## Medicare Monthly Review

### Contents

<table>
<thead>
<tr>
<th>National Government Services – Articles for Part A Part B Providers</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revised and Retired LCDs and Articles: May-June 2016</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Government Services – Articles for Part A Providers</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Admission(s) Prior to Medicare Entitlement (Pre-Entitlement) Quick Steps Job Aid</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Centers for Medicare &amp; Medicaid Services – Articles for Part A and Part B Providers</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>System Specific Enhancements 2014: Move PAP Smear Risk Indicator and Technical/Professional Dates to Screening Auxiliary File (MM9188)</td>
<td>6</td>
</tr>
<tr>
<td>2016 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System Code Jurisdiction List (MM9481 Revised)</td>
<td>8</td>
</tr>
<tr>
<td>Clarification of Inpatient Psychiatric Facilities Requirements for Certification, Recertification and Delayed/Lapsed Certification and Recertification (MM9522)</td>
<td>10</td>
</tr>
<tr>
<td>Coding Revisions to National Coverage Determinations (MM9540)</td>
<td>13</td>
</tr>
<tr>
<td>Claim Status Category and Claim Status Codes Update (MM9550)</td>
<td>15</td>
</tr>
<tr>
<td>Updates to Pub. 100-04, Chapters 1 and 16 to Correct Remittance Advice Messages (MM9578)</td>
<td>17</td>
</tr>
<tr>
<td>JW Modifier: Drug Amount Discarded/Not Administered to any Patient (MM9603 Revised)</td>
<td>19</td>
</tr>
<tr>
<td>Update to Internet-Only-Manual Publication 100-04, Chapter 18, Section 30.6 (MM9606)</td>
<td>21</td>
</tr>
<tr>
<td>Stem Cell Transplantation for Multiple Myeloma, Myelofibrosis, and Sickle Cell Disease, and Myelodysplastic Syndromes (MM9620)</td>
<td>22</td>
</tr>
<tr>
<td>Coding Revisions to National Coverage Determinations (MM9631)</td>
<td>27</td>
</tr>
<tr>
<td>Quarterly Update to the Medicare Physician Fee Schedule Database - July Calendar Year 2016 Update (MM9633)</td>
<td>29</td>
</tr>
<tr>
<td>Quarterly Healthcare Common Procedure Coding System Drug/Biological Code Changes - July 2016 Update (MM9636)</td>
<td>32</td>
</tr>
<tr>
<td>Percutaneous Left Atrial Appendage Closure (MM9638)</td>
<td>34</td>
</tr>
<tr>
<td>Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims (SE1521 Revised)</td>
<td>39</td>
</tr>
<tr>
<td>Medicare Coverage of Substance Abuse Services (SE1604)</td>
<td>42</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Centers for Medicare &amp; Medicaid Services – Articles for Part A Providers</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 (MM8822 Revised)</td>
<td>49</td>
</tr>
<tr>
<td>Billing of Vaccine Services on Hospice Claims (MM9052)</td>
<td>53</td>
</tr>
<tr>
<td>Shared Savings Program (SSP) Accountable Care Organization Qualifying Stay Edits (MM9568)</td>
<td>55</td>
</tr>
<tr>
<td>Making Principal Diagnosis Codes Mandatory for Notice of Election to be Accepted (MM9575)</td>
<td>57</td>
</tr>
<tr>
<td>System Changes to Implement Section 231 of the Consolidated Appropriations Act, 2016, Temporary Exception for Certain Severe Wound Discharges From Certain Long-Term Care Hospitals (MM9599)</td>
<td>58</td>
</tr>
</tbody>
</table>
Phase 2 of Updating the Fiscal Intermediary Shared System to Make Payment for Drugs and Biologicals Services for Outpatient Prospective Payment System Providers (MM9601)  63
July 2016 Update of the Hospital Outpatient Prospective Payment System (MM9658)  66
July 2016 Integrated Outpatient Code Editor (I/OCE) Specifications Version 17.2 (MM9661)  75
Rural Health Clinics Healthcare Common Procedure Coding System Reporting Requirement and Billing Updates (SE1611)  78

Revisions to Private Contracting/Opt-out Manual Sections Due to the Medicare Access and CHIP Reauthorization Act of 2015 (MM9616)  82

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 we site at http://www.NGSMedicare.com.
Revised and Retired LCDs and Articles: May-June 2016

May 2016 Revisions

Blepharoplasty - Medical Policy Article (A52837)
Removed place of service guidelines, and made minor template changes, effective for services rendered on or after 10/1/2015.

Panretinal (Scatter) Laser Photocoagulation (L33628)
Deleted “or xenon arc” under Limitations of coverage section because the technology is clinically outdated.

June 2016 Revisions

Bortezomib (e.g., Velcade®) – Related to LCD L33394 (A52371)
Based on a reconsideration request for antibody mediated rejection (AMR), sources have been added to the “Sources of Information” section of the article. No changes were made in coverage. Non-Hodgkin lymphoma – Castleman’s disease has been added to the “Indications” section of the article and ICD-10-CM codes D36.0, R59.0, R59.1 and R59.9 have been added effective for dates of service on or after 6/1/2016. The first paragraph in the “Indications” section of the article has been revised to include Lexi-Drug compendium. Lexi-Drug website has been added to the “Sources of Information” section of the article.

Biologic Products for Wound Treatment and Surgical Interventions (L33391)
Based on a reconsideration request, the Integra® Dermal Regeneration Template (IDRT)/Integra® Omnigraft™ Dermal Regeneration Matrix (Omnigraft™) and Integra® Bilayer Wound Dressing article (A52418) was revised to include coverage for diabetic foot ulcers (DFUs) effective for dates of service on or after 6/1/2016.

Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L33394)
Based on a reconsideration request for antibody mediated rejection (AMR) for bortezomib, the Bortezomib article (A52371) has been revised to add sources and an indication for non-hodgkin lymphoma – Castleman’s disease in addition to adding ICD-10-CM codes. The Filgrastim, Pegfilgrastim, Tbo-filgrastim, Filgrastim-sndz (e.g., Neupogen®, Neulasta™, Granix™ Zarxio™) article (A52408) has been revised to add indications for Tbo-filgrastim in addition to adding ICD-10-CM codes.

Filgrastim, Pegfilgrastim, Tbo-filgrastim, Filgrastim-sndz (e.g., Neupogen®, Neulasta™, Granix™ Zarxio™) - Related to LCD L33394 (A52408)
The “Indications” for Tbo-filgrastim have been revised to include:

- in mobilization of hematopoietic progenitor cells in the autologous setting as a single agent, following combination chemotherapy, or in combination with plerixafor when the transplant procedure is a covered benefit
- supportive care in the post-transplant setting

ICD-10-CM codes Z52.011 and Z94.84 have been added for Tbo-filgrastim effective for dates of service on or after 6/1/2016. The first paragraph in the “Indications” section of the article has been revised to include Lexi-Drug compendium. Lexi-Drug website has been added to the “Sources of Information” section of the article.

Incision and Drainage (I & D) of Abscess of Skin, Subcutaneous and Accessory Structures (L33563)
ICD-10-CM codes M23.000, M23.001, M23.003, M23.004, M23.006, M23.007, M23.011, M23.012, M23.021, M23.022, M23.031, M23.032, M23.041, M23.042, M23.051, M23.052, M23.061 and M23.062 were added to the “ICD-10-CM Codes that Support Medical Necessity” section.
Integra® Dermal Regeneration Template (IDRT)/Integra® Omnigraft™ Dermal Regeneration Matrix (Omnigraft™) and Integra® Bilayer Wound Dressing – Related to LCD L33391 (A52418)

Based on a reconsideration request, coverage was expanded to include diabetic foot ulcers (DFUs). The “Article Title,” “Abstract,” “Indications,” “Limitations,” “Utilization Guidelines,” “Sources of Information and Basis for Decision” and “ICD-10-CM Codes that Support Medical Necessity” sections have been revised.

Noninvasive Vascular Studies (L33627)

ICD-10 codes I82.401, I82.402 and I82.403 have been added to the payable diagnoses for Group 4, Extremity Venous Evaluation (93965, 93970 and 93971), effective 10/1/2015.

Self-Administered Drug Exclusion List – Medical Policy Article - JK (A53021) and J6 (A53022)

Added ixekizumab (Taltz™) (C9399, J3590) effective 7/15/2016

Retired Supplemental Instruction Articles

The SIAs, listed below have been retired, effective 5/1/2016. Please refer to the Ophthalmology Billing Guide on our website for coding and billing information (Ophthalmology/Optometry Billing Guide).

- Cataract Extraction (A52819)
- Corneal Pachymetry (A52820)
- Implantable Miniature Telescope (IMT) (A52857)
- Ophthalmic Biometry for Intraocular Lens Power Calculation (A52821)
- Ophthalmology: Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography) (A52861)
- Panretinal (Scatter) Laser Photocoagulation (A52822)
- Visual Fields Testing (A52829)

National Government Services Articles for Part A Providers

Inpatient Admission(s) Prior to Medicare Entitlement (Pre-Entitlement) Quick Steps Job Aid

When a beneficiary is admitted as an inpatient to an acute care hospital prior to the beneficiary’s Medicare entitlement effective date this is considered pre-entitlement. For inpatient claims (11X claim type) to be processed correctly by Medicare, claims must be submitted following the steps:

1. The Admission date Field Locator (FL) 12 equals the actual admission date to the hospital
2. The statement covers from/through period (FL) 6 shows
   - From Date equal to the effective date of Medicare coverage
   - Through Date equal to the discharge date from the hospital.
3. The covered days reflect the covered days billed in the statement covered period in (FL) 6

Utilization is not counted for any nonentitlement days even if those days are treated as covered for outlier calculation. Therefore, the services rendered during the entire stay are billed on the UB-04 as covered charges. The admission date will reflect the date of admission to the hospital, while the from/through dates will only reflect the actual entitlement through discharge.

When the beneficiary becomes entitled after admission, the hospital may not bill the beneficiary or other persons for days of care preceding entitlement except for days in excess of any outlier threshold. The entire stay is paid under the appropriate MS-DRG; therefore, no ancillary charges should be billed on a TOB 13X.

Related Content

CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 3, Section 40 (1 MB)
This MLN Matters® Article is intended for institutional providers and Home Health Agencies (HHAs) submitting inquiries to Medicare Administrative Contractors (MACs) for information on PAP smear services provided to Medicare beneficiaries.

**What You Need to Know**

CR9188 announces changes to Medicare systems regarding the placement of PAP smear data on Medicare’s internal files. The PAP smear data is displayed on the following provider inquiry screens:

- HIQA - Healthcare inquiry for part A for online transactions
- HIQH - Healthcare inquiry for Home Health for online transactions
- ELGA - Eligibility for part A
- ELGH - Eligibility for Home Health
- HUQA - Healthcare Update Inquiry for part A

The Healthcare Common Procedure Coding System (HCPCS) codes for PAP screening displayed on these screens are P3000, G0123, G0143, G0144, G0145, G0147 and G0148, and the screens can show up to three occurrences per HCPCS.

The other significant change for providers is that on the unformatted provider inquiry, HUQA, PAP information will now be carried in screening data location 4053-4612, instead of 780-784.
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.

Disclaimer

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

MLN Matters® Number: MM9481 Revised  Related Change Request (CR) #: CR9481
Related CR Release Date: May 10, 2016  Effective Date: January 1, 2016
Related CR Transmittal #: R3520CP  Implementation Date: February 1, 2016

2016 Durable Medical Equipment Prosthetics, Orthotics, and Supplies
Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List

Note: This article was revised on May 10, 2016, due to a revised Change Request (CR). The CR revised the jurisdiction for HCPCS E0781 to DME MAC only and omitted the local carrier jurisdiction for this code in the attachment to the CR. The CR release date, transmittal number and link to the CR also changed. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

CR9481 notifies suppliers that the spreadsheet containing an updated jurisdiction list of Healthcare Common Procedure Coding System (HCPCS) codes is updated annually to reflect codes that have been added or discontinued (deleted) each year. Changes in Chapter 23, Section 20.3 of the “Medicare Claims Processing Manual” are reflected in the recurring update notification. The spreadsheet for the 2016 DMEPOS Jurisdiction List is an Excel® spreadsheet and is available under the Coding Category at http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html and is also attached to CR9481.

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>
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Clarification of Inpatient Psychiatric Facilities (IPF) Requirements for Certification, Recertification and Delayed/ Lapsed Certification and Recertification

Provider Types Affected

This MLN Matters® Article is intended for physicians and other specified providers submitting claims to Medicare Administrative Contractors (MACs) to certify and recertify the medical necessity of inpatient psychiatric services provided to Medicare beneficiaries.

