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MLN Matters Disclaimer Statement

Below is the CMS Medicare Learning Network (MLN) Matters Disclaimer statement that applies to all MLN Matters articles in this bulletin.

“This article was prepared as a service to the public and is not intended to grant rights or impose obligations. MLN Matters articles may contain references or links to statutes, regulations or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.”

Sources for “Medicare A News” Articles

The purpose of “Medicare A News” is to educate the Noridian Medicare Part A provider community. The educational articles can be advice written by Noridian staff or directives from CMS. Whenever we publish material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material. Noridian includes “Source” following CMS derived articles to allow for those interested in the original material to research it at the CMS website, http://www.cms.gov/manuals. The CMS Change Request (CR) and the date issued will be referenced within the “Source” portion of applicable articles.

CMS publishes a series of educational articles within their Medicare Learning Network (MLN), titled “MLN Matters.” These “MLN Matters” articles are also included in Noridian bulletins. The Medicare Learning Network is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives.

Quarterly Provider Update from CMS

The Quarterly Provider Update is a comprehensive resource published by CMS on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including Change Requests (CRs), manual changes and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update.

The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
• Communicate the specific days that CMS business will be published in the Federal Register.

Sign up for the Quarterly Provider Update listserv to receive notification when regulations and program instructions are added throughout the quarter, (electronic mailing list) at http://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/index.html?redirect=/AboutWebsite/EmailUpdates/list.asp. Indicate that you wish to receive the CMS-QPU Listserv on the list of available publications.

The Quarterly Provider Update can be accessed on the CMS website at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html?redirect=/QuarterlyProviderUpdates. We encourage you to bookmark this website and visit it often for this valuable information.

Source: PM AB-03-075, CR 2686 dated May 23, 2003

Unsolicited or Voluntary Refunds Reminder

All Medicare providers need to be aware that the acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Background

Medicare carriers and intermediaries and A/B MACs receive unsolicited or voluntary refunds from providers. These voluntary refunds are not related to any open accounts receivable. Providers billing intermediaries typically make these refunds by submitting adjustment bills, but they occasionally submit refunds via check. Providers billing carriers usually send these voluntary refunds by check.

Related Change Request (CR) 3274 is intended mainly to provide a detailed set of instructions for Medicare carriers and intermediaries regarding the handling and reporting of such refunds. The implementation and effective dates of that CR apply to the carriers and intermediaries. But, the important message for providers is that the submission of such a refund related to Medicare claims in no way limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Additional Information


Effective Date: January 1, 2005

Implementation Date: January 4, 2005


Affordable Care Act - Operating Rules - Requirements for Phase II and Phase III Compliance for Batch Processing

MLN Matters® Number: MM9358
Related Change Request (CR) #: CR 9358
Related CR Release Date: September 16, 2016
Effective Date: April 1, 2017
Related CR Transmittal #: R1716OTN
Implementation Date: April 3, 2017
Provider Types Affected

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

What You Need to Know

Change Request (CR) 9358 requires MACs to meet the connectivity and security requirements for the Phases II and III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Operating Rules as well as the batch processing requirements for the Phase II CAQH CORE Operating Rules.

Background

The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing Operating Rules adopted under Section 1104 of the Affordable Care Act. The Secretary of the Department of Health and Human Services (HHS) named the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules (CORE) as the authoring entity of the Phase I, II, and III Operating Rule. The Operating Rules are intended to provide additional direction and clarification to the Electronic Data Interchange (EDI) standard adopted under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. CMS is currently in the process of implementing the batch requirements for the Phase II rules for the Claim Status Inquiry and Response as well as the Phase III rules for the Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT).

HIPAA transactions are referred to in the following manner:

- **276**: ASC X12 Health Care Claim Status Request
- **277**: ASC X12 Health Care Information Status Notification
- **835**: ASC X12 Health Care Claim Payment/Advice
- **999**: ASC X12 Implementation Acknowledgment For Health Care Insurance

CR9358 requires the MACs to implement a solution to comply with CAQH CORE Phase II Connectivity Rule 270, including the use of X.509 Client Certificates over SSL. This solution must be able to receive and post the batch 276/277 transactions for using the public internet for the Hypertext Transfer Protocol within a connection encrypted by Transport Layer Security (HTTP/S) transport. The MACs shall accept 276 transactions up until 9pm Eastern time of a business day, which equates to receipt of the 276 within the EDI front-end system for any 276 transactions submitted via either the MAC’s Electronic Data Interchange (EDI) gateway or the public Internet. The MAC must then return the 277 transaction by 7:00 am Eastern time the next business day. The MACs must also track the times of any received inbound messages with the capability to generate a report (audit log) that tracks the 999 response to the inbound 276 as well as date and timestamp for the 277, including the date and time the message was sent in HTTP+MIME or SOAP+WSDL Message Header tags. The MACs must support both Message Envelope Standards and Message Exchanges (HTTP+MIME) and Simple Object Access Protocol and Web Service Definition Language (SOAP+WSDL) Message. The solution must be able to report HTTP server errors with an HTTP 500 Internal Service Error or a HTTP 503 Service Unavailable error message for 276/277/835/999 transactions. The MACs must support Submitter Authentication Standards as detailed in Operating rule 153 for the 276/277/835/999 transactions.

The MACs will also develop and implement a solution using HTTP/S Version 1.1 over the public Internet as a transport method for the 835 in accordance with the Phase III Infrastructure Rule 350, which requires entities to support the Phase II CORE 270 Connectivity Rule Version 2.2.0. If a trading partner decides to transition to exchanging files over the public Internet, and the MAC’s environment does not permit for dual submission/retrieval using CORE and non-CORE connectivity, there will not be a transition period, just a scheduled flash cut. If the MAC’s environment has the ability to support the use of either gateway or public Internet, the MACs shall have discretion to make the business decision on transition and ability to switch between connectivity options.

MACs will make updates to their enrollment procedures, forms and trading partner management system for connectivity over the public Internet. **Enrollment in the Internet needs to be at the trading partner level.**
Additional Information

Correction of Remark Code Information
MLN Matters® Number: MM9641
Related Change Request (CR) #: CR 9641
Related CR Release Date: July 15, 2016
Effective Date: October 17, 2016
Related CR Transmittal #: R3560CP
Implementation Date: October 17, 2016

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

What You Need to Know
Change Request (CR) 9641 updates the “Medicare Claims Processing Manual,” Chapter 30, to make corrections to Remittance Advice Codes and general punctuation and grammar corrections. All Remittance Advice messaging must follow a prescribed set of rules. Specifically, Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) may only be used in specified combinations laid out by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE), the designated Standards Development Organization (SDO). The CARC and RARC code sets are available via the Washington Publishing Company (WPC) at http://www.wpc-edi.com/Reference.

Additional Information

MPPR on the Professional Component of Certain Diagnostic Imaging Procedures
MLN Matters® Number: MM9647
Related Change Request (CR) #: CR 9647
Related CR Release Date: August 5, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3578CP
Implementation Date: January 3, 2017

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

Provider Action Needed
Change Request (CR) 9647 informs providers that Section 502(a)(2) of the Consolidated Appropriations Act of 2016 revised the Multiple Procedure Payment Reduction (MPPR) for the Professional Component (PC) of the second and subsequent procedures from 25 percent to 5 percent of the physician fee schedule amount. Make sure that your billing staffs are aware of these changes.
Background

Medicare currently applies the MPPR of 25 percent to the PC of certain diagnostic imaging procedures. The reduction applies to PC-only services, and the PC portion of global services, for the procedures with a multiple surgery value of ‘4’ in the Medicare Fee Schedule database.

