9472</td>
<td>Inj talimogene laherparepvec</td>
<td>Injection, talimogene laherparepvec, 1 million plaque forming units (PFU)</td>
<td>K2</td>
</tr>
<tr>
<td>C9473</td>
<td>Injection, mepolizumab</td>
<td>Injection, mepolizumab, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9474</td>
<td>Inj, irinotecan liposome</td>
<td>Injection, irinotecan liposome, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>C9475</td>
<td>Injection, necitumumab</td>
<td>Injection, necitumumab, 1 mg</td>
<td>K2</td>
</tr>
<tr>
<td>J7503</td>
<td>Tacrol envarsus ex rel oral</td>
<td>Tacrolimus, extended release, (envarsus xr), oral, 0.25 mg</td>
<td>K2</td>
</tr>
</tbody>
</table>

c. Revised Status Indicator for HCPCS Codes

Effective April 1, 2016, the PI for HCPCS code J0130 (Injection abciximab, 10 mg) will change from ASC PI= K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.) to ASC PI=N1 (Packaged service/item; no separate payment made.).

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Effective April 1, 2016, the PI for HCPCS code J0583 (Injection, bivalirudin, 1 mg) will change from ASC PI= K2 (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.) to ASC PI=N1 (Packaged service/item; no separate payment made.).

d. Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

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

Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may ask their MAC to adjust such previously processed claims.

3. Coverage Determinations

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

Additional Information


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

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New Waived Tests

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9563 informs MACs of new Clinical Laboratory Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Center for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests so that MACs can accurately process claims. Make sure your billing staffs are aware of these changes.

Background

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed in the following table are the latest tests approved by the FDA as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW (CLIA waived test). However, the CPT codes 81002, 81025, 82270,
82272, 82962, 83026, 84830, 85013, and 85651 do not require a QW modifier to be recognized as a waived test.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Effective Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81007QW</td>
<td>September 25, 2015</td>
<td>Jant Pharmacal Corporation Accutest Uriscreen (Bacteriuria)</td>
</tr>
<tr>
<td>G0434QW</td>
<td>From November 3, 2015, to December 31, 2015, and G0477QW on and after January 1, 2016</td>
<td>Nantong Egens Biotechnology Co., Ltd., EGENS Urine Test Marijuana (THC) Cassette</td>
</tr>
<tr>
<td>G0434QW</td>
<td>From November 3, 2015, to December 31, 2015, and G0477QW on and after January 1, 2016</td>
<td>Nantong Egens Biotechnology Co., Ltd., EGENS Urine Test Marijuana (THC) Cup</td>
</tr>
<tr>
<td>G0434QW</td>
<td>From November 3, 2015, to December 31, 2015, and G0477QW on and after January 1, 2016</td>
<td>Nantong Egens Biotechnology Co., Ltd., EGENS Urine Test Marijuana (THC) DipCard</td>
</tr>
<tr>
<td>G0434QW</td>
<td>From November 3, 2015, to December 31, 2015, and G0477QW on and after January 1, 2016</td>
<td>Nantong Egens Biotechnology Co., Ltd., EGENS Urine Test MDMA Cup</td>
</tr>
<tr>
<td>G0434QW</td>
<td>From November 3, 2015, to December 31, 2015, and G0477QW on and after January 1, 2016</td>
<td>Nantong Egens Biotechnology Co., Ltd., EGENS Urine Test MDMA DipCard</td>
</tr>
<tr>
<td>87631QW</td>
<td>December 3, 2015</td>
<td>Cepheid Gene Xpert Xpress System (Xpert Flu+RSV Xpress)</td>
</tr>
<tr>
<td>G0434QW</td>
<td>From December 17, 2015, to December 31, 2015, and G0477QW on and after January 1, 2016</td>
<td>Premier BIOTECH Premier Bio-cup &amp; Bio-Dip</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Effective Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0477QW</td>
<td>January 13, 2016</td>
<td>Medical Distribution Group Inc., Identify Diagnostics Drug Test Cards</td>
</tr>
<tr>
<td>G0477QW</td>
<td>January 13, 2016</td>
<td>Medical Distribution Group Inc., Identify Diagnostics Drug Test Cups</td>
</tr>
<tr>
<td>G0477QW</td>
<td>January 21, 2016</td>
<td>American Screening Corporation, Inc. Discover Plus Drug Test Cards</td>
</tr>
<tr>
<td>G0477QW</td>
<td>January 21, 2016</td>
<td>American Screening Corporation, Inc. Discover Plus Multi-Panel Drug Test Cups</td>
</tr>
</tbody>
</table>