What You Need to Know

A physician or other specified providers need to certify the medical necessity of inpatient services. This is required at admission, and if the service is needed for an extended period of time, a recertification is necessary. CR9522 clarifies that your MAC will cease denials of Inpatient Psychiatric Facility (IPF) providers that do not use “the statement” that “the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel” for recertification when documentation is present that validates (without using any particular words) that the patient continues to need care.

Background

Currently, the IPF Prospective Payment System (PPS) requires facilities to provide “the statement” for recertification. As a result, payments to providers whose documentation validates all the necessary requirements to continue care were being denied because they did not use “the statement.”
CR9522 clarifies physician certification, recertification and delayed/lapsed certification and recertification with respect to IPF services in the “Medicare General Information, Eligibility and Entitlement Manual,” Chapter 4, Section 10.9 and in the “Medicare Benefit Policy Manual,” Chapter 2, Section 30.2.1.

There is also a difference in the content of the certification and recertification. In certification the physician is required to document that the IPF admission was medically necessary for either: (1) treatment which could reasonably be expected to improve the patient's condition, or (2) diagnostic study.

**Key Points of CR9522**

- Your MAC will use the beneficiary’s IPF medical record, if the statement “that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel” is not present in the physician's recertification documentation, to determine if all the required elements for recertification were met.
- Your MAC will allow providers to adopt any method that permits verification of all the elements IPFs require to continue treatment. No specific procedures or forms are required for certification and recertification. The recertification may be entered on provider generated forms, in progress notes, or in the records (relating to the stay in question) and must be signed by a physician.
- Your MAC will deny IPF claims that do not have timely certifications and recertifications. However, delayed certifications and recertifications will be honored where, for instance, there has been an oversight or lapse, and there is a legitimate reason for the delay. Denial of payment for lack of the required certification and recertification is considered a technical denial, which means a statutory requirement has not been met.
- MACs will allow the reopening of technical denial decisions (initiated by the provider or contractor).
- MACs will reverse any delayed/lapsed certification or recertification denials where the provider later produced a legitimate reason for the delay.
- MACs will review provider explanations/reasons for delayed certification and recertification. The submission of documents must include an explanation for the delay and any medical or other evidence the IPF considers relevant for purposes of explaining the delay.
- MACs will allow the IPF to determine the format of delayed certification and recertification statements, and the method by which they are obtained. A delayed certification may be included with one or more recertifications on a single signed statement. Separate signed statements for each delayed certification and recertification are not required, as they would be if timely certification and recertification had been completed. For all IPF services, a delayed certification may not extend past discharge. An IPF certification or recertification statement may only be signed by a physician.
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.
Coding Revisions to National Coverage Determinations

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) 9540 is the 7th maintenance update of the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

Background

The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically, CR7818, CR8109, CR8197, CR8691, CR9087, and CR9252. You may review the corresponding MLN Matters® Articles MM7818, MM8109, MM8197, MM8691, MM9087, and MM9252 for these CRs on the Centers for Medicare & Medicaid Services (CMS) website. Some are the result of revisions required to other NCD-related CRs released separately.

Updated NCD coding spreadsheets related to CR9540 are available at http://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9540.zip. CR9540 updates the following 14 NCDs:

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1. NCD20.29 - Hyperbaric Oxygen Therapy  
2. NCD90.1 - Pharmacogenomic Testing for Warfarin Response  
3. NCD110.18 - Aprepitant for Chemotherapy-Induced Emesis  
4. NCD150.3 - Bone Mineral Density Studies  
5. NCD160.18 - Vagus Nerve Stimulation for Treatment of Seizures  
6. NCD160.24 - Deep Brain Stimulation for Essential Tremor  
7. NCD210.3 - Colorectal Cancer Screening Tests  
8. NCD210.14 - Screening for Lung Cancer with Low-Dose CT (CR9246)  
9. NCD230.18 - Sacral Nerve Stimulation for Urinary Incontinence  
10. NCD260.1 - Adult Liver Transplantation (CR9252, CR8109)  
11. NCD110.4 - Exacorporeal Photopheresis  
12. NCD20.33 - Transcatheter Mitral Valve Repair (CR9002, TDL150341, policy effective August 7, 2014)  
13. NCD220.13 - Percutaneous Image-Guided Breast Biospy  
14. NCD220.4 - Mammograms  

MACs will adjust any claims already processed, if erroneously impacted by the above changes, if you bring such claims to their 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 under - How Does It Work.
Claim Status Category and Claim Status Codes Update

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9550 informs MACs about the changes to Claim Status Category Codes and Claim Status Codes. Make sure that your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions of new codes, as well as modifications and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes.

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Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the June 2016 committee meeting will be posted on the above mentioned websites on or about July 1, 2016.

The Centers for Medicare & Medicaid Services (CMS) will issue future CRs regarding the need for future updates to these codes. These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR9550.

**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.
Updates to Pub. 100-04, Chapters 1 and 16 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.

Provider Action Needed

If Change Request (CR) 9578 updates Chapter 1 and Chapter 16 of the “Medicare Claims Processing Manual” to reflect the standard format and to correct any non-compliant remittance advice code combinations. Make sure that your billing staffs are aware of the corrected code combinations.

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).
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.

CR9578 makes the following code revisions:

1. When a MAC rejects an out of jurisdiction professional claim as unprocessable, the following codes are used:
   - Group Code of CO
   - CARC 109, and
   - RARC N104

2. When a MAC rejects misdirected Railroad Retirement Board claims as unprocessable, the following codes are used:
   - Group Code of CO
   - CARC 109, and
   - RARC N105

3. When a MAC rejects misdirected United Mine Workers Association claims as unprocessable, the following codes are used:
   - Group Code CO
   - CARC 109, and
   - RARC N127

4. In the above 3 situations, RARC MA130 was used previously, but will no longer be used in these situations.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.
MLN Matters® Number: MM9603 Revised Related Change Request (CR) #: CR 9603
Related CR Release Date: May 24, 2016 Effective Date: July 1, 2016
Related CR Transmittal #: R3530CP Implementation Date: July 5, 2016

**JW Modifier: Drug Amount Discarded/ Not Administered to any Patient**

*Note:* This article was revised on May 25, 2016, to reflect an updated Change Request (CR). That CR updated the X-Ref Requirement number in the CR's Supporting Information Section. In the article, the CR release date, transmittal number and link to the CR was changed. All other information remains the same.

**Provider Types Affected**

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

**Provider Action Needed**

The Centers for Medicare & Medicaid Services (CMS) issued CR 9603 to alert MACs and providers of the change in policy regarding the use of the JW modifier for discarded Part B drugs and biologicals.

Effective July 1, 2016, providers are required to:

- Use the JW modifier for claims with unused drugs or biologicals from single use vials or single use packages that are appropriately discarded (except those provided under the Competitive Acquisition Program (CAP) for Part B drugs and biologicals) and
- Document the discarded drug or biological in the patient's medical record when submitting claims with unused Part B drugs or biologicals from single use vials or single use packages that are appropriately discarded

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Make sure that your billing staffs are aware of these changes. Remember that the JW modifier is not used on claims for CAP drugs and biologicals.

Background

The “Medicare Claims Processing Manual,” Chapter 17, Section 40 provides policy detailing the use of the JW modifier for discarded Part B drugs and biologicals. The current policy allows MACs the discretion to determine whether to require the JW modifier for any claims with discarded drugs or biologicals, and the specific details regarding how the discarded drug or biological information should be documented.

Be aware in order to more effectively identify and monitor billing and payment for discarded drugs and biologicals, **CMS is revising this policy to require the uniform use of the JW modifier for all claims with discarded Part B drugs and biologicals.**

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>Document History</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 25, 2016</td>
<td>The article was revised to reflect an updated CR. That CR updated the X-Ref Requirement number in the CR's Supporting Information Section. In the article, the CR release date, transmittal number and link to the CR was changed. All other information remains the same.</td>
</tr>
</tbody>
</table>

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MLN Matters® Number: MM9606  Related Change Request (CR) #: CR 9606
Related CR Release Date: May 13, 2016  Effective Date: June 14, 2016
Related CR Transmittal #: R3522CP  Implementation Date: June 14, 2016

Update to Internet-Only-Manual Publication 100-04, Chapter 18, Section 30.6

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

Provider Action Needed
CR9606 advises the MACs of an update to the “Medicare Claims Processing Manual,” Chapter 18, Section 30.6. CR9606 updates the manual by replacing an incorrect diagnosis code for screening of cervical cancer with HPV testing. The manual shows an incorrect ICD-10 code of Z12.92 and the correct ICD-10 code is Z12.72 (encounter for screening for malignant neoplasm of the vagina). Make sure that your billing staffs are aware of this change.

Additional Information
The official instruction, CR9606, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3522CP.pdf. The updated manual section is attached to the CR.

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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Stem Cell Transplantation for Multiple Myeloma, Myelofibrosis, and Sickle Cell Disease, and Myelodysplastic Syndromes

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9620, from which this article was developed, notifies providers that effective for claims with dates of service on and after January 27, 2016, for the use of allogeneic Hematopoietic Stem Cell Transplantation (HSCT) for treatment of Multiple Myeloma, Myelofibrosis, and Sickle Cell Disease is covered by Medicare, but only if provided in the context of a Medicare-approved clinical study meeting specific criteria under the Coverage with Evidence Development (CED) paradigm.

CR9620 also clarifies the ICD-9 and ICD-10 diagnosis codes for allogeneic HSCT for treatment of Myelodysplastic Syndromes (MDS) in the context of a Medicare-approved, prospective clinical study under CED. Specifically, for dates of service on or after August 4, 2010, through September 30, 2015, the ICD-9-CM diagnosis codes are 238.72, 238.73, 238.74, or 238.75 AND clinical trial ICD-9-CM diagnosis code V70.7. For dates of service on or after October 1, 2015, the ICD-10-CM diagnosis codes are D46.A, D46.B, D46.C, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, or D46.Z AND clinical trial ICD-10-CM diagnosis code Z00.6. Make sure your billing staff is aware of these determinations.

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Background

HSCT is a process that includes mobilization, harvesting, and transplant of stem cells and the administration of high-dose chemotherapy and/or radiotherapy prior to the actual transplant. During the process stem cells are harvested from either the patient (autologous) or a donor (allogeneic) and subsequently administered by intravenous infusion to the patient.

Multiple myeloma is a neoplastic plasma-cell disorder. Myelofibrosis is a stem cell-derived hematologic disorder. Sickle cell disease is a group of inherited red blood cell disorders created by the presence of abnormal hemoglobin genes. On April 30, 2015, the Centers for Medicare & Medicaid Services (CMS) accepted a formal request from the American Society for Blood and Marrow Transplantation (ASBMT) to reconsider its policy and expand coverage of allogeneic HSCT for sickle cell disease, Myelofibrosis, multiple myeloma and rare diseases.

Myelodysplastic Syndrome (MDS) refers to a group of diverse blood disorders in which the bone marrow does not produce enough healthy, functioning blood cells. On August 4, 2010, CMS issued a final decision stating that allogeneic HSCT for MDS is covered by Medicare only if provided pursuant to a Medicare-approved clinical study under CED. CR 7137 (see the article, MM7137 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7137.pdf) provides specific ICD-9 related coding and claims processing requirements regarding this particular coverage decision, and CRs 8197 and 8691 (see MM8197 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8197.pdf and MM8691 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8691.pdf) provide ICD-10 related coding requirements. On November 30, 2015, CMS accepted a formal request from the National Marrow Donor Program (NMDP) to clarify the list of ICD-9-CM and ICD-10-CM diagnosis codes covered for allogeneic HSCT for the treatment of MDS in the context of a Medicare-approved clinical study under CED.