The Centers for Medicare & Medicaid Services (CMS) currently makes full payment for the PC of the highest-priced procedure and payment at 75 percent for the PC of each additional procedure when furnished by the same physician (or physician in the same group practice) to the same patient, in the same session on the same day.

Section 502(a)(2) of the Consolidated Appropriations Act of 2016 revised the MPPR for the PC of the second and subsequent procedures from 25 percent to 5 percent of the physician fee schedule amount. The MPPR on the Technical Component (TC) of imaging remains at 50 percent.

Effective January 1, 2017, MACs shall pay 95 percent of the fee schedule amount for the PC of each additional procedure furnished by the same physician (or physician in the same group practice) to the same patient, in the same session on the same day.

The current payment, and the payment as of January 1, 2017, are summarized in the example table below:

<table>
<thead>
<tr>
<th>Procedure 1</th>
<th>Procedure 2</th>
<th>Current Total Payment</th>
<th>Revised Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC</td>
<td>$100</td>
<td>$160 ($100 + (.75 x $80))</td>
<td>$176 ($100 +(.95 x $80))</td>
</tr>
<tr>
<td>TC</td>
<td>$500</td>
<td>$700 ($500 + (.50 x $400))</td>
<td>$700 ($500 + (.50 x $400))</td>
</tr>
<tr>
<td>Global</td>
<td>$600</td>
<td>$860 ($600 + (.75 x $80) + (.50 x $400))</td>
<td>$876 ($600 + (.95 x $80) + (.50 x $400))</td>
</tr>
</tbody>
</table>

Additional Information


CWF to Locate Medicare Beneficiary Record and Provide Responses to Provider Queries

MLN Matters® Number: MM9740
Related Change Request (CR) #: CR 9740
Related CR Release Date: July 29, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R1687OTN
Implementation Date: January 3, 2017

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 to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9740 informs MACs about the changes to the Medicare’s Common Working File (CWF) to add an auto-search capability to CWF provider queries and eliminate the need for providers to query multiple CWF hosts for Medicare beneficiary eligibility information. Make sure that your billing staffs are aware of these changes, which reduce burden on providers.
Background
Medicare beneficiaries are assigned a primary host at CWF based on their primary address. At the time of querying CWF for eligibility information using CWF provider queries, ELGA, HIQA, ELGH, HIQH, and HUQA, providers may not know the CWF primary host of the Medicare beneficiary. When the CWF primary host of the Medicare beneficiary is not known, Providers must query multiple CWF hosts (up to 9) until they find the host that has the Medicare beneficiary record and get the eligibility information. As the CWF hosts are connected to each other, it is possible for CWF to automatically locate the primary host where the Medicare beneficiary record exists. This will eliminate the need for providers to search and locate the Medicare beneficiary record and may also reduce the number of provider queries received.

Additional Information

Next Generation Accountable Care Organization – Implementation
MLN Matters® Number: SE1613
Effective Date: January 1, 2016
Implementation Date: January 1, 2016

Provider Types Affected
This MLN Matters® Article is intended for providers who are participating in Next Generation Accountable Care Organizations (NGACOs) and submitting claims to Medicare Administrative Contractors (MACs) for certain skilled nursing facility, telehealth, and post-discharge home visit services to Medicare beneficiaries that would not otherwise be covered by Original fee-for-service (FFS) Medicare.

Provider Action Needed
This MLN Matters Special Edition Article provides information on the NGACO Model’s benefit enhancement waiver initiatives and supplemental claims processing direction. Make sure that your billing staffs are aware of these changes.

Background
The Centers for Medicare & Medicaid Services (CMS) implemented the Next Generation ACO Model (NGACO or the Model) on January 1, 2016. The Model is the first in the next generation of ACO provider-based models that will test opportunities for increased innovation around care coordination and management through greater accountability for the total cost of care.

The aim of the Model is to improve the quality of care, population health outcomes, and patient experience for the beneficiaries who choose traditional Medicare FFS through greater alignment of financial incentives and greater access to tools that may aid beneficiaries and providers in achieving better health at lower costs.

Core principles of the Model are:
• Protecting Medicare FFS beneficiaries’ freedom to seek the services and providers of their choice
• Creating a financial model with long-term sustainability
• Utilizing a prospectively set benchmark that:
  – Rewards quality
  – Rewards both attainment of and improvement in efficiency, and
  – Ultimately transitions away from updating benchmarks based on the ACO’s recent expenditures
• Engaging beneficiaries in their care through benefit enhancements that directly improve the patient experience and incentivize coordinated care from ACOs
• Mitigating fluctuations in aligned beneficiary populations and respecting beneficiary preferences through supplementing a prospective claims-based alignment process with a voluntary process, and
• Smoothing ACO cash flow and improving investment capabilities through alternative payment mechanisms.

Additional information on NGACO is available at https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/.

Participants and Preferred Providers

NGACO defines two categories of providers/suppliers and their respective relationships to the ACO entity: Next Generation Participants and Next Generation Preferred Providers. Next Generation Participants are the core providers/suppliers in the Model. Beneficiaries are aligned to the ACO through the Next Generation Participants and these providers/suppliers are responsible for, among other things, reporting quality through the ACO and committing to beneficiary care improvement. Preferred Providers contribute to ACO goals by extending and facilitating valuable care relationships beyond the ACO. For example, Preferred Providers may participate in certain benefit enhancements. Services furnished by Preferred Providers will not be considered in alignment and Preferred Providers are not responsible for reporting quality through the ACO.

Table 5.1 Types of Providers/Suppliers and Associated Functions

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Next Generation Participant</th>
<th>Preferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alignment</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Quality Reporting Through ACO</td>
<td>X</td>
<td></td>
</tr>
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<td>Eligible for ACO Shared Savings</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>PBP</td>
<td>X</td>
<td>X</td>
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<tr>
<td>All-Inclusive PBP</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Coordinated Care Reward</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Telehealth</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3-Day SNF Rule</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Post-Discharge Home Visit</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

1 This table is a simplified depiction of key design elements with respect to Next Generation Participant and Preferred Provider roles. It does not necessarily imply that this list is exhaustive with regards to possible ACO relationships and activities.

Three Benefit Enhancements

In order to emphasize high-value services and support the ability of ACOs to manage the care of beneficiaries, CMS uses the authority under section 1115A of the Social Security Act (section 3021 of the Affordable Care Act) to conditionally waive certain Medicare payment requirements as part of the NGACO Model. An ACO may choose not to implement all or any of these benefit enhancements.

1. 3-Day SNF Rule Waiver

CMS makes available to qualified NGACOs a waiver of the 3-day inpatient stay requirement prior to admission to a SNF or acute-care hospital or Critical Access Hospital (CAH) with swing-bed approval for SNF services (“swing-bed hospital”). This benefit enhancement allows beneficiaries to be admitted to qualified Next Generation ACO SNF Participants and Preferred Providers either directly or with an inpatient stay of fewer than three days. The waiver will apply only to eligible aligned beneficiaries admitted to Next Generation ACO SNF Participants and Preferred Providers.