The Healthcare Common Procedure Coding System (HCPCS) code G6040QW [Alcohol (ethanol); any specimen except breath] was discontinued on December 31, 2015. The new HCPCS code G0477 [Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg immunoassay) capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service] was effective January 1, 2016.

HCPCS code G0477QW describes the waived testing previously assigned code G6040QW. All tests in the attachment to CR9563 that previously had HCPCS G6040QW are now assigned G0477QW.

The new waived complexity code 87631QW [Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus) includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 3-5 targets] was assigned for the detection of influenza A, influenza B and respiratory syncytial virus viral RNA by reverse transcriptase polymerase chain reaction assay performed using the Cepheid Gene Xpert Xpress System (Xpert Flu+RSV Xpress).

Note that MACs will not search their files to either retract payment or retroactively pay claims processed before implementation of CR9563. However, MACs will adjust such claims that you bring to their attention.

**Additional Information**


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Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits

Provider Types Affected

This MLN Matters® Special Edition article is intended for Chiropractors and other practitioners who submit claims to Medicare Administrative Contractors (MACs) for chiropractic services provided to Medicare beneficiaries.

This article is part of a series of Special Edition (SE) articles prepared for Chiropractors by CMS in response to the request for educational materials at the September 24, 2015, Special Open Door Forum titled: “Improving Documentation of Chiropractic Services”. Other articles in the series are SE1602, which details the use of the AT modifier on chiropractic claims and SE1603, which identifies other useful resources to help chiropractors bill Medicare correctly for covered services.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is providing this Special Edition article to help clarify the CMS policy regarding Medicare coverage of chiropractic services for Medicare beneficiaries and documentation requirements for the beneficiary’s initial visit and subsequent visits to the Chiropractor.

Be aware of these policies along with any Local Coverage Determinations (LCDs) for these services in your area that might limit circumstances under which Medicare pays for active/corrective chiropractic services.

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**Background**

In 2014, the Comprehensive Error Testing Program (CERT) that measures improper payments in the Medicare Fee-For-Service (FFS) program reported a 54 percent error rate on claims for Chiropractic services. The majority of those errors were due to insufficient documentation or other documentation errors.

Medicare coverage of chiropractic services is specifically limited to treatment by means of manual manipulation (that is, by use of the hands) of the spine to correct a subluxation. The patient must require treatment by means of manual manipulation of the spine to correct a subluxation, and the manipulative services rendered must have a direct therapeutic relationship to the patient’s condition and provide reasonable expectation of recovery or improvement of function. Additionally, manual devices (that is, those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself.

Chiropractors are limited to billing three Current Procedural Terminology (CPT) codes under Medicare: 98940 (chiropractic manipulative treatment; spinal, one to two regions), 98941 (three to four regions), and 98942 (five regions). When submitting manipulation claims, chiropractors must use an Acute Treatment (AT) modifier to identify services that are active/corrective treatment of an acute or chronic subluxation. The AT modifier, when applied appropriately, should indicate expectation of functional improvement, regardless of the chronic nature or redundancy of the problem.

**Documentation Requirements**

The Social Security Act states that “no payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.” See the Social Security Act (Section 1833(e)) on the Internet.

In addition, the “Medicare Benefit Policy Manual” requires that the initial visit and all subsequent visits meet specific documentation requirements. See Chapter 15 (Section 240.1.2) on the CMS website.