On January 27, 2016, CMS issued a final decision to expand national coverage of items and services necessary for research in an approved clinical study via Coverage with Evidence Development (CED) under Section 1862(a)(1)(E) of the Social Security Act (the Act) for allogeneic HSCT for the following indications:

- Multiple Myeloma
- Myelofibrosis
- Sickle Cell Disease

Refer to the following Medicare manual sections for more information regarding this NCD and further billing instructions specific to this NCD and the business requirements specific to CR9620:

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In addition to the diagnosis codes detailed at the beginning of this article, providers need to be aware of the other billing requirements, as follows:

**Inpatient Claims**

For claims submitted on type of bill 11X for discharges on or after January 27, 2016, for HSCT for the treatment of Multiple Myeloma, Myelofibrosis, or Sickle Cell Disease, the claim must show:

- An ICD-10-PCS procedure code of 30230G1, 30230Y1, 30233G1, 30233Y1, 30240G1, 30240Y1, 30243G1, 30243Y1, 30250G1, 30250Y1, 30253G1, 30253Y1, 30260G1, 30260Y1, 30263G1, or 30263Y1 AND
- The clinical trial ICD-10-CM code of Z00.6 AND
- Condition code 30, denoting qualifying clinical trial AND
- Value code D4 showing the Clinical Trial Number (assigned by NLM/NIH with an 8-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
  - Multiple Myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 OR
  - Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 OR
  - Sickle Cell Disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

**Outpatient Claims**

For claims submitted on type of bill 13X or 85X for dates of service on or after January 27, 2016, for HSCT for the treatment of Multiple Myeloma, Myelofibrosis, or Sickle Cell Disease, the claim must show:

- An HSCT CPT code of 38240 AND
- The clinical trial ICD-10-CM code of Z00.6 AND
- Condition code 30, denoting qualifying clinical trial AND
• Value code D4 showing the Clinical Trial Number (assigned by NLM/NIH with an 8-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
  o Multiple Myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 OR
  o Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 OR
  o Sickle Cell Disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Method II Critical Access Hospital (CAH) Claims

For claims submitted on type of bill 85X with Revenue Codes 96X, 97X, or 98X for dates of service on or after January 27, 2016, for HSCT for the treatment of Multiple Myeloma, Myelofibrosis, or Sickle Cell Disease, the claim must show:

• An HSCT CPT code of 38240 AND
• The clinical trial ICD-10-CM code of Z00.6 AND
• Condition code 30, denoting qualifying clinical trial AND
• Value code D4 showing the Clinical Trial Number (assigned by NLM/NIH with an 8-digit clinicaltrials.gov identifier number listed on the CMS website) along with the appropriate ICD-10-diagnosis code of:
  o Multiple Myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 OR
  o Myelofibrosis-ICD-10-CM diagnosis code C94.40, C94.41, C94.42, D47.4, or D75.81 OR
  o Sickle Cell Disease-ICD-10-CM diagnosis code D57.00, D57.01, D57.02, D57.1, D57.20, D57.211, D57.212, D57.219, D57.40, D57.411, D57.412, D57.419, D57.80, D57.811, D57.812, or D57.819

Professional Claims

For professional claims submitted on type of bill 85X with Revenue Codes 96X, 97X, or 98X for dates of service on or after January 27, 2016, for HSCT for the treatment of Multiple Myeloma, Myelofibrosis, or Sickle Cell Disease, the claim must show:

• An HSCT CPT code of 38240 AND
• The clinical trial ICD-10-CM code of Z00.6 AND
• The Q0 modifier AND
• A Place of Service Code of 19, 21, or 22 along with the appropriate ICD-10-CM diagnosis code of:
  o Multiple Myeloma-ICD-10-CM diagnosis code C90.00, C90.01, or C90.02 OR

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For all of the above claims types submitted without the requisite coding, MACs will deny the claims using the following messages:

- Claim Adjustment Reason Code (CARC) 50 - These are non-covered services because this is not deemed a ‘medical necessity’ by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remarks Code (RARC) N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code - Patient Responsibility (PR) if an Advance Beneficiary Notice (ABN)/Hospital Notice on Non-Coverage (HINN), otherwise Contractual Obligation (CO)

For claims with dates of service prior to the implementation date of CR9620, MACs shall perform necessary adjustments only when the provider brings such claims to the attention of their MAC.

Additional Information


If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.
MLN Matters® Number: MM9631  
Related Change Request (CR) #: CR 9631

Related CR Release Date: May 13, 2016  
Effective Date: October 1, 2016 - unless noted differently in CR9631

Related CR Transmittal #: R1665OTN  
Implementation Date: October 3, 2016

Coding Revisions to National Coverage Determinations (NCDs)

Provider Types Affected

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

Provider Action Needed

CR9631 is the 8th maintenance update of International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR7818, CR8109, CR8197, CR8691, CR9087, CR9252, and CR9540, while others are the result of revisions required to other NCD-related CRs released separately. Review MLN Matters® Articles MM7818, MM8109, MM8197, MM8691, MM9087, MM9252, and MM9540 for information pertaining to these CR’s.

Background

The translations from ICD-9 to ICD-10 are not consistent one-to-one matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMS) guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. For these reasons, there may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable.
No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Updated NCD coding spreadsheets related to CR9631 are available at https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9631.zip.

Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process.

To be specific, CR9631 makes adjustments to the following NCDs:

- NCD 20.4 - Implantable Automatic Defibrillators
- NCD 20.7 - Percutaneous Transluminal Angioplasty (PTA)
- NCD 20.9 - Artificial Hearts
- NCD 20.29 - Hyperbaric Oxygen Therapy
- NCD 50.3 - Cochlear Implants
- NCD 110.18 - Aprepitant
- NCD 210.3 - Colorectal Cancer Screening
- NCD 220.4 - Mammography
- NCD 230.9 - Cryosurgery of Prostate
- NCD 260.9 - Heart Transplants
- NCD 210.4 - Smoking/Tobacco-Use Cessation Counseling
- NCD 210.4.1 - Counseling to Prevent Tobacco Use

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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Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9633 amends payment files that were issued to your MAC based upon the CY 2016 MPFS Final Rule published in the Federal Register on November 16, 2015. These payment files are to be effective for services furnished between January 1, 2016, and December 31, 2016. Make sure your billing staff is aware of these changes.

Background

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

Key Changes in CR9633

Unless otherwise stated, the changes included in the July update to the 2016 MPFSDB are effective for dates of service on and after January 1, 2016.
The key changes for the July update, effective as of January 1, 2016, are as follows.

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0296</td>
<td>Multiple Surgery = 0; Diagnostic Imaging Family Indicator = 99</td>
</tr>
<tr>
<td>G9678</td>
<td>Procedure Status = C (Effective for services on or after 7-1-2016.)</td>
</tr>
<tr>
<td>10036</td>
<td>Multiple Surgery Indicator = 0</td>
</tr>
<tr>
<td>37188</td>
<td>Multiple Surgery Indicator = 0</td>
</tr>
<tr>
<td>45346</td>
<td>Endo Base Code = 45330</td>
</tr>
<tr>
<td>61651</td>
<td>Multiple Surgery Indicator = 0</td>
</tr>
<tr>
<td>65855</td>
<td>Bilateral Indicator = 1</td>
</tr>
<tr>
<td>69209</td>
<td>PC/TC indicator = 3</td>
</tr>
</tbody>
</table>

The following new codes in CR9636 have also been added to the MPFSDB.

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Short Descriptor</th>
<th>Procedure Status</th>
<th>RVU</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5102</td>
<td>Inj., infliximab biosimilar</td>
<td>E</td>
<td>no RVUs</td>
<td>4-5-16</td>
</tr>
<tr>
<td>Q9981</td>
<td>rolapitant, oral, 1mg</td>
<td>E</td>
<td>no RVUs</td>
<td>7-1-16</td>
</tr>
<tr>
<td>Q9982</td>
<td>flutemetamol f18 diagnostic</td>
<td>E</td>
<td>no RVUs</td>
<td>7-1-16</td>
</tr>
<tr>
<td>Q9983</td>
<td>florbetaben f18 diagnostic</td>
<td>E</td>
<td>no RVUs</td>
<td>7-1-16</td>
</tr>
</tbody>
</table>


**CPT Codes effective on or after July 1, 2016**

The new CPT Category III codes listed below have been added to the MPFSDB effective for dates of service on and after July 1, 2016.

There are no RVUs for these codes, and the following payment policy indicators are the same for each code: Procedure Status = C, Multiple Surgery = 0, Bilateral Surgery = 0, Assistant at Surgery = 0, Co-Surgeons = 0, Team Surgeons = 0, PC/TC = 0, Physician Supervision of Diagnostic Procedures = 09, and Diagnostic Imaging Family = 99. The Global Surgery Days for 0437T, 0439T, and 0443T = ZZZ; the rest are YYY.

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<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0437T</td>
<td>Impl tj synth rncmt abdl wal</td>
<td>Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>0438T</td>
<td>Tprnl plmt biodegrdabl mattrl</td>
<td>Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance</td>
</tr>
<tr>
<td>0439T</td>
<td>Myocrd contrast prfuj echo</td>
<td>Myocardial contrast perfusion echocardiography; at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>0440T</td>
<td>Abltj perc uxtr/perph nrv</td>
<td>Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve</td>
</tr>
<tr>
<td>0441T</td>
<td>Abltj perc lxtr/perph nrv</td>
<td>Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve</td>
</tr>
<tr>
<td>0442T</td>
<td>Abltj perc plex/trncl nrv</td>
<td>Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)</td>
</tr>
<tr>
<td>0443T</td>
<td>R-t spctrl alys prst8 tiss</td>
<td>Real time spectral analysis of prostate tissue by fluorescence spectroscopy</td>
</tr>
<tr>
<td>0444T</td>
<td>1st plmt drug elut oc ins</td>
<td>Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral</td>
</tr>
<tr>
<td>0445T</td>
<td>Sbsqt plmt drug elut oc ins</td>
<td>Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral</td>
</tr>
</tbody>
</table>

**Note:** MACs will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, they will adjust claims brought to their 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/MLN Matters Articles/index.html under - How Does It Work.

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Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9636 informs Medicare providers and suppliers that effective for claims with dates of service on or after July 1, 2016, new Healthcare Common Procedure Coding System (HCPCS) codes Q9981 (rolapitant, oral, 1mg); Q9982 (flutemetamol f18 diagnostic); and Q9983 (florbetaben f18 diagnostic) will be payable for Medicare. In addition, the HCPCS code set will contain code Q5102 (Inj., infliximab biosimilar), which is effective for dates of service on or after April 5, 2016. Claims for Q5102 must also have the modifier ZB (Pfizer/hospira). Make sure that your billing staffs are aware of these changes.

Background

The HCPCS code set is updated on a quarterly basis and CR9636 provides that effective July 1, 2016, the HCPCS codes contained in the following table will be established:
<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Long Description</th>
<th>Type of Service (TOS) Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9981</td>
<td>rolapitant, oral, 1mg</td>
<td>Rolapitant, oral, 1 mg</td>
<td>1</td>
</tr>
<tr>
<td>Q9982</td>
<td>flutemetamol f18 diagnostic</td>
<td>Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries</td>
<td>4</td>
</tr>
<tr>
<td>Q9983</td>
<td>florbetaben f18 diagnostic</td>
<td>Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries</td>
<td>4</td>
</tr>
</tbody>
</table>

Also, as of July 1, the HCPCS code set will contain code Q5102 (short descriptor – Inj., infliximab biosimilar – and long descriptor – Injection, Infliximab, 10 mg). Code Q5102 will be effective for dates of service on or after April 5, 2016, and will have TOS codes of 1 and P. In addition, claims for Q5102 must also have the modifier ZB (Pfizer/hospira).

**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.
Percutaneous Left Atrial Appendage Closure (LAAC)

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9638 informs MACs that the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD) covering percutaneous Left Atrial Appendage Closure (LAAC) through Coverage with Evidence Development (CED) when LAAC is furnished in patients with Non-Valvular Atrial Fibrillation (NVAF) and the device has received Food and Drug Administration (FDA) Premarket Approval (PMA) for that device’s FDA-approved indication and meets all the specified conditions. Make sure that your billing staffs are aware of these changes.

Background

LAAC is a strategy to reduce the risk of stroke by closing the Left Atrial Appendage (LAA) in patients with NVAF. Patients with NVAF, an abnormally rapid, irregular heartbeat, are at an increased risk of stroke. Some evidence suggests that many of the strokes attributed to NVAF originate from the LAA. The LAA is a tubular structure that opens into the left atrium of the heart. LAAC with a percutaneously implanted device could be used in patients with...
NVAF to reduce cardioembolic stroke risk as a potential alternative to oral anticoagulation.

On February 8, 2016, CMS issued an NCD covering percutaneous LAAC through CED when LAAC is furnished in patients with NVAF and the device has received FDA PMA for that device’s FDA-approved indication and meets all the specified conditions. Coverage requires that patients must have:

- A CHADS2 score ≥ 2 (Congestive heart failure, Hypertension, Age >75, Diabetes, Stroke/transient ischemia attack/thromboembolism) or CHA2DS2-VASc score ≥ 3 (Congestive heart failure, Hypertension, Age ≥ 65, Diabetes, Stroke/transient ischemia attack/thromboembolism, Vascular disease, Sex category)

- A formal shared decision making interaction with an independent non-interventional physician using an evidence-based decision tool on oral anticoagulation in patients with NVAF prior to LAAC. Additionally, the shared decision making interaction must be documented in the medical record

- A suitability for short-term warfarin but deemed unable to take long term oral anticoagulation following the conclusion of shared decision making, as LAAC is only covered as a second line therapy to oral anticoagulants

The NCD lists the criteria for the physician and facility criteria and includes a requirement for a multidisciplinary team to be engaged in patient care.