An aligned beneficiary will be eligible for admission in accordance with this waiver if:

1. The beneficiary does not reside in a nursing home, SNF, or long-term nursing facility and receiving Medicaid at the time of the decision to admit to an SNF, and
2. The beneficiary meets all other CMS criteria for SNF admission, including that the beneficiary must:
a. Be medically stable  
b. Have confirmed diagnoses (for example, does not have conditions that require further testing for proper diagnosis)  
c. Not require inpatient hospital evaluation or treatment; and  
d. Have an identical skilled nursing or rehabilitation need that cannot be provided on an outpatient basis or through home health services.

NGACOs identify the SNF Participant and Preferred Providers with which they will partner in this waiver through the annual submission of Next Generation Participant and Preferred Provider lists.

**Claims**

Next Generation Model 3-day SNF rule waiver claims do not require a demo code to be manually affixed to the claim. When a qualifying stay does not exist, the Fiscal Intermediary Standard System (FISS) checks whether 1) the beneficiary is aligned to an NGACO approved to use the SNF 3-day rule waiver; 2) the SNF provider is also approved to use the waiver; and 3) the SNF is a provider for the same NGACO for which the beneficiary is aligned. Once eligibility is confirmed, demo code 74 (for the NGACO Model) and indicator value 4 (for the 3-day SNF rule waiver) is placed on the claim.

If an eligible NGACO SNF 3-day waiver claim includes demo code 62 (for the BPCI Model 2 SNF 3-day rule waiver), for example, the FISS will not check to validate whether the claim is a valid NGACO SNF 3-day rule waiver. CMS has instructed that FISS only validate when no demo code has been affixed and no qualifying 3-day inpatient hospital stay has been met.

To assist MACs in troubleshooting provider SNF 3-day rule waiver claim questions, CMS instructed the FISS and the Multi Carrier System (MCS) maintainers to create screens. The FISS maintainer created a Sub-menu of the 6Q – CMS Demonstrations Screen to allow for inquiry of both the NGACO Provider File Data and the NGACO Beneficiary File Data. The screen shows the following data value for this waiver: 3 Day SNF Waiver = Value 4. The MCS maintainer created two screens to allow for SNF 3-day rule waiver validation inquiry as listed:

- MCS created screen PROVIDER ACCOUNTABLE CARE ORGANIZATION (ACO) so that MACs would be able to see which ACO a provider is aligned with.
- MCS created screen BENEFICIARY ACCOUNTABLE CARE ORGANIZATION (ACO) so that MACs would be able to see which ACO a beneficiary is aligned with.

**Telehealth Expansion**

CMS makes available to qualified NGACOs a waiver of the requirement that beneficiaries be located in a rural area and at a specified type of originating site in order to be eligible to receive telehealth services. This benefit enhancement will allow payment of claims for telehealth services delivered by Next Generation ACO Participants or Preferred Providers to aligned beneficiaries in specified facilities or at their residence regardless of the geographic location of the beneficiary.

**Claims**

For those telehealth services originating at the beneficiary’s home (in a rural or non-rural geographic setting) place of service (POS) code 12 (home) must be added to the claim.

Claims will **not** be allowed for the following telehealth services rendered to aligned beneficiaries located at their residence:

- Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs. Healthcare Common Procedure Coding System (HCPCS) codes G0406-G0408.
- Subsequent hospital care services, with the limitation of one telehealth visit every 3 days. Current Procedural Terminology (CPT) codes 99231-99233.
- Subsequent nursing facility care services, with the limitation of one telehealth visit every 30 days. CPT codes 99307-99310.

For those telehealth services originating in a non-rural area a provider does not need to insert a demonstration code in order for the claim to process successfully.
Notwithstanding these waivers, all telehealth services must be furnished in accordance with all other Medicare coverage and payment criteria, and no additional reimbursement will be made to cover set-up costs, technology purchases, training and education, or other related costs. In particular, the services allowed through telehealth are limited to those described under section 1834(m)(4)(F) of the Social Security Act and subsequent additional services specified through regulation.

3. 3. Post-Discharge Home Visits

CMS makes available to qualified NGACOs waivers to allow “incident to” claims for home visits to non-homebound aligned beneficiaries by licensed clinicians under the general supervision—instead of direct supervision—of Next Generation Participants or Preferred Providers.

Licensed clinicians, as defined in 42 C.F.R. § 410.26(a)(1), may be any employees, leased employees, or independent contractors who are licensed under applicable state law to perform the ordered services under physician (or other practitioner) supervision. A Participant or Preferred Provider may contract with licensed clinicians to provide this service and the service is billed by the Participant or Preferred Provider.

Claims for these visits will only be allowed following discharge from an inpatient facility (including, for example, inpatient prospective payment system (IPPS) hospitals, Critical Access Hospitals (CAHs), SNFs, Inpatient Rehabilitation Facilities (IRFs) and will be limited to no more than one visit in the first 10 days following discharge and no more than one visit in the subsequent 20 days. Payment of claims for these visits will only be allowed as services and supplies that are incident to the service of a physician or other practitioner as described under 42 CFR §410.26. This provision is not generally applicable to home visits; however, for purposes of this payment waiver, CMS intends to use the same definition of general supervision as outlined in this provision.

Claims

Post-discharge home visit service waiver claims must contain one of the following Evaluation and Management (E/M) Healthcare Common Procedure Coding System (HCPCS) codes:

- 99324-99337
- 99339-99340
- 99341-99350

Providers are not required to add a demonstration code to process these claims.

Additional Information

Additional information about the Next Generation ACO Model is available at: https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/.

Protecting Patient PHI

MLN Matters® Number: SE1616

Provider Types Affected

This MLN Matters® Article is intended for physicians, including physician group practices, that are covered entities under the Health Insurance Portability and Accountability Act (HIPAA) using electronic systems to store Personal Health Information (PHI) of their Medicare patients.

Provider Action Needed

This MLN Matters Special Edition Article reminds physicians of the HIPAA requirement to protect the confidentiality of the PHI of their patients. Recently, the Centers for Medicare & Medicaid Services (CMS) learned of a potential security breach in which someone was offering for sale over 650,000 records of orthopedic patients. Remember that a covered entity must notify the Secretary of Health and Human Services if it discovers a breach of unsecured protected health information. See 45 C.F.R. § 164.408. Also, keep abreast of any issues that your business associates, especially those entities that provide you with hardware and/or software support for your patient electronic health records. Be sure they are required to report any actual or potential security breaches to you, especially threats that compromise patient PHI.
Background

CMS is providing this information in response to a recent report from the Cyber Health Working Group. This group recently reported the detection of an offer to sell six databases, three of which were databases that appeared to be orthopedic databases. Providers need to be extremely conscious of their systems security, especially with systems that connect to the Internet.

Additional Information


Information on reporting breaches of security is available at [http://www.hhs.gov/hipaa/for-professionals/breach-notification/breach-reporting/index.html](http://www.hhs.gov/hipaa/for-professionals/breach-notification/breach-reporting/index.html).