**Documentation Requirements for the Initial Visit**

The following documentation requirements apply for initial visits whether the subluxation is demonstrated by x-ray or by physical examination:

1. **History:** The history recorded in the patient record should include the following:
   - Chief complaint including the symptoms causing patient to seek treatment;
   - Family history if relevant; and

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- Past medical history (general health, prior illness, injuries, or hospitalizations; medications; surgical history).

2. **Present Illness:** Description of the present illness including:

- Mechanism of trauma;
- Quality and character of symptoms/problem;
- Onset, duration, intensity, frequency, location, and radiation of symptoms;
- Aggravating or relieving factors;
- Prior interventions, treatments, medications, secondary complaints; and
- Symptoms causing patient to seek treatment.

**Note:** Symptoms must be related to the level of the subluxation that is cited. A statement on a claim that there is “pain” is insufficient. The location of the pain must be described and whether the particular vertebra listed is capable of producing pain in that area.

3. **Physical Exam:** Evaluation of musculoskeletal/nervous system through physical examination. To demonstrate a subluxation based on physical examination, two of the following four criteria (one of which must be asymmetry/misalignment or range of motion abnormality) are required and should be documented:

- **P - Pain/tenderness:** The perception of pain and tenderness is evaluated in terms of location, quality, and intensity. Most primary neuromusculoskeletal disorders manifest primarily by a painful response. Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation, provocation, etc. Furthermore, pain intensity may be assessed using one or more of the following; visual analog scales, algometers, pain questionnaires, and so forth.

- **A - Asymmetry/misalignment:** Asymmetry/misalignment may be identified on a sectional or segmental level through one or more of the following: observation (such as, posture and heat analysis), static palpation for misalignment of vertebral segments, diagnostic imaging.

- **R - Range of motion abnormality:** Changes in active, passive, and accessory joint movements may result in an increase or a decrease of sectional or segmental mobility. Range of motion abnormalities may be identified through one or more of the following: motion palpation, observation, stress diagnostic imaging, range of motion, measurement(s).

- **T - Tissue tone, texture, and temperature abnormality:** Changes in the characteristics of contiguous and associated soft tissue including skin, fascia, muscle, and ligament may be identified through one or more of the following procedures: observation, palpation, use of instrumentation, test of length and strength.
Note: The P.A.R.T. (Pain/tenderness; Asymmetry/misalignment; Range of motion abnormality; and Tissue tone, texture, and temperature abnormality) evaluation process is recommended as the examination alternative to the previously mandated demonstration of subluxation by x-ray/MRI/CT for services beginning January 1, 2000. The acronym P.A.R.T. identifies diagnostic criteria for spinal dysfunction (subluxation).

4. Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named. The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine. This designation is made in relation to the part of the spine in which the subluxation is identified as shown in the following table:

<table>
<thead>
<tr>
<th>Area of Spine</th>
<th>Names of Vertebrae</th>
<th>Number of Vertebrae</th>
<th>Short Form or Other Name</th>
<th>Subluxation ICD-10 code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td>Occiput</td>
<td>7</td>
<td>Occ, CO C1-C7</td>
<td>M99.00 M99.01</td>
</tr>
<tr>
<td></td>
<td>Cervical</td>
<td></td>
<td>C1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Atlas</td>
<td></td>
<td>C2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Axis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td>Dorsal or Thoracic Costovertebral</td>
<td>12</td>
<td>D1-D12 T1-T12 R1-R12 R1-R12</td>
<td>M99.02</td>
</tr>
<tr>
<td></td>
<td>Costotransverse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Back</td>
<td>Lumbar</td>
<td>5</td>
<td>L1-L5</td>
<td>M99.03</td>
</tr>
<tr>
<td>Pelvis</td>
<td>Ilii, R and L (I, Si)</td>
<td></td>
<td>I, Si</td>
<td>M99.05</td>
</tr>
<tr>
<td>Sacral</td>
<td>Sacrum, Coccyx</td>
<td></td>
<td>S, SC</td>
<td>M99.04</td>
</tr>
</tbody>
</table>

In addition to the vertebrae and pelvic bones listed, the Ilii (R and L) are included with the sacrum as an area where a condition may occur which would be appropriate for chiropractic manipulative treatment.