The patient must be enrolled in, and the multidisciplinary team (MDT) and hospital must participate in a prospective, national, audited registry that: 1) consecutively enrolls LAAC patients and 2) tracks the specified annual outcomes for each patient for a period of at least four years from the time of the LAAC. The registry must address pre-specified research questions, adhere to standards of scientific integrity, and be approved by CMS. Approved registries will be posted at [https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/LAAC.html](https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/LAAC.html). The process for submitting a registry to Medicare is outlined in the NCD.

For devices and indications that are not approved by FDA, patients must be enrolled in a qualifying FDA-approved Randomized Controlled Trial (RCT). The clinical study must address pre-specified research questions, adhere to standards of scientific integrity, and be approved by CMS. Approved studies will be posted at [https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/LAAC.html](https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/LAAC.html). The process for submitting a clinical research study to Medicare is outlined in the NCD.
LAAC claims with dates of service on or after February 8, 2016, will be billed with temporary level III CPT code 0281T (percutaneous transcatheter closure of the left atrial appendage with implant, including fluoroscopy, transseptal puncture, catheter placement(s) left atrial angiography, left atrial appendage angiography, radiological supervision and interpretation) and will be MAC-priced. CMS will issue further instructions, once a permanent CPT level 1 replaces the temporary code.

LAAC is non-covered for the treatment of NVAF when not furnished under CED according to the criteria outlined in the NCD, which is at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R192NCD.pdf.

**Additional Billing Instructions**

On institutional claims (type of bill 11X), hospitals should show:

- ICD-10 procedure code of 02L73DK (Occlusion of Left Atrial Appendage with Intraluminal Device, Percutaneous Approach)
- A primary diagnosis code of one of the following:
  - I48.0 – Paroxysmal atrial fibrillation
  - I48.1 – Persistent atrial fibrillation
  - I48.2 – Chronic atrial fibrillation
  - I48.91 – Unspecified atrial fibrillation
- A secondary ICD-10 diagnosis code of Z00.6 – Encounter for examination for normal comparison and control in clinical research program
- Condition Code 30 (Qualifying Clinical Trial), and
- Value Code D4 - Clinical Trial Number (assigned by NLM/NIH with an 8-digit clinicaltrials.gov identifier number listed on the CMS website)

MACs will fully reject inpatient claims for LAAC with discharges on or after February 8, 2016, when billed without the appropriate procedure, diagnosis, or clinical trial codes, with the following messages:

- Claim Adjustment Reason Code (CARC) 50: These are non-covered services because this is not deemed a “medical necessity” by the payer.
- Remittance Advice Remarks Code (RARC) N386: This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code - Contractual Obligation (CO)

Professional claims with dates of service on or after February 8, 2016, for LAAC under CED will be paid only when billed with the following codes:

- CPT 0281T
- Primary ICD-10 diagnosis code (one of the following):

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- I48.0 – Paroxysmal atrial fibrillation,
- I48.1 – Persistent atrial fibrillation,
- I48.2 – Chronic atrial fibrillation,
- I48.91 – Unspecified atrial fibrillation
- Place of Service code of 21 (inpatient hospital)
- Secondary diagnosis code Z00.6
- Modifier Q0
- Clinical trial number in item 23 of the CMS-1500 form or electronic equivalent

MACs will deny LAAC claims when billed without the appropriate diagnosis codes, with the following messages:

- CARC 50 - These are non-covered services because this is not deemed a “medical necessity” by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code – Contractual Obligation (CO).

MACs will deny claims for LAAC with 0281T with a POS code other than 21 using the following messages:

- CARC 58: “Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N386: “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- Group Code – Contractual Obligation (CO).

MACs will return claim lines on professional claims for 0281T as unprocessable when the Q0 modifier is not present using messages:

- 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.”
- Group Code – Contractual Obligation (CO)
MACs will return claim lines with 0281T as unprocessable when billed without secondary diagnosis code Z00.6 using the following messages:

- CARC 16: “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)”
- RARC M76: “Missing/incomplete/invalid diagnosis or condition.”
- Group Code – Contractual Obligation (CO)

Finally, failure to include the clinical trial number will result in MACs returning claim lines as unprocessable using the following messages:

- CARC 16: “Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)”
- RARC MA50: Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number.
- Group Code – Contractual Obligation (CO)

Note that MACs will not search their files for claims for LAAC with dates of service on or after February 8, 2016, that were processed prior to implementation of CR9638. However, they will adjust such claims that you bring to their 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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Limiting the Scope of Review on Redeterminations and Reconsiderations of Certain Claims

Note: This article was revised on May 9, 2016, to provide updated information regarding redetermination requests received by Medicare Administrative Contractors (MACs) or Qualified Independent Contractors (QICs) on or after April 18, 2016.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians, providers, and suppliers who submit claims to MACs for services provided to Medicare beneficiaries.

What You Need to Know

This Special Edition article is being published by the Centers for Medicare & Medicaid Services (CMS) to inform providers of the clarification CMS has given to the MACs and QICs regarding the scope of review for redeterminations (Technical Direction Letter-160305, which rescinds and replaces Technical Direction Letter-150407). This updated instruction applies to redetermination requests received by a MAC or QIC on or after April 18, 2016, and will not be applied retroactively.

Background

CMS recently provided direction to MACs and QICs regarding the applicable scope of review for redeterminations and reconsiderations for certain claims. Generally, MACs and QICs have discretion while conducting appeals to develop new issues and review all aspects of coverage and payment related to a claim or line item. As a result, in some cases where the original denial reason is cured, this expanded review of additional evidence or issues results in an unfavorable appeal decision for a different reason.

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For redeterminations and reconsiderations of claims denied following a complex prepayment review, a complex post-payment review, or an automated post-payment review by a contractor, CMS has instructed MACs and QICs to limit their review to the reason(s) the claim or line item at issue was initially denied. Prepayment reviews occur prior to Medicare payment, when a contractor conducts a review of the claim and/or supporting documentation to make an initial determination. Post-payment review or audit refers to claims that were initially paid by Medicare and subsequently reopened and reviewed by, for example, a Zone Program Integrity Contractor (ZPIC), Recovery Auditor, MAC, or Comprehensive Error Rate Testing (CERT) contractor, and revised to deny coverage, change coding, or reduce payment. Complex reviews require a manual review of the supporting medical records to determine whether there is an improper payment. Automated reviews use claims data analysis to identify improper payments. If an appeal involves a claim or line item denied on an automated pre-payment basis, MACs and QICs may continue to develop new issues and evidence at their discretion and may issue unfavorable decisions for reasons other than those specified in the initial determination.

Please note that contractors will continue to follow existing procedures regarding claim adjustments resulting from favorable appeal decisions. These adjustments will process through CMS systems and may suspend due to system edits. Claim adjustments that do not process to payment because of additional system imposed payment limitations, conditions or restrictions (for example, frequency limits or Correct Coding Initiative edits) may result in new denials with full appeal rights. In addition, if a MAC or QIC conducts an appeal of a claim or line item that was denied on pre- or post-payment review because a provider, supplier, or beneficiary failed to submit requested documentation, the contractor will review all applicable coverage and payment requirements for the item or service at issue, including whether the item or service was medically reasonable and necessary. As a result, claims initially denied for insufficient documentation may be denied on appeal if additional documentation is submitted and it does not support medical necessity.

This clarification and instruction applies to redetermination and reconsideration requests received by a MAC or QIC on or after April 18, 2016. It will not be applied retroactively. Appellants will not be entitled to request a reopening of a previously issued redetermination or reconsideration for the purpose of applying this clarification on the scope of review. CMS encourages providers and suppliers to include any audit or review results letters with their appeal request. This will help alert contractors to appeals where this instruction applies.

**Additional Information**


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You can also find out more about 1) conducting a redeterminations in 42 CFR 405.948, at [http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1948](http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1948); and 2) conducting a reconsideration in 42 CFR 405.968 at [http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1968](http://www.ecfr.gov/cgi-bin/text-idx?SID=06584dd6a5fc15094e7633ff5f6cb359&mc=true&node=pt42.2.405&rgn=div5#se42.2.405_1968) on the Internet.

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MEDICARE COVERAGE OF SUBSTANCE ABUSE SERVICES

Provider Types Affected

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

What You Need to Know

While there is no distinct Medicare benefit category for substance abuse treatment, such services are covered by Medicare when reasonable and necessary. The Centers for Medicare & Medicaid Services (CMS) provides a full range of services, including those services provided for substance abuse disorders. This article summarizes the available services and provides reference links to other online Medicare information with further details about these services.

Background

Services for substance abuse disorders are available under Medicare, as long as those services are reasonable and necessary. These services include:

Inpatient Treatment

- Inpatient treatment would be covered if reasonable and necessary.
- Professional services provided during that care would be paid either:
  - as part of the inpatient stay (for professional services provided by clinicians not recognized for separate billing, for instance peer counselors), or

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separately, to the professional billing for the provided services if they are recognized under Part B and considered separate from the inpatient stay (for instance, physicians, and NPPs within their state scopes of practice).

- Any medication provided as part of inpatient treatment would be bundled into the inpatient payment and not paid separately.

**Outpatient Treatment**

- Similar to inpatient treatment, coverage of outpatient treatment would depend on the provider of the services.

- Pursuant to the Social Security Act, Medicare does not recognize substance abuse treatment facilities as an independent provider type, nor is there an integrated payment for the bundle of services those providers may provide (either directly, or incident to a physician’s service).

- Coverage and payment would be on a service by service basis for those services that are recognized by Medicare. For instance, Medicare could pay for counseling by an enrolled licensed clinical social worker, psychologist or psychiatrist.

- Some services could be provided by auxiliary personnel incident to a physician’s services.

- Medications used in an outpatient setting that are not usually self-administered may be covered under Part B if they meet all Part B requirements.

**Partial Hospitalization Program (PHP)**

The PHP is an intensive outpatient psychiatric day treatment program that is furnished as an alternative to inpatient psychiatric hospitalization. This means that without the PHP services, the person would otherwise be receiving inpatient psychiatric treatment. Patients admitted to a PHP must be under the care of a physician who certifies and re-certifies the need for partial hospitalization and require a minimum of 20 hours per week of PHP therapeutic services, as evidenced by their plan of care. PHPs may be available in your local hospital outpatient department and Medicare certified Community Mental Health Center (CMHCs). PHP services include:

- Individual or group psychotherapy with physicians, psychologists, or other mental health professionals authorized or licensed by the State in which they practice (for example, licensed clinical social workers, clinical nurse specialists, certified alcohol and drug counselors);

- Occupational therapy requiring the skills of a qualified occupational therapist. Occupational therapy, if required, must be a component of the physicians treatment plan for the individual;

- Services of other staff (social workers, psychiatric nurses, and others) trained to work with psychiatric patients;

- Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes (subject to limitations specified in 42 CFR 410.29);

- Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient’s diagnosed condition and for progress toward treatment goals;

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• Family counseling services for which the primary purpose is the treatment of the patient’s condition;
• Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual’s care and treatment of his/her diagnosed psychiatric condition; and
• Medically necessary diagnostic services related to mental health treatment.

Similar to inpatient and individual outpatient treatment, coverage of PHP services would depend on the provider of the services.

MLN Matters® Special Edition article SE1512 titled “Partial Hospitalization Program (PHP) Claims Coding & CY2015 per Diem Payment Rates” is intended for hospitals and Community Mental Health Centers (CMHCs) that submit claims to MACs for PHP services provided to Medicare beneficiaries. In SE1512, CMS reminds hospitals and CMHCs that provide PHP services to follow existing claims coding requirements given in the “Medicare Claims Processing Manual” (Chapter 4, Section 260) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf on the CMS website.

Coverage and payment would be for those PHP services that are recognized by Medicare. For instance, Medicare could pay for psychotherapy by an enrolled licensed clinical psychologist or psychiatrist.

**Substance Abuse Treatment by Suppliers of Services**

There are individuals under the Medicare Part B program who are authorized as suppliers of services that are eligible to furnish substance abuse treatment services providing the services are reasonable and necessary and fall under their State scope of practice.

These suppliers of services include:

- Physicians (medical doctor or doctor of osteopathy);
- Clinical psychologists;
- Clinical social workers;
- Nurse practitioners;
- Clinical nurse specialists;
- Physician assistants; and,
- Certified nurse-midwives.

**Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services**

SBIRT is an early intervention approach that targets individuals with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. This approach differs from the primary focus of specialized treatment of individuals with more severe substance use, or those who meet the criteria for diagnosis of a substance use disorder.