Holding Claims for Pricing Based on the October 2016 FISS Release

Effective October 1, 2016, Part A claims with dates of service on/after October 1, 2016 will be placed on a 15 day hold while pricing files are installed into the Fiscal Intermediary Shared System (FISS). This will allow claims to be verified for correct pricing to ensure proper payment.

All claims held during this time will be released no later than October 15, 2016.

Jump Point Feature Added to IVR

Effective August 26, 2016, a new feature called “Jump Point” is being added to the Noridian Interactive Voice Response (IVR) system. Jump Point will help streamline the call process of getting claim denial details related to patient eligibility without taking any extra steps. It will also eliminate the need for callers to go through the main menu and then eligibility prompt. Moving forward, details will be provided immediately following the claim details.

The following are the denials that the IVR Jump Point will provide details on:

- MSP
- Managed Care
- Part A and B Effective Dates

For any question regarding the IVR Jump Point, please contact our [Provider Contact Center](mailto:ProviderContactCenter@noridian.com).

Portal Enhancements Implemented July 15, 2016

The Norian Medicare Portal recently received several enhancements in response to provider/supplier recommendations received through the website satisfaction survey. Some of the changes made available July 15, 2016 improved Provider Administrator’s access to oversee 25 Tax Identification Numbers, improved the calendar date entry options, corrected a beneficiary name format issue, and improved the appeals submission success rate. The results for the remittance advice and DME financial inquiry were also improved.

The number one recommendation received regarding the Noridian Medicare Portal is to not require the complete Medicare Health Insurance Claim Number and/or to be more lenient with the spelling of the first and last name for eligibility inquiries. We do appreciate the position many providers and suppliers are in and the fact they may not have access to obtain a copy of the Medicare card; however, the requirement surrounding the accuracy of the eligibility data entry elements is driven by the [CMS HIPAA Eligibility Transaction System (HETS) criteria](https://www.cms.gov/Medicare/Eligibility-Benefits-Calculation/HETS/index.htm).

Please share your recommendations with Noridian by completing the website satisfaction survey each time it is presented in your website navigation or portal experience.
News & Announcements

• HHS Announces Physician Groups Selected for an Initiative Promoting Better Cancer Care
• Open Payments Program Posts 2015 Financial Data
• Hospice CAHPS® Exemption for Size Deadline: August 10
• Help Us Improve Access to DMEPOS
• Revised CMS-855R Application: Reassignment of Medicare Benefits
• July Quarterly Provider Update Available
• Rule Gives Providers/Employers Improved Access to Information for Better Patient Care

Claims, Pricers & Codes

• Modifications to HCPCS Code Set

Upcoming Events

• SNF Quality Reporting Program Call — July 12

Medicare Learning Network® Publications & Multimedia

• Medicare Quarterly Provider Compliance Newsletter Educational Tool — New
• Subscribe to the Medicare Learning Network Educational Products and MLN Matters® Electronic Mailing Lists

FYI


Medicare Proposes Substantial Improvements to Paying for Care Coordination and Planning, Primary Care, and Mental Health in Doctor Payment Rule

Medicare also expands the Diabetes Prevention Program

Today, the Centers for Medicare & Medicaid Services (CMS) proposed changes to the Physician Fee Schedule to transform how Medicare pays for primary care through a new focus on care management and behavioral health designed to recognize the importance of the primary care work physicians perform. The rule also proposes policies to expand the Diabetes Prevention Program within Medicare starting January 1, 2018. This is the first time a preventive service model from the CMS Innovation Center would be expanded into the Medicare program.

The rule’s primary care proposals improve how Medicare pays for services provided by primary care physicians and other practitioners for patients with multiple chronic conditions, mental and behavioral health issues, as well as cognitive impairment or mobility-related impairments.

These changes will improve payment for clinicians who are making investments of time and resources to provide more coordinated and patient-centered care. These proposed coding and payment changes will better reflect the resources involved in furnishing contemporary primary care, care coordination and planning, mental health care, and care for cognitive impairment, such as Alzheimer’s disease. In addition, these proposed changes further reinforce Medicare’s transformation to better align priorities and reward physicians for quality care through the Quality Payment Program.

“Today’s proposals are intended to give a significant lift to the practice of primary care and to boost the time a physician can spend with their patients listening, advising and coordinating their care -- both for physical and mental health,” said CMS Acting Administrator Slavitt. “If this rule is finalized, it will put our nation’s money where its mouth is by continuing to recognize the importance of prevention, wellness, and mental health and chronic disease management.”
To learn more about these efforts to support and improve access to primary care, please visit the CMS Blog at https://blog.cms.gov/2016/07/07/focusing-on-primary-care-for-better-health/.

In March 2016, CMS announced that the Diabetes Prevention Program met the statutory eligibility criteria for expansion into Medicare. Today, CMS is proposing to expand the Diabetes Prevention Program into Medicare beginning January 1, 2018. Our proposal would allow Medicare Diabetes Prevention Program suppliers, recognized by the Centers for Disease Control and Prevention, to submit claims to Medicare for providing diabetes prevention services. CMS is proposing a process for suppliers to enroll in the program so they can furnish services and bill Medicare as soon as possible after the program becomes effective.

“Through expansion of the Diabetes Prevention Program, beneficiaries across the nation will be able to access a community-based intervention that prevents diabetes and keeps people healthy. This is part of our efforts for better care, smarter spending, and healthier people,” said Patrick Conway, Acting Principal Deputy Administrator and CMS Chief Medical Officer. “Today’s proposal is an exciting milestone for prevention and population health.”

CMS hopes that the expansion of the Diabetes Prevention Program into Medicare can serve as a model for employers and insurers who may want to initiate diabetes prevention programs in their populations as well. To learn more about the Diabetes Prevention Program, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-07.html.

The annual Physician Fee Schedule updates payment policies, payment rates, and quality provisions for services provided in calendar year 2017. These services include, but are not limited to visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services. In addition to physicians, the fee schedule pays a variety of practitioners and entities, including nurse practitioners, physician assistants, physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities. Additional policies proposed in the 2017 payment rule include:

- **Primary Care and Care Coordination:** The rule proposes revisions to payment for chronic care management, including payment for new codes and for extra care management furnished by a physician or practitioner following the initiating visit for patients with multiple chronic conditions. This proposed change is a significant update to the Physician Fee Schedule and will support primary care when and where patients need it most.

- **Mental and Behavioral Health:** CMS is proposing to pay for specific behavioral health services furnished using the Collaborative Care Model, which has demonstrated benefits in a variety of settings. In this model, patients are cared for through a team approach, involving a primary care practitioner, behavioral health care manager, and psychiatric consultant. CMS is also proposing to pay more broadly for other approaches to behavioral health integration services.

- **Cognitive Impairment Care Assessment and Planning:** CMS is proposing a new code to pay for cognitive and functional assessment and care planning for patients with cognitive impairment (e.g., for patients with Alzheimer’s). This is a major step forward for care planning for these populations.

- **Care for Patients with Mobility-Related Impairments:** CMS is proposing to pay physicians more accurately for furnishing services to beneficiaries with mobility-related impairments. This increase in payment will improve quality and access for this vulnerable population.

In addition, CMS evaluated concerns about payment adjustments to Puerto Rican clinicians based on local costs and is proposing a change that would more accurately reflect these costs and significantly increase payments in the Commonwealth. Other changes in the proposed regulation would enhance program integrity and data transparency in the Medicare Advantage program.