There are two ways in which the level of the subluxation may be specified in patient's record.

- The exact bones may be listed, for example: C 5, 6;
- The area may suffice if it implies only certain bones such as: occipito-atlantal (occiput and Cl (atlas)), lumbo-sacral (L5 and Sacrum) sacro-iliac (sacrum and ilium).

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Following are some common examples of acceptable descriptive terms for the nature of the abnormalities:

- Off-centered;
- Misalignment;
- Malpositioning;
- Spacing - abnormal, altered, decreased, increased;
- Incomplete dislocation;
- Rotation;
- Listhesis - antero, postero, retro, lateral, spondylo; and
- Motion - limited, lost, restricted, flexion, extension, hypermobility, hypomotility, aberrant.

Other terms may be used. If they are understood clearly to refer to bone or joint space or position (or motion) changes of vertebral elements, they are acceptable.

**X-rays**

As of January 1, 2000, an x-ray is not required by Medicare to demonstrate the subluxation. However, an x-ray may be used for this purpose if you so choose.

The x-ray must have been taken reasonably close to (within 12 months prior or 3 months following) the beginning of treatment. In certain cases of chronic subluxation (for example, scoliosis), an older x-ray may be accepted if the beneficiary’s health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent.

A previous CT scan and/or MRI are acceptable evidence if a subluxation of the spine is demonstrated.

5. **Treatment Plan**: The treatment plan should always include the following:

- Recommended level of care (duration and frequency of visits);
- Specific treatment goals; and
- Objective measures to evaluate treatment effectiveness.

**Date of the initial treatment.**

**The patient’s medical record.**

- Validate all of the information on the face of the claim, including the patient’s reported diagnosis(s), physician work (CPT code), and modifiers.
- Verify that all Medicare benefit and medical necessity requirements were met.
Documentation Requirements for Subsequent Visits

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

1. History
   a. Review of chief complaint;
   b. Changes since last visit; and
   c. Systems review if relevant.

2. Physical examination
   a. Examination of area of spine involved in diagnosis;
   b. Assessment of change in patient condition since last visit;
   c. Evaluation of treatment effectiveness.

3. Documentation of treatment given on day of visit.

Necessity for Treatment of Acute and Chronic Subluxation

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient’s condition and provide reasonable expectation of recovery or improvement of function.

The patient must have a subluxation of the spine as demonstrated by x-ray or physical examination, as described below.

Most spinal joint problems fall into the following categories:

- **Acute subluxation** - A patient’s condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical examination as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient’s condition.

- **Chronic subluxation** - A patient’s condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition); however, the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

You must place the HCPCS (Healthcare Common Procedure Coding System) modifier AT on a claim when providing active/corrective treatment to treat acute or chronic subluxation.

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However, the presence of the HCPCS modifier AT may not in all instances indicate that the service is reasonable and necessary.

ICD-10 Codes that Support Medical Necessity for Chiropractor Services

The chiropractic Local Coverage Determinations (LCDs) for MACs include ICD-10 Coding Information for ICD-10 Codes that support the medical necessity for Chiropractor services. There may be additional documentation information in your LCD. There are links to the chiropractic LCDs in the Additional Information section of this article.

The **Group 1 (primary) codes** are the only covered ICD-10-CM codes that support medical necessity for Chiropractor services.

- **Primary:** ICD-10-CM Codes (Names of Vertebrae)
- The precise level of subluxation must be listed as the primary diagnosis.