SBIRT services aim to prevent the unhealthy consequences of alcohol and drug use among those who may not reach the diagnostic level of a substance use disorder, and helping those with the disease of addiction enter and stay with treatment. You may easily use SBIRT services in primary...
care settings, enabling you to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work, or family issues. For more information on the Medicare's SBIRT services, refer to Medicare's fact sheet, “Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services” at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SBIRT_Factsheet_ICN904084.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SBIRT_Factsheet_ICN904084.pdf) on the CMS website.

SBIRT consists of three major components:

1. **Structured Assessment (Medicare) or Screening (Medicaid):** Assessing or screening a patient for risky substance use behaviors using standardized assessment or screening tools;
2. **Brief Intervention:** Engaging a patient showing risky substance use behaviors in a short conversation, providing feedback and advice; and
3. **Referral to Treatment:** Providing a referral to brief therapy or additional treatment to patients whose assessment or screening shows a need for additional services.

The first component to the SBIRT process is assessment or screening which uses tools including the World Health Organization’s Alcohol Use Disorders Identification Test (AUDIT) Manual and the Drug Abuse Screening Test (DAST). For more information on SBIRT assessment and screening tools, as well as examples of tools, visit [http://www.integration.samhsa.gov/clinical-practice/sbirt/screening](http://www.integration.samhsa.gov/clinical-practice/sbirt/screening) on the Internet.

Medicare covers only reasonable and necessary SBIRT services that meet the requirements of diagnosis or treatment of illness or injury (that is, when the service is provided to evaluate and/or treat patients with signs/symptoms of illness or injury) per the Social Security Act (Section 1862(a)(1)(A); see [https://www.ssa.gov/OP_Home/ssact/title18/1862.htm](https://www.ssa.gov/OP_Home/ssact/title18/1862.htm) on the Internet).

Medicare pays for medically reasonable and necessary SBIRT services furnished in physicians’ offices (by physicians and non-physician practitioners) and outpatient hospitals. In these settings, you assess for and identify individuals with, or at-risk for, substance use-related problems and furnish limited interventions/treatment. To bill Medicare, suppliers of SBIRT services must be:

- Licensed or certified to perform mental health services by the State in which they perform the services;
- Qualified to perform the specific mental health services rendered; and
- Working within their State Scope of Practice Act.

Medicare pays for these services under the Medicare Physician Fee Schedule (PFS) and the hospital Outpatient Prospective Payment System (OPPS). For more information on Medicare’s payment for SBIRT services, refer to the “Medicare Claims Processing Manual” (Chapter 4, Section 200.6) at [https://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/clm104c04.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/clm104c04.pdf) on the CMS website.

**Drugs Used to Treat Opioid Dependence**

Medicare Part D sponsors must include coverage for Part D drugs, either by formulary inclusion or via an exception, when medically necessary for the treatment of opioid dependence. Coverage is not limited to single entity products such as Subutex®, but must include combination products when medically necessary (for example, Suboxone®). For any new enrollees, CMS requires sponsors to
have a transition policy to prevent any unintended interruptions in pharmacologic treatment with Part D drugs during their transition into the benefit. This transition policy, along with CMS' non-formulary exceptions/appeals requirements, should ensure that all Medicare enrollees have timely access to their medically necessary Part D drug therapies for opioid dependence.

A Part D drug is defined, in part, as “a drug that may be dispensed only upon a prescription.” Consequently, methadone is not a Part D drug when used for treatment of opioid dependence because it cannot be dispensed for this purpose upon a prescription at a retail pharmacy. (NOTE: Methadone is a Part D drug when indicated for pain). State Medicaid Programs may continue to include the costs of methadone in their bundled payment to qualified drug treatment clinics or hospitals that dispense methadone for opioid dependence.

See the “Medicare Prescription Drug Benefit Manual” (Chapter 6, Section 10.8 (Drugs Used to Treat Opioid Dependence)) at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/chapter6.pdf on the CMS website.

Note: Medicare covers diagnostic clinical laboratory services that are reasonable and necessary for the diagnosis or treatment of an illness or injury. For beneficiaries being treated for substance abuse, testing for drugs of abuse when reasonable and necessary can help manage their treatment. Information on the clinical laboratory fee schedule is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Clinical-Laboratory-Fee-Schedule-Fact-Sheet-ICN006818.pdf on the CMS website.

**Additional Information**

Providers may want to review the following resources:

- “Summary of Medicare Reporting and Payment of Services for Alcohol and/or Substance (Other than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services;” see https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1013.pdf on the CMS website.
- National Coverage Determinations (NCDs): Inpatient Hospital Stays for the Treatment of Alcoholism (130.1); Outpatient Hospital Services for Treatment of Alcoholism (130.2); Chemical & Electrical Aversion Therapy for Treatment of Alcoholism (130.3, 130.4); Treatment of Alcoholism and Drug Abuse in a Freestanding Clinic (130.5); Treatment of Drug Abuse (Chemical Dependency) (130.6); Withdrawal Treatments for Narcotic Addictions (130.7): See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/nccd103c1_Part2.pdf on the CMS website.

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Centers for Medicare & Medicaid Services
Articles for Part A Providers
MLN Matters® Number: MM8822 Revised
Related Change Request (CR) #: CR 8822

Related CR Release Date: April 26, 2016
Effective Date: July 1, 2016 - except in Round 1 Re-compete CBP areas where effective date is January 1, 2017

Related CR Transmittal #: R1644OTN
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 April 29, 2016, due to a revised CR8822. 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. You can find the associated MLN Matters article at http://www.cms.gov/Outreach-and-
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>
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<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

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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, 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.**

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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.

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 29, 2016</td>
<td>The article was changed due to a revised CR8822. Only the CR release date, transmittal number, and the Web address for the CR were changed in the article. All other information remains the same.</td>
</tr>
<tr>
<td>March 24, 2016</td>
<td>The article was revised 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.</td>
</tr>
</tbody>
</table>
Billing of Vaccine Services on Hospice Claims

Provider Types Affected

This MLN Matters® Article is intended for hospices submitting claims to Medicare Administrative Contractors (MACs) for influenza, pneumococcal, and hepatitis B vaccine services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9052 informs MACs about the changes to Original Medicare systems and provides billing instructions to allow hospices to submit institutional claims for influenza, pneumococcal, and hepatitis B vaccine services. Make sure that your billing staffs are aware of these changes.

Background

Influenza virus, pneumococcal, and hepatitis B vaccines may be covered when furnished by a hospice to those beneficiaries who request them, including those who have elected the hospice benefit. Currently, hospices must obtain a supplier number in order to bill Medicare for these services and must submit the services on a professional claim. Hospice provider associations have requested that Medicare allow hospices to bill these services under their hospice enrollment, using the institutional claim format. Hospices use the institutional claim to bill all other covered services.

Effective for dates of service on or after October 1, 2016, Medicare hospice providers may bill for vaccine services on institutional claims. Payment is made using the same methodology as if the hospice were a supplier, that is, payment will be based on the...
Medicare Physician Fee Schedule (MPFS). These vaccines and their administration are not subject to deductible and coinsurance.

Since these services are not part of the Medicare hospice benefit, they must be billed on a separate claim that includes only the vaccines and their administration. Specifically, when submitted on an institutional claim (Type of Bill 081x or 082x) for services on or after October 1, 2016, the claim must show revenue code 0771 (and may also show revenue code 0636). No other revenue codes may be on the claim for a vaccine. If other codes are on the claim, the claim will be returned to the provider.

For more payment information, see the updated “Medicare Claims Processing Manual,” Chapter 18, Preventive and Screening Services, Section 10.2.3, Institutional Claims Submitted to Home Health and Hospice (HH&H) MACs. This updated manual section is attached to CR9052.

Additional Information


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

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Shared Savings Program (SSP) Accountable Care Organization (ACO) Qualifying Stay Edits

Provider Types Affected

This MLN Matters® Article is intended for Hospitals and Skilled Nursing Facilities (SNFs) working with Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (SSP) and submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9568 allows the processing of SNF claims without having to meet the 3-day hospital stay requirement for certain designated SNFs that have a relationship with an ACO participating in the SSP. Make sure that your SNF is clear on whether or not it is eligible to participate in this initiative and that your billing staffs are aware of these changes.

Background

The Medicare SNF benefit is for beneficiaries who require a short-term intensive stay in a SNF, requiring skilled nursing and/or rehabilitation care. Pursuant to Section 1861(i) of the Social Security Act (the Act), beneficiaries must have a prior inpatient hospital stay of no fewer than 3 consecutive days in order to be eligible for Medicare coverage of inpatient SNF care. This has become known as the SNF 3-day rule.

The Centers for Medicare & Medicaid Services (CMS) understands that, in certain circumstances, it could be medically appropriate for some patients to receive skilled nursing

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care and/or rehabilitation services provided in a SNF without prior hospitalization or with an inpatient hospital length of stay of less than 3 days.

Section 3022 of the Affordable Care Act amended Title XVIII of the Act by adding a new Section 1899 to establish the Medicare SSP. Under Section 1899(f), the Secretary of Health and Human Services is permitted to waive “such requirements of . . . title XVIII of this Act as may be necessary to carry out the provisions of this section.” As a result, CMS proposed and finalized through rulemaking (80 FR 32692 at [http://www.gpo.gov/fdsys/pkg/FR-2015-06-09/pdf/2015-14005.pdf](http://www.gpo.gov/fdsys/pkg/FR-2015-06-09/pdf/2015-14005.pdf)) a waiver of the prior 3-day inpatient hospitalization requirement in order to provide Medicare SNF coverage when certain beneficiaries assigned to SSP ACOs in Track 3 are admitted to designated SNF affiliates either directly from an inpatient hospital stay or after fewer than 3 inpatient hospital days, starting in January 2017. The waiver will be available for SSP ACOs in Track 3 that demonstrate the capacity and infrastructure to identify and manage patients who would be either directly admitted to a SNF or admitted to a SNF after an inpatient hospital stay of fewer than 3 days, for services otherwise covered under the Medicare SNF benefit.

To identify the beneficiaries eligible to receive the SNF 3-Day Waiver, CMS provides ACOs with a prospective beneficiary assignment list for the performance year. ACOs will receive the prospective assignment list close to the start of each performance year.

To identify the SNFs eligible to use the SNF 3-Day Waiver, ACOs designate SNFs (as SNF affiliates) eligible to participate in the SNF 3-Day Waiver with the ACO.

CMS will reimburse designated SNFs (specifically, SNF affiliates participating in Track 3 SSP ACOs), for the Medicare SNF benefit without the required 3-day in-patient hospitalization for beneficiaries that are prospectively assigned to the Track 3 ACO.

**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.

You can learn more about the SSP by visiting our website at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html). To learn more about the SNF 3-Day Waiver, visit the SSP webpage and click on Statutes/Regulations/Guidance.

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Making Principal Diagnosis Codes Mandatory for Notice of Election (NOE) to be Accepted

Provider Types Affected

This MLN Matters® Article is intended for hospices submitting claims containing a Notice of Election (NOE) to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 9575 which informs MACs that hospices must report a principal diagnosis code with an NOE. Failure to submit the principal diagnosis code with the NOE will result in the claim (type of bill 8xA) being returned to the hospice without being processed. Make sure that your billing staffs are aware of this requirement.

Additional Information


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System Changes to Implement Section 231 of the Consolidated Appropriations Act, 2016, Temporary Exception for Certain Severe Wound Discharges From Certain Long-Term Care Hospitals (LTCHs)

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9599 implements a temporary exception for certain wound care discharges from the site neutral payment rate for certain LTCHs. Make sure your billing staffs are aware of this exception.

Background

Under the LTCH Prospective Payment System (PPS), for LTCH discharges in cost reporting periods beginning on or after October 1, 2015, Medicare established two separate payment categories for LTCH patients upon discharge. LTCH cases meeting specific clinical criteria are paid the LTCH PPS standard Federal rate payment and those cases not meeting specific clinical criteria are paid the site neutral rate payment (that is, the lesser of an “Inpatient Prospective Payment System (IPPS)-comparable” payment amount or 100 percent of the estimated cost of the case).
In general, in order to be paid at the LTCH PPS standard Federal rate payment amount, an LTCH discharge must either:

1. Have been admitted directly from an IPPS hospital during which at least 3 days were spent in an Intensive Care Unit (ICU) or Coronary Care Unit (CCU), but the discharge must not have a principal diagnosis in the LTCH of a psychiatric or rehabilitation diagnosis; or

2. Have been admitted directly from an IPPS hospital and the LTCH discharge is assigned to an MS-LTC-DRG based on the receipt of ventilator services of at least 96 hours, but must not have a principal diagnosis in the LTCH of a psychiatric or rehabilitation diagnosis.

Section 231 of the Consolidated Appropriations Act, 2016, establishes a temporary exception from the site neutral payment rate for certain patients discharged from certain LTCHs before January 1, 2017.