For more information, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-07-2.html.

CMS will accept comments on the proposed rule until September 6, 2016, and will respond to comments in a final rule. The proposed rule will appear in the July 15, 2016, Federal Register and can be downloaded from the Federal Register at: https://www.federalregister.gov/public-inspection.

Get CMS news at cms.gov/newsroom, sign up for CMS news via email and follow CMS on Twitter @CMSgov.

Physician Fee Schedule: Proposed CY 2017 Changes

Medicare also expands the Diabetes Prevention Program

On July 7, CMS proposed changes to the Physician Fee Schedule to transform how Medicare pays for primary care through a new focus on care management and behavioral health designed to recognize the importance of the primary care work physicians perform. The rule also proposes policies to expand the Diabetes Prevention Program within Medicare starting January 1, 2018.

The annual Physician Fee Schedule updates payment policies, payment rates, and quality provisions for services provided in calendar year 2017. These services include, but are not limited to visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services. In addition to physicians, the fee schedule pays a variety of practitioners and entities, including nurse practitioners, physician assistants, physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities. Additional policies proposed in the 2017 payment rule include:

- Primary care and care coordination
- Mental and behavioral health
- Cognitive impairment care assessment and planning
- Care for patients with mobility-related impairments

For More Information:
- Proposed Rule (CMS-1654-P): Comments due no later than 5 pm on September 6, 2016
- Fact Sheet
- Blog
- Diabetes Prevention Program

See the full text of this excerpted CMS press release (issued July 7).

Hospital and ASC: Proposed OPPS Changes for CY 2017

On July 6, CMS proposed updated payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. Several of the proposed policy changes would improve the quality of care Medicare patients receive by better supporting their physicians and other health care providers. These proposals are based on feedback from stakeholders, including beneficiary and patient advocates, as well as health care providers, including hospitals, ambulatory surgical centers and the physician community.

Proposed changes include:

- Addressing physicians’ concerns regarding pain management
- Focusing payments on patients rather than setting
- Improving patient care through technology
- Emphasizing health outcomes that matter to the patient

CMS estimates that the updates in the proposed rule would increase OPPS payments by 1.6 percent and ASC payments by 1.2 percent in 2017.

For More Information:
- Proposed Rule (CMS-1656-P): Comments due no later than 5 pm on September 6, 2016
- Fact Sheet

See the full text of this excerpted CMS press release (issued July 6).
Editor’s Note:
This week’s eNews includes a new section on Provider Compliance, highlighting common billing errors. Check out the first message in this series on chiropractic services and learn how to bill Medicare correctly the first time.

News & Announcements
• New Hospice Report Available July 17
• Clinical Laboratory Fee Schedule Resources
• HIPAA Administrative Simplification Enforcement and Testing Tool
• 2017 QRDA Hospital Quality Reporting Implementation Guide, Schematrons, and Sample File
• Upcoming Medicare Learning Network® Website Redesign

Provider Compliance
• Chiropractic Services: High Improper Payment Rate within Medicare FFS Part B

Upcoming Events
• ESRD QIP: Reviewing Your Facility’s PY 2017 Performance Data Call — August 2
• IRF Quality Reporting Program Provider Training — August 9 and 10
• PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call — August 10
• LTCH Quality Reporting Program Provider Training — August 11

Medicare Learning Network Publications & Multimedia
• Medicare Billing Certificate Program for Part A Providers WBT — Revised
• Medicare Billing Certificate Programs for Part B Providers WBT — Revised
• Complying With Medicare Signature Requirements Fact Sheet — Revised
• DMEPOS Accreditation Fact Sheet — Revised
• Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet — Reminder

Editor’s Note:
Our Medicare Learning Network (MLN) website is updated to improve your access to education resources and make finding what you need easier. We hope you will take a look and share your thoughts with us. Learn more in this week’s eNews.

News & Announcements
• Improved Medicare Learning Network Website
• IRF Quality Reporting Program Data Submission Deadline: August 15
FYI

- LTCH Quality Reporting Program Data Submission Deadline: August 15
- Hospice Quality Reporting: Reconsideration Period Ends Soon
- SNF Readmission Measure: Top 10 Things You Should Know
- Enhanced Administrative Simplification Website

Provider Compliance
- CMS Provider Minute: CT Scans Video

Claims, Pricers & Codes
- Billing for Nursing Visits in Home Health Shortage Areas by an RHC or FQHC

Upcoming Events
- ESRD QIP: Reviewing Your Facility’s PY 2017 Performance Data Call — August 2
- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call — August 10

Medicare Learning Network® Publications & Multimedia
- Clinical Labs Call: Audio Recording and Transcript — New
- IMPACT Act Call: Audio Recording and Transcript — New
- Medicare Podiatry Services: Information for FFS Health Care Professionals Fact Sheet — Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Booklet — Revised
- How to Use the National Correct Coding Initiative Tools Booklet — Revised

MLN Connects Provider eNews – July 28, 2016

News & Announcements
- Overall Hospital Quality Star Ratings: Evaluation of National Distributions
- Million Hearts® Cardiovascular Disease Risk Reduction Model
- New Payment Models and Rewards for Better Care at Lower Cost
- $42 Billion Saved in Medicare and Medicaid Primarily Through Prevention
- SNF Quarterly Reports Available through Nursing Home Compare
- SNF QRP: Requirements for the FY 2018 Reporting Year Fact Sheet Available
- EHR Incentive Programs: Submit Comments on CY 2017 Hospital OPPS and ASC Proposed Rule by September 6
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis

Provider Compliance
- Home Health Care: Proper Certification Required

Claims, Pricers & Codes
- July 2016 OPPS Pricer File Update

Upcoming Events
- ESRD QIP: Reviewing Your Facility’s PY 2017 Performance Data Call — August 2
FYI

- Special Open Door Forum: Open Payments Notice to Inform Future Rulemaking — August 2
- Medicare Diabetes Prevention Program Webinar — August 9
- IRF Quality Reporting Program Provider Training — August 9 and 10
- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call — August 10
- Comparative Billing Report on IHC and Special Stains Webinar — August 10
- LTCH Quality Reporting Program Provider Training — August 11
- SNF Quality Reporting Program Provider Training — August 24
- IMPACT Act: Data Elements and Measure Development Call — August 31

Medicare Learning Network® Publications & Multimedia

- Protecting Patient Personal Health Information MLN Matters Article — New
- SNF Quality Reporting Program Call: Audio Recording and Transcript — New
- Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody under a Penal Authority Fact Sheet — Revised
- Electronic Mailing Lists: Keeping Health Care Professionals Informed Fact Sheet — Revised
- SNF Billing Reference Fact Sheet — Reminder
- Suite of Products & Resources for Compliance Officers Educational Tool — Reminder
- Suite of Products & Resources for Educators & Students Educational Tool — Reminder
- Suite of Products & Resources for Inpatient Hospitals Educational Tool — Reminder
- Suite of Products & Resources for Billers & Coders Educational Tool — Reminder