The Groups 2, 3, and 4 ICD-10-CM codes support the medical necessity for diagnoses and involve short, moderate, and long term treatment:

- **Group 2 Codes:** Category I - ICD-10-CM Diagnosis (diagnoses that generally require short term treatment)
- **Group 3 Codes:** Category II - ICD-10-CM Diagnosis (diagnoses that generally require moderate term treatment)
- **Group 4 Codes:** Category III - ICD-10-CM Diagnosis (diagnoses that may require long term treatment)

ICD-10 Codes that DO NOT Support Medical Necessity are **all** ICD-10-CM codes **not** listed in LCDs under *ICD-10-CM Codes That Support Medical Necessity*.

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.

To review MM3449, Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063 go to: [MM3449](http://www.cms.gov) on the CMS website.

Other articles in this series on chiropractic services are **SE1602**, which discusses the use of the AT modifier and **SE1603**, which lists a wide array of other materials to assist chiropractors in delivering covered services to Medicare beneficiaries and correctly billing for those services.

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Use of the AT modifier for Chiropractic Billing (new information along with information in MM3449)

Provider Types Affected

This Special Edition (SE) MLN Matters® article is intended for Chiropractors and other practitioners who submit claims to Medicare Administrative Contractors (MACs) for chiropractic services provided to Medicare beneficiaries.

This article is part of a series of Special Edition (SE) articles prepared for Chiropractors by the Centers for Medicare & Medicaid Services (CMS) in response to the request for educational materials at the September 24, 2015, Special Open Door Forum titled: Improving Documentation of Chiropractic Services.

Provider Action Needed

The Active Treatment (AT) modifier was developed to clearly define the difference between active treatment and maintenance treatment. Medicare pays only for active/corrective treatment to correct acute or chronic subluxation. Medicare does not pay for maintenance therapy. Claims should include a primary diagnosis of subluxation and a secondary diagnosis that reflects the patient’s neuro musculoskeletal condition. The patient’s medical record should support the services submitted. Related MLN Matters Article SE1601 discusses those medical record documentation requirements.

Be aware of these policies along with any local coverage determinations (LCDs) for these services in your area that might limit circumstances under which active/corrective chiropractic services are paid.
**Background**

In 2014, the Comprehensive Error Testing Program (CERT) that measures improper payments in the Medicare Fee-for-Service program reported a 54 percent error rate for Chiropractic services. The majority of those errors were due to insufficient documentation/documentation errors. Year after year these error rates appear. CMS is providing an explanation of the AT modifier to assist providers with correctly documenting claims for chiropractic services provided to Medicare beneficiaries.

The Active Treatment (AT) modifier defines the difference between active treatment and maintenance treatment. Effective October 1, 2004, the AT Modifier is required under Medicare billing to receive reimbursement for CPT codes 98940-98942. For Medicare purposes, the AT modifier is used only when chiropractors bill for active/corrective treatment (acute and chronic care). The policy requires the following:

1. Every chiropractic claim for 98940/98941/98942, with a date of service on or after October 1, 2004, should include the AT modifier if active/corrective treatment is being performed; and

2. The AT modifier should not be used if maintenance therapy is being performed. MACs deny chiropractic claims for 98940/98941/98942, with a date of service on or after October 1, 2004, that does not contain the AT modifier.

The following categories help determine coverage of treatment. (See the **Necessity for Treatment**, Chapter 15, Section 240.1.3, of the “Medicare Benefit Policy Manual” (pages 226-227)).

1. **Acute subluxation**: A patient's condition is considered acute when the patient is being treated for a new injury (identified by x-ray or physical examination). (See **SE1601** for details of the x-ray and examination requirements.) The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression of, the patient's condition.

2. **Chronic subluxation**: A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition); however, the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

Both of the above scenarios are covered by CMS as long as there is active treatment which is well documented and improvement is expected.
Maintenance: Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. The AT modifier must **not** be placed on the claim when maintenance therapy has been provided.

Chiropractors should consider obtaining an Advance Beneficiary Notice (ABN) from beneficiaries in the event of a denial of a claim. Information about the ABN, including downloadable forms is available at [https://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html](https://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html) on the CMS website. Also, see the “Medicare Claims Processing Manual,” Chapter 23 Section 20.9.1.1 pages 49 and 50, for important information about the use of an appropriate modifier on your claims with regard to the ABN.