As implemented, this exception applies to discharges occurring on or after April 21, 2016, and prior to January 1, 2017, from LTCHs “identified by the amendment made by Section 4417(a) of the Balanced Budget Act of 1997” and “located in a rural area” or “treated as being so located” pursuant to Section 1886(d)(8)(E) of the Social Security Act when the individual discharged had a “severe wound.” The final payment for discharges that meet the statutory provider-level and discharge-level criteria as implemented by the Centers for Medicare & Medicaid Services (CMS) is based on the LTCH PPS standard Federal payment rate. This temporary statutory exception from the site neutral payment rate was implemented in an interim final rule with comment period (IFC) (published in the Federal Register on April 21, 2016).

Provider-Level Criteria:

The statute specifies that the temporary exclusion for certain discharges from the site neutral payment rate is applicable to an LTCH that is “identified by the amendment made by Section 4417(a) of the Balanced Budget Act of 1997.” As discussed in the IFC, CMS has interpreted the phrase to mean hospitals which are described in 42 CFR Section 412.23(e)(2)(i) that meet the criteria of Section 412.22(f), which are a group of LTCHs commonly referred to as “grandfathered hospitals-within-hospitals” (or grandfathered HwHs). Note: An HwH is defined in the regulations at 42 CFR 412.22(e) as a hospital which occupies space in a building also used by another hospital or on the campus of another hospital). Therefore, in order to be eligible for this temporary exception, an LTCH must have participated in Medicare as an LTCH and have been co-located with another hospital as of September 30, 1995, and must currently meet the requirements of Section 412.22(f).

Section 412.22(f) requires that, in order to maintain grandfathered status, an HwH must continue to operate under the same terms and conditions including but not limited to the number of beds. There are several reasons for which an LTCH described in Section 412.23(e)(2)(i) may not currently meet the criteria in Section 412.22(f). For example, the
LTCH may have more than one location, or the HwH may have increased beds after September 30, 2003 (CMS notes these examples are not intended to be an exhaustive list of the reasons an LTCH may not meet the criteria in Section 412.22(f)). MACs must verify that an LTCH described in Section 412.23(e)(2)(i) currently meets the criteria in Section 412.22(f) in order for the LTCH to be eligible for this temporary exception from the site neutral payment rate for certain wound care discharges. This process will likely involve direct outreach to LTCHs in order to verify the required information. Additional information on the requirement that grandfathered HwHs meet the criteria in § 412.22(f) can be found in the following IPPS rules: FY 1997 IPPS final rule (62 FR 46012); FY 2004 IPPS final rule (68 FR 45463); May 22, 2008 LTCH PPS interim final rule with comment period (73 FR 29703); and FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 43980).

The temporary statutory exclusion for certain discharges from the site neutral payment rate is further limited to grandfathered HwH LTCHs that are “located in a rural area” or “treated as being so located” pursuant to Section 1886(d)(8)(E) of the Act. For purposes of this provision, “located in a rural area” refers to LTCHs that are currently located in a rural area as defined under § 412.503 (that is, located in any area outside an urban area, which is an area within a Metropolitan Statistical Area (as defined by the Office of Management and Budget)). (Information on the current labor market area geographic classifications used under the LTCH PPS is available in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50180 through 50185)).

Section 1886(d)(8)(E) of the Act provides for an urban IPPS hospital that is located in an urban area to be reclassified as a rural hospital if it submits an application in accordance with CMS’ established criteria and meets certain conditions (see Section 412.103). (Additional information on CMS’ policies for IPPS hospitals located in urban areas and that apply for reclassification as rural under § 412.103 can be found in the FY 2012 IPPS/ LTCH PPS final rule (76 FR 51595).) For the purpose of implementing the phrase “treated as being so located” pursuant to Section 1886(d)(8)(E) of the Act for the temporary statutory exclusion for certain LTCH discharges from the site neutral payment rate, CMS revised its regulations to “borrow” the existing rural reclassification process for urban IPPS hospitals under § 412.103 and to allow grandfathered HwH LTCHs (defined above) to apply to their CMS Regional Office for treatment as being located in a rural area for the sole purpose of qualifying for this temporary exclusion from the application of the site neutral payment rate.

For grandfathered HwH LTCHs that qualify for this temporary exception for certain wound care discharges from the site neutral payment rate by applying for and satisfying the criteria to reclassify as rural under the provisions of § 412.103, the exception from the site neutral payment rate for qualifying discharges is effective beginning the effective date of the rural reclassification (that is, as of the filing date of the application as specified in § 412.103). 

**Note:** This policy only allows grandfathered HwH LTCHs to apply for this reclassification, and the rural treatment only extends to this statutory temporary exception for certain wound care discharges from the site neutral payment rate, and reclassifying grandfathered HwH LTCH will not be treated as rural under the LTCH PPS for any other reason including, but
not limited to, the 25 percent policy and wage index). Any rural treatment under the provisions of § 412.103 for a grandfathered HwH LTCH will expire at the same time as this temporary provision (that is, December 31, 2016).

Discharge-Level Criteria:

As implemented, the statutory temporary exclusion for certain discharges from the site neutral payment rate for certain LTCHs is applicable to discharges occurring on or after April 21, 2016, and on or before December 31, 2016, that had a “severe wound.” The statute defines a “severe wound” as, “a stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, infected wound, fistula, osteomyelitis, or wound with morbid obesity as identified in the claim from the long-term care hospital.”

To implement this statutory definition, CMS has defined wound as “an injury, usually involving division of tissue or rupture of the integument or mucous membrane with exposure to the external environment.” To implement this definition, CMS is using ICD-10 diagnosis codes on the claim where ICD-10 diagnosis codes contain sufficient specificity for this purpose or through the use of a payer-specific condition code where the ICD-10 diagnosis codes lack sufficient specificity for this purpose.

For six of the eight statutory categories included in the definition of “severe wound” (stage 3 wound, stage 4 wound, unstageable wound, non-healing surgical wound, fistula, and osteomyelitis), CMS is using the list of ICD-10 diagnosis codes found on the CMS website at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html).

Note: Under the CMS definition of wound, the ICD-10 diagnosis codes used to identify severe wounds in the osteomyelitis category are also part of the ICD-10 diagnosis codes used to identify severe wounds in the fistula category so no separate identification of ICD-10 codes for osteomyelitis is necessary.

The remaining two statutory categories included in the definition of “severe wound” (infected wound and wound with morbid obesity) lack ICD-10 diagnosis codes with sufficient specificity to identify the presence of a “severe” wound, so claims containing such wounds will be identified by using specified “payer-only” condition codes. For the purposes of this provision, CMS has defined a “wound with morbid obesity” as “a wound in those with morbid obesity that require complex, continuing care including local wound care occurring multiple times a day” and an “infected wound” as “a wound with infection requiring complex, continuing care including local wound care occurring multiple times a day.” If an LTCH has a discharge meeting this definition of “wound with morbid obesity” or “infected wound” the LTCH will inform its MAC, and the MAC will then place the payer-only condition code “M4” on the claim for processing.

The presence of that designated payer-only condition code on the claim for qualifying rural (or reclassified rural) grandfathered HwH LTCHs will generate a standard Federal payment rate payment for the claim (that is, exclusion from the site neutral payment rate) consistent with this statutory provision in the LTCH PPS Pricer and claims processing system.

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MACs will reprocess claims with a through date (for interim claims) or a discharge date (for final claims) on or after April 21, 2016 through December 31, 2016, when the Temporary Relief Indicator for an LTCH on the Provider Specific File (PSF) equals ‘Y’ and one of the ICD-10 diagnosis codes listed on the CMS website mentioned above is present. The claims shall be reprocessed within 60 days from the implementation date of this change request. MACs will adjust impacted LTCH inpatient claims with a through date (for interim claims) or a discharge date (for final claims) on or after April 21, 2016, through December 31, 2016, processed prior to implementation of CR9599 or after when brought to the attention of the MAC by a qualifying LTCH.

**Note:** Claims for LTCHs which are treated as rural for the purposes of this provision will be reprocessed with a through date (for interim claims) or a discharge date (for final claims) on or after the effective date of the rural reclassification.

**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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Phase 2 of Updating the Fiscal Intermediary Shared System (FISS) to Make Payment for Drugs and Biologicals Services for Outpatient Prospective Payment System (OPPS) Providers

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs and Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS).

Provider Action Needed

Change Request (CR) 9601 informs MACs about the implementation of phase 2 of system changes necessary to the Fiscal Intermediary Shared System (FISS) and Integrated Outpatient Code Editor (IOCE) which are necessary to make payment for drugs and biologicals to OPPS providers. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) pays for all outpatient drugs using the Average Sales Price (ASP) methodology. The schedule for submission of all ASP pricing is statutory per Section 621(a) of the Medicare Modernization Act. Drug manufacturers are required to submit drug ASPs within 30 days of the close of their fiscal quarter. Given the complexity, volume of data, and the number of drugs affected, approximately 6 weeks are required to process, validate, and issue final ASPs for a given quarter. As a result, the ASP rates for drugs furnished on or after January 1, 2016, were not

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available until mid-December 2015. The ASP rates for drugs furnished on or after April 1, 2016, were not available until mid-March 2016. The ASP rates for drugs furnished on or after July 1, 2016, will not be available until mid-June 2016 and the ASP rates for drugs furnished on or after October 1, 2016, will not be available until mid-September 2016 respectively.

CMS supplies MACs with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis and this file is used for payment to most institutional providers by FISS. OPPS claims were an exception to this process. Payment for OPPS claims were based on tables provided to the OPPS Pricer to account for some of the special processing rules that are unique to OPPS providers (such as, pass-through status necessary and drugs provided solely in the hospital setting).

Starting on October 1, 2016, drug HCPCS on OPPS claims will no longer be priced by the Outpatient PPS Pricer. The fee schedule amount from the ASP drug file or any future drug fee schedule amount will be used by FISS to price covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS. Phase 2 includes logic for FISS to cap the coinsurance amounts for procedures (which include blood and drug services) to the inpatient deductible amount for each calendar year and to insure the rural floor is applied.

The following examples are part of CR9601 to demonstrate the capped inpatient deductible amount:

**Example 1 of inpatient deductible capped amount:**

Drug Line A has a fee of $2,000.00, a payment of $1,600.00, and coinsurance of $400.00.
Drug Line B has a fee of $1,000.00, a payment of $800.00, and coinsurance of $200.00.
Drug Line C has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.
Drug Line D has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.

Highest wage adjusted national coinsurance amount for a procedure line is $888.00.
The Inpatient Part A deductible is $1,288.00 for 2016

$1,288.00 - $888.00 = $400.00 remaining coinsurance to be applied toward inpatient deductible cap.

Drug Lines A-D coinsurance is $800.00.

$400.00 cap remaining / $800.00 drug line(s) coinsurance = 50% reduction to coinsurance due to inpatient deductible cap

Apply 50% reduction of the coinsurance amounts for each line and add the remaining 50% back into the payment amount.
Drug Line A has a final payment of $1,800.00, and coinsurance of $200.00.
Drug Line B has a final payment of $900.00, and coinsurance of $100.00.
Drug Line C has a final payment of $450.00, and coinsurance of $50.00.
Drug Line D has a final payment of $450.00, and coinsurance of $50.00.

**Example 2 of inpatient deductible capped amount:**
Drug Line A has a fee of $2,000.00, a payment of $1,600.00, and coinsurance of $400.00.
Drug Line B has a fee of $1,000.00, a payment of $800.00, and coinsurance of $200.00.
Drug Line C has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.
Drug Line D has a fee of $500.00, a payment of $400.00 and coinsurance of $100.00.
Highest wage adjusted national coinsurance amount for a procedure line is $1,588.00.
The Inpatient Part A deductible is $1,288.00 for 2016
$1,588.00 is greater than $1,288.00. The OPPS Pricer will cap the coinsurance amount to be applied on the highest wage adjusted national coinsurance procedure line prior to application of the cap on the drug lines.
Drug Lines A-D coinsurance is $800.00.
$0 cap remaining / $800.00 = 100% reduction to coinsurance due to inpatient deductible cap
Drug Line A has a final payment of $2,000.00, and no coinsurance.
Drug Line B has a final payment of $1,000.00, and no coinsurance.
Drug Line C has a final payment of $500.00, and no coinsurance.
Drug Line D has a final payment of $500.00, and no coinsurance.

**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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**July 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 and which are paid under the Outpatient Prospective Payment System (OPPS).

**Provider Action Needed**

Change Request (CR) 9658 describes changes to, and billing instructions for, various payment policies implemented in the July 2016 OPPS update. It identifies the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions that are reflected in the July 2016 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer. Make sure that your billing staffs are aware of these changes.