MLN Connects Provider eNews – August 4, 2016

MLN Connects® Provider eNews for August 4, 2016

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News & Announcements

- Hospital IPPS and LTCH PPS Final Rule Policy and Payment Changes for FY 2017
- SNFs: Final FY 2017 Payment and Policy Changes
- Hospice Benefit: Final FY 2017 Payment and Policy Changes
- IRFs: Final FY 2017 Payment and Policy Changes
- Inpatient Psychiatric Facilities: Final FY 2017 Payment and Policy Changes
- CMS Announces Next Phase in Largest-ever Initiative to Improve Primary Care in America
- CMS Extends, Expands Fraud-Fighting Enrollment Moratoria Efforts in Six States
- First Release of the Overall Hospital Quality Star Rating on Hospital Compare
- Home Health Agencies: New PEPPER Available
- Partial Hospitalization Programs: New PEPPER Available
- Physician Compare: 2014 Quality Data Available
- Teaching Hospital Closures: Apply for Resident Slots by October 31, 2016
- PQRS: EIDM Accounts Required to Access Feedback Reports and 2015 Annual QRURs
FYI

- Replacement of Accessories for Beneficiary-Owned CPAP Device or RAD
- Administrative Simplification Statutes and Regulations
- ICD-10 Coding Resources
- Vaccines are Not Just for Kids

Provider Compliance
- Hospital Discharge Day Management Services

Upcoming Events
- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call — August 10
- Data Collection on Resources Used in Furnishing Global Services Information Session — August 11
- IMPACT Act: Data Elements and Measure Development Call — August 31
- National Partnership to Improve Dementia Care and QAPI Call — September 15

Medicare Learning Network® Publications & Multimedia
- Remittance Advice Information: An Overview Fact Sheet — Reminder
- Medicare Costs at a Glance: 2016 Educational Tool — Revised

MLN Connects Provider eNews – August 11, 2016

News & Announcements
- Medicare Announces Participants in Effort to Improve Access, Quality of Care in Rural Areas
- Affordable Care Act Payment Model Continues to Improve Care, Lower Costs
- ESRD QIP PY 2020 Proposed Rule: New Fact Sheet and Video
- CMS to Release a CBR on Positive Airway Pressure Devices, Respiratory Assist Devices and Accessories in August
- TEP on IMPACT Act Quality Measures: Nominations due August 21

Provider Compliance
- Preventive Services

Claims, Pricers & Codes
- ICD-10 GEMS for 2017 Available

Upcoming Events
- ESRD QIP PY 2020 Proposed Rule Call-In Session — August 16
- Global Surgery Proposed Data Collection Town Hall — August 25
- IMPACT Act: Data Elements and Measure Development Call — August 31
- National Partnership to Improve Dementia Care and QAPI Call — September 15

Medicare Learning Network® Publications & Multimedia
- Timely Reporting of Provider Enrollment Information Changes MLN Matters® Article — New
- IRFs: Improving Documentation Positively Impacts CERT Web-Based Training Course — New
FYI

- Physician Compare Call: Addendum — New
- RHCs HCPCS Reporting Requirement and Billing Updates MLN Matters Article — Revised
- MLN Guided Pathways Provider Specific Medicare Resources Booklet — Revised
- PECOS Technical Assistance Contact Information Fact Sheet — Revised

MLN Connects Provider eNews – August 18, 2016

MLN Connects® Provider eNews for August 18, 2016
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News & Announcements
- CMS Updates Nursing Home Five-Star Quality Ratings
- IMPACT Act Standardized Assessment Data: Comments due August 26
- Medicare Outpatient Observation Notice: Public Comment Period Ends September 1
- Open Payments: Limited Time for Physicians to Dispute 2015 Data
- Programs of All-Inclusive Care for the Elderly
- Administrative Simplification: Adopted Standards and Operating Rules

Compliance
- Nasal Endoscopy

Claims, Pricers & Codes
- 2017 ICD-10-CM and ICD-10-PCS Code Updates
- Hospice Claim Adjustments Will Correct Routine Home Care Day Count

Upcoming Events
- IRF and LTCH Quality Reporting Program: Public Reporting Webinar — August 23
- Global Surgery Proposed Data Collection Town Hall — August 25
- IMPACT Act: Data Elements and Measure Development Call — August 31
- SNF Quality Reporting Program Webcast — September 14
- National Partnership to Improve Dementia Care and QAPI Call — September 15

Medicare Learning Network® Publications & Multimedia
- Medicare Part B Clinical Laboratory Fee Schedule: Guidance to Laboratories for Collecting and Reporting Data for the Private Payor Rate-Based Payment System MLN Matters Article — New
- ESRD QIP Call: Audio Recording and Transcript — New
- Health Insurance Portability and Accountability Act (HIPAA) EDI Standards Web-Based Training Course — Revised

MLN Connects Provider eNews – August 25, 2016

MLN Connects® Provider eNews for August 25, 2016
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News & Announcements
- ICD-10: Updated Questions and Answers
FYI

• IMPACT Act Standardized Assessment Data: Comments due September 12

Provider Compliance
• Lumbar Spinal Infusion

Upcoming Events
• SNF Quality Reporting Program Webcast — September 14
• National Partnership to Improve Dementia Care and QAPI Call — September 15
• Comparative Billing Report on PAP/RAD and Accessories — September 21

Medicare Learning Network® Publications & Multimedia
• Next Generation Accountable Care Organization – Implementation MLN Matters® Article — New
• Medicare and Medicaid Basics Booklet — New
• PQRS Call: Audio Recording and Transcript — New
• Global Surgery Information Session: Audio Recording and Transcript — New

MLN Connects Provider eNews – September 1, 2016
MLN Connects® Provider eNews for September 1, 2016
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News & Announcements
• PY 2015 Medicare ACO Results
• EHR Incentive Programs: Submit Comments on Proposed Rule by September 6
• TEP on IMPACT Act Quality Measures: Nominations due September 7
• ESRD QIP Preview Period for PY 2017 Extended to September 30
• New ST PEPPER Available
• ICD-10 Assessment and Maintenance Toolkit
• Are You Required to Comply with Electronic Standards?
• September is Prostate Cancer Awareness Month

Provider Compliance
• Psychiatry and Psychotherapy

Upcoming Events
• SNF Quality Reporting Program Webcast — September 14
• National Partnership to Improve Dementia Care and QAPI Call — September 15
• SNF Value-Based Purchasing Program Call — September 28

Medicare Learning Network® Publications & Multimedia
• September 2016 Catalog Available
• HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet — Revised
• Guided Pathways to Medicare Resources Provider Specific Booklet — Revised
• Suite of Products & Resources for Rural Health Providers Educational Tool — Revised
• Medicare Part B Immunization Billing Fact Sheet — Reminder
FYI

- Vaccine and Vaccine Administration Payments under Medicare Part D Fact Sheet — Reminder
- Suite of Products & Resources for Compliance Officers Educational Tool — Reminder

MLN Connects Provider eNews – September 8, 2016

MLN Connects® Provider eNews for September 8, 2016
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News & Announcements
- EHR Incentive Program 2017 Medicare Payment Adjustment for Hospitals
- IRF and LTCH QRP Provider Preview Reports Available until September 30
- DMEPOS Suppliers: Use Revised CMS-855S Beginning January 1
- DMEPOS Fee Schedule: Corrections to the July 2016 File
- DMEPOS Fee Schedule: Assignment Monitoring Data Posted
- SNF 30-Day Potentially Preventable Readmission Measure — Updated
- 2015 PQRS Feedback Reports and 2015 Annual QRURs: Are You Ready?
- New Look for Think Cultural Health
- Healthy Aging® Month — Discuss Preventive Services with your Patients