Be aware that once the provider cannot determine there is any improvement, treatment becomes maintenance and is no longer covered by Medicare.

**Key Points**

For Medicare purposes, a chiropractor must place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary. As always, MACs may deny if appropriate after medical review determines that the medical record does not support active/corrective treatment.

**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.

To review MM3449, Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063 go to: [MM3449](https://www.cms.gov) on the CMS website.

Other articles in this series on chiropractic services are [SE1601](#), which discusses Medicare's medical record documentation requirements for chiropractic services and [SE1603](#), which lists a wide array of other materials to assist chiropractors in delivering covered services to Medicare beneficiaries and correctly billing for those services.

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Educational Resources to Assist Chiropractors with Medicare Billing

Provider Types Affected

This Special Edition (SE) MLN Matters® article is intended for Chiropractors submitting claims to Medicare Administrative Contractors (MACs) for chiropractic services provided to Medicare beneficiaries.

This article is part of a series of SE articles prepared for Chiropractors by CMS in response to the request for educational materials at the September 24, 2015 Special Open Door Forum titled: Improving Documentation of Chiropractic Services.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is providing this article in order to provide education for chiropractic billers on accessing the correct resources for proper billing. This article is intended to be a comprehensive resource for chiropractic documentation and billing.

Be aware of these policies along with any local coverage determinations (LCDs) for these services in your area that might limit circumstances under which active/corrective chiropractic services are paid.

Background

In 2014, the Comprehensive Error Testing Program (CERT) that measures improper payments in the Medicare Fee-for-Service program reported a 54 percent error rate for Chiropractic services. The majority of those errors were due to insufficient documentation/documentation errors. This article provides a detailed list of

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informational/educational resources that can help chiropractors avoid these errors. Those resources are as follows:

**Enrollment Information**

The “Medicare General Information, Eligibility, and Entitlement Manual,” Chapter 5, includes Section 70.6, “Chiropractors.” This section outlines the definition of a chiropractor, licensure and authorization to practice, and minimum standards.

The “Medicare Benefit Policy Manual,” Chapter 15, “Covered Medical and Other Health Services,” includes Section 40.4, “Definition of Physician/Practitioner.” This section explains that the opt out law does not define physician to include a chiropractor; therefore, a chiropractor may not opt out of Medicare and provide services under a private contract.

The “Medicare Program Integrity Manual,” Chapter 15 “Medicare Enrollment,” includes Section 15.4.4.11, “Physicians.” This section explains that a physician must be legally authorized to practice medicine by the State in which he/she performs such services in order to enroll in the Medicare Program and to retain Medicare billing privileges. A chiropractor who meets Medicare qualifications may enroll in the Medicare Program.

**Coverage, Documentation, and Billing**

The other articles in this series of articles on chiropractic services are SE1601, which discusses Medicare's medical record documentation requirements for chiropractic services, and SE1602, which discusses the importance of using the AT modifier on claims for chiropractic services.

MLN Matters Article MM3449, discusses Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063.

The “Medicare Benefit Policy Manual,” Chapter 15, “Covered Medical and Other Health Services,” includes the following sections explaining coverage for a chiropractor’s services:

- 30.5: Chiropractor’s Services;
- 220.1.3: Certification and Recertification of Need for Treatment and Therapy Plans of Care;
- 240: Chiropractic Services – General; This section establishes that payment for chiropractic services is based on the Medicare Physician Fee Schedule (MPFS) and that payment is made to the beneficiary or, on assignment, to the chiropractor.
- 240.1.1: Manual Manipulation;
- 240.1.2: Subluxation May Be Demonstrated by X-Ray or Physician’s Exam;
- 240.1.3: Necessity for Treatment;
- 240.1.4: Location of Subluxation; and
- 240.1.5: Treatment Parameters.
The Chiropractic Local Coverage Determinations (LCDs) for MACs include ICD-10 Coding Information for ICD-10 Codes that support the medical necessity for Chiropractor services. Each contractor has an LCD for Chiropractors. There may be additional documentation information in your LCD. There are links to the chiropractic LCDs in the additional information section of this article. Some of those LCDs are as follows:

- National Government Services (LCD L33613);
- First Coast Options, Inc (LCD L33840);
- CGS Administrators, LLC (LCD L33982);
- Noridian Healthcare Solutions, LLC (Jurisdiction F) (LCD L34009);
- Noridian Healthcare Solutions, LLC (Jurisdiction E) (LCD 34242);
- Wisconsin Physicians Service Insurance Corporation (LCD L34585); and
- Novitas Solutions, Inc (LCD L35424).

The Fact Sheet “Misinformation on Chiropractic Services” is designed to provide education on Medicare regulations and policies on chiropractic services to Medicare providers. It includes information on the documentation needed to support a claim submitted to Medicare for medical services.

The MLN Matters® Article – SE (Special Edition)1101 Revised “Overview of Medicare Policy Regarding Chiropractic Services” highlights Medicare policy regarding coverage of chiropractic services for Medicare beneficiaries.

The MLN Matters® Article – SE1305 Revised “Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)” explains that chiropractors are not eligible to order or refer supplies or services.

The “Medicare Claims Processing Manual,” Chapter 1 “General Billing Requirements” includes the following sections which apply to billing for a chiropractor’s services:

- 30.3.12: Carrier Annual Participation Program;
- 30.3.12.1: Annual Open Participation Enrollment Process;
- 30.3.12.1.2: Annual Medicare Physician Fee Schedule File Information; and
- 80.3.2.1.3: A/B MAC (B) Specific Requirements for Certain Specialties/Services.

The “Medicare Claims Processing Manual,” Chapter 12 “Physicians/Nonphysician Practitioners,” includes Section 220, “Chiropractic Services.” This section explains the documentation requirements when billing for a chiropractor’s services. Also the claims processing edits related to payment for a chiropractor’s services are explained.

The “Medicare Claims Processing Manual,” Chapter 26 “Completing and Processing Form CMS-1500 Data Set,” includes Section 10.4, “Items 14-33 – Provider of Service or Supplier Information.” This section includes specific instructions for chiropractic services for items 14, 17, and 19.

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The “NCCI Policy Manual for Medicare Services” under the Downloads section, Chapter XI, “Medicine, Evaluation and Management Services (CPT Codes 90000-99999),” includes information on chiropractic manipulative treatment.

More Resources: A chiropractor is eligible to receive incentive payments under the Physician Quality Reporting System (PQRS), Electronic Prescribing (eRx) Incentive Program, and Electronic Health Record (EHR) Incentive Program. Information on reporting these measures is available in the Physician and Other Enrolled Health Care Professionals pathway.

The “Medicare Claims Processing Manual, Chapter 23 “Fee Schedule Administration and Coding Requirements,” includes Section 30, “Services Paid Under the Medicare Physician’s Fee Schedule.” This section explains that a chiropractor is paid under the MPFS.

The booklet MLN Guided Pathways - Provider Specific Medicare Resources, pages 25-28, contains many resources useful for chiropractic billing.

**Advance Beneficiary Notice (ABN) Information**

The “Medicare Benefit Policy Manual,” Chapter 15 “Covered Medical and Other Health Services,” includes reference to Advance Beneficiary Notices (ABNs) in Section 240.1.3, “Necessity for Treatment.”

The “Medicare Claims Processing Manual,” Chapter 23 “Fee Schedule Administration and Coding Requirements,” includes Section 20.9.1.1, “Instructions for Codes With Modifiers (Carriers Only).” This section outlines the modifiers that may be used when a chiropractor notifies a beneficiary the item or service may not be covered.


Information about the ABN, including downloadable forms is available at https://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html on the CMS website.

**Additional Information**

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