**Key Points of CR9658**

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

**Billing Instructions for IMRT Planning**

The revised Intensity Modulated Radiation Therapy (IMRT) planning billing instructions (in the paragraph, below), that were also included in the April 2016 Update of the Hospital OPPS (CR9549), replace the instructions discussed in the 2016 OPPS final rule at 80 FR 70401-70402 and in the January 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS) (CR9486). The effective date of these instructions is January 1, 2016.

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These instructions state that payment for the services identified by CPT codes 77014, 77280, 77285, 77290, 77295, 77306 through 77321, 77331, and 77370 are included in the APC payment for CPT code 77301 (IMRT planning). You should not report these codes in addition to CPT code 77301, when provided prior to, or as part of, the development of the IMRT plan.


**Upper Eyelid Blepharoplasty and Blepharoptosis Repair**

The Centers for Medicare & Medicaid Services (CMS) payment policy does not allow separate payment for a blepharoplasty procedure (CPT codes 15822, 15823) in addition to a blepharoptosis procedure (CPT codes 67901-67908) on the ipsilateral upper eyelid. Any removal of upper eyelid skin in the context of an upper eyelid blepharoptosis surgery is considered a part of the blepharoptosis surgery.

A blepharoplasty cannot be billed to Medicare and the beneficiary cannot be separately charged for a cosmetic procedure regardless of the amount of upper eyelid skin that is removed on a patient receiving a blepharoptosis repair because removal of (any amount) of upper eyelid skin is part of the blepharoptosis repair. In addition, the following are not permitted:

- Operating on the left and right eyes on different days when the standard of care is bilateral eyelid surgery
- Charging the beneficiary an additional amount for a cosmetic blepharoplasty when a blepharoptosis repair is performed
- Charging the beneficiary an additional amount for removing orbital fat when a blepharoplasty or a blepharoptosis repair is performed
- Performing a blepharoplasty on a different date of service than the blepharoptosis procedure for the purpose of unbundling the blepharoplasty or charging the beneficiary for a cosmetic surgery
- Performing blepharoplasty as a staged procedure, either by one or more surgeons (note that under certain circumstances a blepharoptosis procedure could be a staged procedure)
- Billing for two procedures when two surgeons divide the work of a blepharoplasty performed with a blepharoptosis repair
- Using modifier 59 to unbundle the blepharoplasty from the ptosis repair on the claim form; this applies to both physicians and facilities
- Treating medically necessary surgery as cosmetic for the purpose of charging the beneficiary for a cosmetic surgery
- Using an Advance Beneficiary Notice of Noncoverage for a service that would be bundled into another service if billed to Medicare

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• In the rare event that a blepharoplasty is performed on one eye and a blepharoptosis repair is performed on the other eye, the services must each be billed with the appropriate RT or LT modifier.

**Revised Status Indicators (SIs) for Pathology CPT Codes**

The SI for CPT code 85396 (Clotting assay whole blood) will change from SI=Q4 (Conditionally packaged laboratory tests) to SI=N (Paid under OPPS; payment is packaged into payment for other services) in the July 2016 update.

The SI for CPT code 88141 (Cytopath c/v interpret) will change from SI=Q4 to SI=N in the July 2016 update.

The SI for CPT code 88174 (Cytopath c/v auto in fluid) will change from SI=N to SI=Q4 in the July 2016 update.

The SI for CPT code 88175 (Cytopath c/v auto fluid redo) will change from SI=N to SI=Q4 in the July 2016 update.

These codes, their Descriptors, and Status Indicators are listed in table 1.

**Table 1 – Pathology CPT Codes with Revised SIs**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>85396</td>
<td>Coagulation/fibrinolysis assay, whole blood (eg, viscoelastic clot assessment),</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>including use of any pharmacologic additive(s), as indicated, including</td>
<td></td>
</tr>
<tr>
<td></td>
<td>interpretation and written report, per day</td>
<td></td>
</tr>
<tr>
<td>88141</td>
<td>Cytopathology, cervical or vaginal (any reporting system), requiring</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>interpretation by physician</td>
<td></td>
</tr>
<tr>
<td>88174</td>
<td>Cytopathology, cervical or vaginal (any reporting system), collected in</td>
<td>Q4</td>
</tr>
<tr>
<td></td>
<td>preservative fluid, automated thin layer preparation; screening by automated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>system, under physician supervision</td>
<td></td>
</tr>
<tr>
<td>88175</td>
<td>Cytopathology, cervical or vaginal (any reporting system), collected in</td>
<td>Q4</td>
</tr>
<tr>
<td></td>
<td>preservative fluid, automated thin layer preparation; with screening by</td>
<td></td>
</tr>
<tr>
<td></td>
<td>automated system and manual rescreening or review, under physician supervision</td>
<td></td>
</tr>
</tbody>
</table>

**Reporting for Certain Outpatient Department Services (That Are Similar to Therapy Services) (“Non-Therapy Outpatient Department Services”) That Are Adjunctive to Comprehensive APC Procedures**

Effective for claims received on or after July 1, 2016, with dates of service on or after January 1, 2015, non-therapy outpatient department services (that are similar to therapy services) that are adjunctive to a comprehensive APC procedure (status indicator (SI) = J1 procedure) (see 80 FR 70326 at [https://www.federalregister.gov/articles/2015/11/13/2015-27943/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment](https://www.federalregister.gov/articles/2015/11/13/2015-27943/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment)) or the specific combination of services assigned to the Observation Comprehensive APC 8011 (SI = J2), should not be reported with therapy CPT codes. This includes services described at 1833(a)(8), namely...
outpatient physical therapy, outpatient speech-language pathology and outpatient occupational therapy furnished either by therapists or non-therapists and included on the same claim as a comprehensive APC procedure. Non-therapy outpatient department services that are adjunctive to J1 or J2 procedures should be reported without a CPT code and instead should be reported with Revenue Code 0940 (Other Therapeutic Services). The SI for this revenue code will be changed from SI=B to SI=N, indicating that the payment for these services will be packaged into the C-APC payment.

**Category III CPT Codes Effective July 1, 2016**
The American Medical Association (AMA) releases Category III Current Procedural Terminology (CPT) codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January. For the July 2016 update, CMS is implementing in the OPPS nine Category III CPT codes that the AMA released in January 2016 for implementation on July 1, 2016. The SIs and APCs for these codes are shown in Table 2. Payment rates for these services are available in Addendum B of the July 2016 OPPS Update that is posted at https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/HospitalOutpatientpps/Addendum-A-and-Addendum-B-Updates.html.

Please note that HCPCS code C9743 (Also listed in Table 2) will be deleted June 30, 2016, since it will be replaced with Category III CPT code 0438T effective July 1, 2016. CPT code 0438T will be assigned to the same SI and APC assignment as its predecessor HCPCS code C9743 effective July 1, 2016.

Table 2 - Category III CPT Codes Effective July 1, 2016

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>Add Date</th>
<th>Term Date</th>
<th>July 2016 OPPS SI</th>
<th>July 2016 OPPS APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0437T</td>
<td>Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to primary procedure)</td>
<td>07/01/2016</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>0438T</td>
<td>Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance</td>
<td>07/01/2016</td>
<td>T</td>
<td>5374</td>
<td></td>
</tr>
<tr>
<td>0439T</td>
<td>Myocardial contrast perfusion echocardiography; at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to primary procedure)</td>
<td>07/01/2016</td>
<td>N</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>0440T</td>
<td>Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve</td>
<td>07/01/2016</td>
<td>J1</td>
<td>5361</td>
<td></td>
</tr>
</tbody>
</table>
Drugs, Biologicals, and Radiopharmaceuticals

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

For CY 2016, payment for both nonpass-through, and 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 of these 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 July 1, 2016, and drug price restatements are available in the July 2016 update of the OPPS Addendum A and Addendum B at [http://www.cms.gov/HospitalOutpatientPPS/](http://www.cms.gov/HospitalOutpatientPPS/).

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

Some drugs and biologicals paid based on the 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/index.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html).

You may resubmit claims that were impacted by adjustments to previous quarter’s payment files.
c. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2016

Five drugs and biologicals have been granted OPPS pass-through status, effective July 1, 2016. These items, along with their descriptors and APC assignments, are identified in Table 3.

Table 3 – Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2016

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9476</td>
<td>Injection, daratumumab, 10 mg</td>
<td>G</td>
<td>9476</td>
</tr>
<tr>
<td>C9477</td>
<td>Injection, elotuzumab, 1 mg</td>
<td>G</td>
<td>9477</td>
</tr>
<tr>
<td>C9478</td>
<td>Injection, sebelipase alfa, 1 mg</td>
<td>G</td>
<td>9478</td>
</tr>
<tr>
<td>C9479*</td>
<td>Instillation, ciprofloxacin otic suspension, 6 mg</td>
<td>G</td>
<td>9479</td>
</tr>
<tr>
<td>C9480</td>
<td>Injection, trabectedin, 0.1 mg</td>
<td>G</td>
<td>9480</td>
</tr>
</tbody>
</table>

*Note on reporting C9479: Each vial of C9479 contains 60 mg, or 10 doses. If one single use vial is used for both patient’s ears with the remainder of the drug in the vial unused, then two units of C9479 should be reported as administered to the patient; any discarded amount should be reported with the JW modifier according to the “Medicare Claims Processing Manual,” Chapter 17 - Drugs and Biologicals, Section 40 - Discarded Drugs and Biologicals.

d. New Drug HCPCS Code

Effective July 1, 2016, one new HCPCS code has been created for reporting drugs and biologicals in the hospital outpatient setting, where there have not previously been specific codes available. This new code is listed in Table 4.

Table 4 – New Drug HCPCS Codes Effective July 1, 2016

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9981</td>
<td>rolapitant, oral, 1mg</td>
<td>Rolapitant, oral, 1 mg</td>
<td>K</td>
<td>1761</td>
</tr>
</tbody>
</table>

e. Biosimilar Biological Product Payment and Required Modifiers

As a reminder, OPPS claims for separately paid biosimilar biological products are required to include a modifier that identifies the manufacturer of the specific product. The modifier does not affect payment determination, but is used to distinguish between biosimilar products that appear in the same HCPCS code but are made by different manufacturers.

On April 5, 2016, the second biosimilar biological product, Inflectra®, was approved by the FDA. Table 5 lists the biosimilar HCPCS codes and required modifiers.
Table 5 – Biosimilar Biological Product Payment and Required Modifiers

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
<th>HCPCS Code Effective Date</th>
<th>Modifier</th>
<th>Modifier Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5101</td>
<td>Inj filgrastim g-csf biosim</td>
<td>Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram</td>
<td>G</td>
<td>1822</td>
<td>03/06/2015</td>
<td>ZA-Novartis/Sandoz</td>
<td>01/01/2016</td>
</tr>
<tr>
<td>Q5102</td>
<td>Inj., infliximab biosimilar</td>
<td>Injection, Infliximab, Biosimilar, 10 mg</td>
<td>K</td>
<td>1761</td>
<td>04/05/2016</td>
<td>ZB–Pfizer/Hospira</td>
<td>04/01/2016</td>
</tr>
</tbody>
</table>

f. Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group

One existing skin substitute product has been reassigned from the low cost skin substitute group to the high cost skin substitute group based on updated pricing information. This product is listed in Table 6.

Table 6 – Reassignment of Skin Substitute Product from the Low Cost Group to the High Cost Group Effective July 1, 2016

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Status Indicator</th>
<th>Low/High Cost Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4164</td>
<td>Helicoll, per square cm</td>
<td>N</td>
<td>High</td>
</tr>
</tbody>
</table>

g. Other Changes to CY 2016 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

Effective July 1, 2016, HCPCS code Q9982, flutemetamol f18 diagnostic, will replace HCPCS code C9459, Flutemetamol f18. The SI will remain G, “Pass-Through Drugs and Biologicals.”

Effective July 1, 2016, HCPCS code Q9983, florbetaben f18 diagnostic, will replace HCPCS code C9458, Florbetaben f18. The SI will remain G, “Pass-Through Drugs and Biologicals.”

Table 7 describes the HCPCS codes changes and effective dates.
Table 7 – Other Changes to CY 2016 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals Effective July 1, 2016

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Added Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9459</td>
<td>Flutemetamol f18</td>
<td>Flutemetamol f18, diagnostic, per study dose, up to 5 millicuries</td>
<td>G</td>
<td>9459</td>
<td>01/01/2016</td>
<td>06/30/2016</td>
</tr>
<tr>
<td>Q9982</td>
<td>flutemetamol f18 diagnostic</td>
<td>Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries</td>
<td>G</td>
<td>9459</td>
<td>07/01/2016</td>
<td></td>
</tr>
<tr>
<td>C9458</td>
<td>Florbetaben f18</td>
<td>Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries</td>
<td>G</td>
<td>9458</td>
<td>01/01/2016</td>
<td>06/30/2016</td>
</tr>
<tr>
<td>Q9983</td>
<td>florbetaben f18 diagnostic</td>
<td>Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries</td>
<td>G</td>
<td>9458</td>
<td>07/01/2016</td>
<td></td>
</tr>
</tbody>
</table>

h. Changes to OPPS Pricer Logic
Effective July 1, 2016, there will be four diagnostic radiopharmaceuticals (2 with new Q-codes replacing the previously used C-codes (as described above in the immediately preceding section g.)) 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 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 on the CMS website.