Provider Compliance
- Coudé Tip Catheters

Claims, Pricers & Codes
- October 2016 Average Sales Price Files Now Available

Upcoming Events
- SNF Quality Reporting Program Webcast — September 14
- National Partnership to Improve Dementia Care and QAPI Call — September 15
- SNF Value-Based Purchasing Program Call — September 28
- 2015 Annual QRURs Webcast — September 29

Medicare Learning Network® Publications & Multimedia
- Advance Care Planning Fact Sheet — New

MLN Connects Provider eNews – September 15, 2016

MLN Connects® Provider eNews for September 15, 2016
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News & Announcements
- Plans for the Quality Payment Program in 2017: Pick Your Pace
- CMS Finalizes Rule to Bolster Emergency Preparedness of Certain Facilities
- DMEPOS Competitive Bidding Payment Amounts and Contract Offers for Round 1 2017
• New Data: 49 States plus DC Reduce Avoidable Hospital Readmissions
• SNF QRP Provider Training Questions and Feedback on MDS 3.0
• EHR Incentive Programs: Materials from August Webinars Available
• ICD-10 Coordination and Maintenance Committee Meeting: Materials Available
• Track ICD-10 Progress and Manage Your Revenue Cycle

Provider Compliance
• Advanced Life Support Ambulance Services: Insufficient Documentation

Upcoming Events
• SNF Value-Based Purchasing Program Call — September 28
• 2015 Annual QRURs Webcast — September 29
• IMPACT Act: Data Elements and Measure Development Call — October 13

Medicare Learning Network® Publications & Multimedia
• Overview of the SNF Value-Based Purchasing Program MLN Matters® Article — New
• Fee-For-Service Data Collection System: Clinical Laboratory Fee Schedule Data Reporting Template MLN Matters Article — New
• Clinical Laboratory Fee Schedule Fact Sheet — Revised
• ICD-10-CM/PCS Myths and Facts Fact Sheet — Revised
• ICD-10-CM Classification Enhancements Fact Sheet — Revised
• ICD-10-CM/PCS The Next Generation of Coding Fact Sheet — Revised
• General Equivalence Mappings Frequently Asked Questions Booklet — Revised
• Quick Reference Chart: Descriptors of G-codes and Modifiers for Therapy Functional Reporting Educational Tool — Revised
• Preventive Services Educational Tool — Reminder

MLN Connects Provider eNews – September 22, 2016
MLN Connects® Provider eNews for Thursday, September 22, 2016
View this edition as a PDF

News & Announcements
• Revised CMS-855R Application Available: Reassignment of Medicare Benefits
• IRF and LTCH QRP Provider Preview Reports – Review Your Data by September 30
• eCQI Resource Center has News and Resources

Compliance
• Reporting Changes in Ownership

Events
• SNF Value-Based Purchasing Program Call — September 28
• 2015 Annual QRURs Webcast — September 29
• Emergency Preparedness Requirements Call — October 5
• IMPACT Act: Data Elements and Measure Development Call — October 13
• Comparative Billing Report on CMT of the Spine Webinar – October 19

Learning Network® Publications & Multimedia
• Fee-For-Service Data Collection System: CLFS Data Reporting Template MLN Matters® Article — Revised
• Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-Based Training — Revised
• Transitional Care Management Services Fact Sheet — Revised
• Federally Qualified Health Center Fact Sheet — Revised
• Health Professional Shortage Area Physician Bonus Program Fact Sheet — Revised
• Hospital Outpatient Prospective Payment System Fact Sheet — Revised
• Dual Eligible Beneficiaries under the Medicare and Medicaid Programs Fact Sheet — Revised
• Medicare Ambulance Transports Booklet — Revised
• Acute Care Hospital Inpatient Prospective Payment System Booklet — Revised
• Critical Access Hospital Booklet — Revised

MLN Connects Provider eNews – September 29, 2016
MLN Connects® Provider eNews for Thursday, September 29, 2016
View this edition as a PDF

Editor’s Note:
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. In this issue, learn about the new Medicare Beneficiary Identifier, and find out how to prepare.

News & Announcements
• Social Security Number Removal Initiative
• 2015 PQRS Feedback Reports and 2015 Annual QRURs Available
• IMPACT Act Cross-Setting Quality Measure on Major Falls: Comments due October 14
• New CERT Documentation Contractor Effective October 14
• Medicare EHR Requirements for 2016 Participation
• EHR Incentive Programs: 2016 Exclusions and Alternate Exclusions
• eCQM: Review and Comment on Proposed Specification Changes
• Updated ICD-10 Flexibility FAQs and 2017 Codes
• Medscape Article for CME Credit: Transforming Clinical Practice to Provide Patient-Centered Quality Care
• National Cholesterol Education Month and World Heart Day

Provider Compliance
• Evaluation and Management: Billing the Correct Level of Service

Claims, Pricers & Codes
• Hospices: Hold on Claim Adjustments for Miscounted Routine Home Care Days

Upcoming Events
• Emergency Preparedness Requirements Call — October 5
Ambulance Staffing Requirements – Revised

MLN Matters® Number: MM9761 Revised
Related Change Request (CR) #: CR 9761
Related CR Release Date: September 12, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R226BP
Implementation Date: December 12, 2016

This article was revised on September 13, 2016, due to a revised Change Request (CR). The CR corrected the implementation date in the manual instruction section of the CR to December 12, 2016. The transmittal number, CR release date and the link to the CR also changed. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for ambulance providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Part B ambulance services provided to Medicare beneficiaries.

Provider Action Needed
CR 9761 manualizes the Calendar Year (CY) 2016 revisions to the ambulance staffing requirements (80 FR 71078-71080) and provides clarifications on the definitions for ground ambulance services for Advanced Life Support, Level 1 (ALS1), ALS assessment, application for ALS, Level 2 (ALS2), Specialty Care Transport (SCT), Paramedic Intercept (PI), emergency response, and inter-facility transportation. Please make sure your billing staff is aware of these revisions.

Background
In the CY 2016 Physician Fee Schedule Final Rule (80 FR 71078-71080), the Centers for Medicare & Medicaid Services (CMS) finalized without modification their proposals to revise:

1. 42 CFR 410.41(b) and the definition of Basic Life Support (BLS) in 42 CFR 414.605, to require that all Medicare covered ambulance transports be staffed by at least two people who meet both the requirements of state and local laws where the services are being furnished, and the current Medicare requirements;

2. 42 CFR 410.41(b) and the definition of BLS in 42 CFR 414.605 to clarify that for BLS vehicles, one of the staff members must be certified at a minimum as an EMT-Basic; and
3. To delete the last sentence in the definition of BLS in 42 CFR 414.605, which sets forth examples of certain state law provisions.

CR9761 updates Chapter 10, Sections 10.1.2; 30.1; and 30.1.1 of the “Medicare Benefit Policy Manual” (Pub. 100-02) to incorporate these revisions.