Addition of C1713 and C1817 to the List of Devices Allowed for the Device Intensive Procedure Edit
CMS will be adding C1713 (Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)) and C1817 (Septal defect implant system, intracardiac) to the list of devices allowed for the device intensive procedure edit in the July 2016 release, and will make it retroactive to January 2016.

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**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.

Please note that your MACs will adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of July 2016 OPPS Pricer.

**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.
Provider Types Affected

This MLN Matters® Article is intended for providers submitting claims to Medicare Administrative Contractors (MACs) for outpatient services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS.

It is also intended for claims for limited services when provided in a Home Health Agency (HHA) not under the Home Health PPS (HH PPS) or claims for services to a hospice patient for the treatment of a non-terminal illness.

Provider Action Needed

Change Request (CR) 9661 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications. Please make sure your billing staff is aware of these updates. Make sure that your billing staffs are aware of these changes.

Background

CR9661 informs the Part A/B MACs, the HHH MACs, and the Fiscal Intermediary Shared System (FISS) that the I/OCE is being updated for July 1, 2016. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE.

The modifications of the I/OCE for the July 2016 v17.2 release are summarized in the following table.
<table>
<thead>
<tr>
<th>Type</th>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
</table>
| Logic              | 7/1/2016       | 95, 96, 97     | Implement new edits under the partial hospitalization program logic for weekly hours of service requirements:  
- Edit 95: Partial hospitalization claim span is equal to or more than 4 days with insufficient number of hours of service (RTP)  
  Criteria: A PHP claim From and Through date spans 4 or more days, but less than 8 days, and there are less than 20 hours of services present.  
- Edit 96: Partial hospitalization interim claim From and Through dates must span more than 4 days (RTP)  
  Criteria: An interim PHP claim (bill type 763 or 133 with condition code 41) From and Through date spans less than 5 days.  
- Edit 97: Partial hospitalization services are required to be billed weekly (RTP)  
  Criteria: A PHP claim From and Through date spans more than 7 days.  
See special processing logic under OPPS (page 7), Appendix C of CR9661-a (Weekly PHP flowchart) and Appendix F(a) (OPPS edits applied by bill type). |
| Logic              | 1/1/2016       | 98             | Implement new edit 98: Claim with pass-through device, drug or biological lacks required procedure (RTP).  
Criteria: A pass-through device, drug or biological HCPCS code is present without an associated, required procedure.  
See special processing logic under OPPS (page 13), Appendix P (flowchart) and Appendix F(a). |
| Logic              | 1/1/2015       |                | Add program logic to exclude certain blood products (packed red cells and whole blood) from packaging if reported on a comprehensive APC claim (see special processing logic under OPPS, page 9 and Appendix L).                                                                                                                                                                                                                          |
| Logic              | 4/5/2016       | 67             | Apply mid-quarter FDA approval date for HCPCS code Q5102.                                                                                                                                                                                                                                                                                                                                                       |
| Logic              | 4/1/2016       | 94             | Apply the edit if new biosimilar HCPCS code Q5102 is reported without the associated new modifier ZB.                                                                                                                                                                                                                                                                                                          |
| Logic              | 7/1/2016       | 87             | Updates to the skin substitute list (Appendix O: move Q4164 from low cost to high cost).                                                                                                                                                                                                                                                                                                                          |
| Logic              | 1/1/2016       | 92             | Updates to the device and device procedure lists.                                                                                                                                                                                                                                                                                                                                                               |
| Logic and Field Definition | 1/1/2016 |                | Change the program logic to provide unique Payer Value Code QU when a condition for device credit is present, reported with condition code 49, 50, or 53 (see special processing logic under OPPS, page 9 and Table 5).                                                                                                                                                                                                                      |

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<table>
<thead>
<tr>
<th>Type</th>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation</td>
<td>1/1/2016</td>
<td></td>
<td>Update Appendix L (Comprehensive APC processing) under the inpatient procedure where the patient expired logic to note non-covered SI values are returned as excluded from packaging under comprehensive APCs, but any associated edits are not returned (documentation only, no change to program logic).</td>
</tr>
<tr>
<td>Documentation</td>
<td>1/1/2015</td>
<td>45</td>
<td>Update the reference on page 8 to indicate the change made for edit 45 to include SI = J1 procedures is retroactive to 1/1/2015 (documentation only, no change to program logic).</td>
</tr>
<tr>
<td>Documentation</td>
<td>7/1/2016</td>
<td></td>
<td>Update Table 2 with reference information for the reporting of modifiers.</td>
</tr>
<tr>
<td>Documentation</td>
<td>1/1/2016</td>
<td></td>
<td>Updated special processing logic on page 9 to include reference to the use of the complexity-adjusted comprehensive APC as the look-up for device credit amount when condition code 49, 50, or 53 are present (documentation only, no change to program logic).</td>
</tr>
<tr>
<td>Content</td>
<td>4/1/2016</td>
<td>22</td>
<td>Add modifier ZB (Pfizer/Hospira) to the list of valid modifiers.</td>
</tr>
<tr>
<td>Content</td>
<td>1/1/2015</td>
<td></td>
<td>Modify the valid revenue list for revenue code 940 (Other therapeutic services) to have SI value changed to N if reported with a blank HCPCS code.</td>
</tr>
<tr>
<td>Content</td>
<td>7/1/2016</td>
<td></td>
<td>Update the following lists for the release (see quarterly data files):</td>
</tr>
<tr>
<td>Content</td>
<td>7/1/2016</td>
<td></td>
<td>- Questionable covered service list (edit 12)</td>
</tr>
<tr>
<td>Content</td>
<td>7/1/2016</td>
<td></td>
<td>- Valid revenue code list</td>
</tr>
<tr>
<td>Content</td>
<td>7/1/2016</td>
<td></td>
<td>- Revised files for pass-through offset conditions (edit 98)</td>
</tr>
<tr>
<td>Content</td>
<td>7/1/2016</td>
<td></td>
<td>- Device and device-procedure lists (edit 92)</td>
</tr>
<tr>
<td>Content</td>
<td>7/1/2016</td>
<td></td>
<td>- Skin substitute product lists (edit 87)</td>
</tr>
<tr>
<td>Content</td>
<td>7/1/2016</td>
<td></td>
<td>Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).</td>
</tr>
<tr>
<td>Content</td>
<td>7/1/2016</td>
<td>20, 40</td>
<td>Implement version 22.2 of the NCCI (as modified for applicable outpatient institutional providers).</td>
</tr>
</tbody>
</table>

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html) under - How Does It Work.
MLN Matters® Number: SE1611  Related Change Request (CR) #: N/A
Related CR Release Date: N/A  Effective Date: October 1, 2016
Related CR Transmittal #: N/A  Implementation Date: October 3, 2016

Rural Health Clinics (RHCs) Healthcare Common Procedure Coding System (HCPCS) Reporting Requirement and Billing Updates

Provider Types Affected

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

Provider Action Needed

This article provides information to assist RHCs in meeting the requirements to report the HCPCS code for each service furnished along with the revenue code on claims to Medicare effective for dates of service on or after April 1, 2016. Make sure your billing staff is aware of these instructions.

Background

From April 1, 2016, through September 30, 2016, all charges for a visit will continue to be reported on the service line with the qualifying visit HCPCS code, minus any charges for preventive services, using revenue code 052x for medical services and/or revenue code 0900 for mental health services. This guidance is available in MLN Matters Article MM9269 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9269.pdf. The RHC Qualifying Visit List (QVL) can be accessed on the RHC Center Page located at https://www.cms.gov/center/provider-type/rural-health-clinics-center.html.

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In April 2016, CMS instructed RHCs to hold claims only for a billable visit shown in red on the RHC QVL until October 1, 2016. Upon billing these claims and/or for claim adjustments beginning on October 1, 2016, RHCs shall add modifier CG (policy criteria applied) to the line with all the charges subject to coinsurance and deductible. The subsequent paragraph explains modifier CG further.

Beginning on October 1, 2016, the MACs will accept modifier CG on RHC claims and claim adjustments. RHCs shall report modifier CG on one revenue code 052x and/or 0900 service line per day, which includes all charges subject to coinsurance and deductible for the visit. For RHCs, the coinsurance is 20 percent of the charges. Therefore, coinsurance and deductible will be based on the charges reported on the revenue code 052x and/or 0900 service line with modifier CG. RHCs will continue to be paid an all-inclusive rate (AIR) per visit.

Coinsurance and deductible are waived for the approved preventive health services in Table 1. When a preventive health service is the primary service for the visit, RHCs should report modifier CG on the revenue code 052x service line with the preventive health service. Medicare will pay 100% of the AIR for the preventive health service.

### Table 1: Approved Preventive Health Services with Coinsurance and Deductible Waived

<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>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>

Each additional service furnished during the visit should be reported with the most appropriate revenue code and charges greater to or equal to $0.01. The additional service
lines are for informational purposes only. MACs will continue to package/bundle the additional service lines, which do not receive the AIR.

When the patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, the subsequent medical service should be billed using revenue code 052x and modifier 59. Beginning on October 1, 2016, RHCs can also report modifier 25 to indicate the subsequent visit was distinct or independent from an earlier visit furnished on the same day. When modifier 59 or modifier 25 is reported, RHCs will receive the AIR for an additional visit. This is the only circumstance in which modifier 59 or modifier 25 should be used.

Finally, note that the HCPCS reporting requirements have no impact in the way that telehealth or chronic care management services are reimbursed.

**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.
Revisions to Private Contracting/Opt-out Manual Sections Due to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

Provider Types Affected

This MLN Matters® Article is intended for physicians and practitioners who are planning to opt-out of Medicare or who have already opted out of Medicare.

Provider Action Needed

Change Request (CR) 9616 alerts physicians and practitioners who signed a valid opt-out affidavit on or after June 16, 2015, that it will automatically renew every 2 years. CR9616 revises the “Medicare Benefit Policy Manual” to be consistent with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) amendments. If physicians and practitioners who filed affidavits effective on or after June 16, 2015, do not want their opt-out to automatically renew at the end of a 2 year opt-out period, they may cancel the renewal by notifying all MACs with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period.

Be aware that valid opt-out affidavits signed before June 16, 2015, will expire 2 years after the effective date of the opt out. If physicians and practitioners that filed affidavits effective before June 16, 2015, want to extend their opt out, they must submit a renewal affidavit within 30 days after the current opt-out period expires to all contractors with which they would have filed claims absent the opt-out.
Background

MACRA amended the private contracting/opt out provisions at Section 1802(b) of the Social Security Act. Prior to the MACRA amendments, the law specified that physicians and practitioners may opt out for a 2-year period. Individuals that wished to renew their opt-out at the end of a 2-year opt-out period were required to file new affidavits with their MAC. Section 106(a) of the MACRA amended section 1802(b)(3) of the Social Security Act to require that opt-out affidavits entered into on or after June 16, 2015, automatically renew every 2 years.

Other Key Points

- Medicare will make payment for covered, medically necessary services that are ordered or certified by a physician/practitioner who has opted out of Medicare if the ordering or certifying physician/practitioner has acquired a National Provider Identifier (NPI), reports his/her Social Security Number, has a valid opt out affidavit on file with his or her MAC, is of a specialty that is eligible to order and certify and provided that the services are not furnished by another physician/practitioner who has also opted out. For example, if an opt-out physician/practitioner admits a beneficiary to a hospital, Medicare will reimburse the hospital for medically necessary care.

- In order for a private contract with a beneficiary to be effective, the physician/practitioner must be opted out of Medicare. The physician/practitioner’s initial 2-year opt-out period begins the date the affidavit meeting Medicare requirements is signed, provided the affidavit is filed within 10 days after the physician/practitioner signs his or her first private contract with a Medicare beneficiary.

- When a 2-year opt-out period ends, the physician/practitioner must enter into new private contracts with each beneficiary for the new 2-year period. The new private contracts must state the expected or known effective date and the expected or known expiration date of the current 2-year opt-out period.

- These points and other information are identified in the revised Chapter 15, Section 40 of the “Medicare Benefit Policy Manual,” which is attached to CR9616.

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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