Key Points of CR9761

BLS Vehicles

BLS ambulances must be staffed by at least two people, who meet the requirements of state and local laws where the services are being furnished and where, at least one of whom must be certified at a minimum as an emergency medical technician-basic (EMT-basic) by the State or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. These laws may vary from state to state or within a state.

ALS Vehicles

Advanced Life Support (ALS) vehicles must be staffed by at least two people, who meet the requirements of state and local laws where the services are being furnished and where at least one of whom must meet the vehicle staff requirements above for BLS vehicles and be certified as an EMT-Intermediate or an EMT-Paramedic by the state or local authority where the services are being furnished to perform one or more ALS services.

Ambulance Services

There are several categories of ground ambulance services and two categories of air ambulance services under the fee schedule. (Note that “ground” refers to both land and water transportation.) All ground and air ambulance transportation services must meet all requirements regarding medical reasonableness and necessity as outlined in the applicable statute, regulations and manual provisions.

Advanced Life Support, Level 1 (ALS1)

Definition: ALS1 is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment by ALS personnel or at least one ALS intervention.

ALS Assessment

Definition: An ALS assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient’s reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service. In the case of an appropriately dispatched ALS Emergency service, as defined below, if the ALS crew completes an ALS Assessment, the services provided by the ambulance transportation service provider or supplier may be covered at the ALS emergency level, regardless of whether the patient required ALS intervention services during the transport, provided that ambulance transportation itself was medically reasonable and necessary.

ALS Intervention

Definition: An ALS intervention is a procedure that is in accordance with state and local laws, required to be done by an emergency medical technician-intermediate (EMT-Intermediate) or EMT-Paramedic.

Application: An ALS intervention must be medically necessary to qualify as an intervention for payment for an ALS level of service. An ALS intervention applies only to ground transports.

Advanced Life Support, Level 1 (ALS1) – Emergency

Definition: When medically necessary, the provision of ALS1 services, in the context of an emergency response.

Advanced Life Support, Level 2 (ALS2)

Definition: ALS2 is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including at least three separate administrations of one or more medications by intravenous (IV) push/bolus or by continuous infusion (excluding crystalloid fluids) or ground
ambulance transport, medically necessary supplies and services, and the provision of at least one of the following ALS2 procedures:

- Manual defibrillation/cardioversion
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical airway
- Intraosseous line

Application: Crystalloid fluids include but are not necessarily limited to 5 percent Dextrose in water (often referred to as D5W), Saline and Lactated Ringer’s. To qualify for the ALS2 level of payment, medications must be administered intravenously. Medications that are administered by other means, for example, intramuscularly, subcutaneously, orally, sublingually, or nebulized do not support payment at the ALS2 level rate.

IV medications are administered in standard doses as directed by local protocol or online medical direction. It is not appropriate to administer a medication in divided doses in order to meet the ALS2 level of payment. For example, if the local protocol for the treatment of Supraventricular Tachycardia (SVT) calls for a 6 mg dose of adenosine, the administration of three 2 mg doses in order to qualify for the ALS 2 level is not acceptable.

The administration of an intravenous drug by infusion qualifies as one intravenous dose. For example, if a patient is being treated for atrial fibrillation in order to slow the ventricular rate with diltiazem and the patient requires two boluses of the drug followed by an infusion of diltiazem then the infusion would be counted as the third intravenous administration and the transport would be billed as an ALS 2 level of service.

The fractional administration of a single dose (for this purpose, meaning a “standard” or “protocol” dose) of a medication on three separate occasions does not qualify for ALS2 payment. In other words, the administering 1/3 of a qualifying dose 3 times does not equate to three qualifying doses to support claiming ALS2-level care. For example, administering one-third of a dose of X medication 3 times might = Y (where Y is a standard/protocol drug amount), but the same sequence does not equal 3 times Y. Thus, if 3 administrations of the same drug are required to claim ALS2 level care, each administration must be in accordance with local protocols; the run will not qualify at the ALS2 level on the basis of drug administration if that administration was not according to local protocol. The criterion of multiple administrations of the same drug requires that a suitable quantity of the drug be administered and that there be a suitable amount of time between administrations, and that both are in accordance with standard medical practice guidelines.

Examples of drug administration that help explain this policy are in the revised manual sections that are attached to CR9761.

ALS Personnel

Definition: ALS personnel are individuals trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic.

Specialty Care Transport (SCT)

Definition: Specialty Care Transport (SCT) is the Inter-facility Transportation (as defined below) of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary’s condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or an EMT-Paramedic with additional training.

Application: SCT is necessary when a beneficiary’s condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area. The EMT-Paramedic level of care is set by each state. Medically necessary care that is furnished at a level above the EMT-Paramedic level of care may qualify as SCT.
To be clear, if EMT-Paramedics - without specialty care certification or qualification - are permitted to furnish a given service in a State, then that service does not qualify for SCT. The phrase “EMT-Paramedic with additional training” recognizes that a state may permit a person who is not only certified as an EMT-Paramedic, but who also has successfully completed additional education as determined by the state in furnishing higher level medical services required by critically ill or injured patients, to furnish a level of service that otherwise would require a health professional in an appropriate specialty care area (for example, a nurse) to provide. “Additional training” means the specific additional training that a State requires a paramedic to complete inorder to qualify to furnish specialty care to a critically ill or injured patient during an SCT.

**Paramedic Intercept (PI)**

**Definition:** Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only Basic Life Support (BLS) level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression, or IV therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient.

Paramedic intercept services furnished on or after March 1, 1999, are payable separate from the ambulance transport when all the requirements in the following three conditions are met:

1. **The intercept service(s) is:**
   - Furnished in a rural area (as defined below) ;
   - Furnished under a contract with one or more volunteer ambulance services; and,
   - Medically necessary based on the condition of the beneficiary receiving the ambulance service.

2. **The volunteer ambulance service involved must:**
   - Meet Medicare’s certification requirements for furnishing ambulance services;
   - Furnish services only at the BLS level at the time of the intercept; and,
   - Be prohibited by state law from billing anyone for any service.

3. **The entity furnishing the ALS paramedic intercept service must:**
   - Meet Medicare’s certification requirements for furnishing ALS services; and,
   - Bill all recipients who receive ALS paramedic intercept services from the entity, regardless of whether or not those recipients are Medicare beneficiaries.

For purposes of the paramedic intercept benefit, a rural area is an area that is designated as rural by a State law or regulation or that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent version of the Goldsmith Modification). (The Goldsmith Modification is a methodology to identify small towns and rural areas within large metropolitan counties that are isolated from central areas by distance or other features). The current list of these areas is periodically published in the Federal Register. See the “Medicare Claims Processing Manual,” Chapter 15, “Ambulance,” Section 20.1.4 for payment of paramedic intercept services.

**Inter-facility Transportation**

For purposes of SCT payment, an inter-facility transportation is one in which the origin and destination are one of the following:

- A hospital or Skilled Nursing Facility (SNF) that participates in the Medicare program, or
- A hospital-based facility that meets Medicare’s requirements for provider-based status.

**Emergency Response**

**Definition:** Emergency response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call. The nature of an
AMBULANCE

Ambulance’s response (whether emergency or not) does not independently establish or support medical necessity for an ambulance transport. Rather, Medicare coverage always depends on, among other things, whether the service(s) furnished is actually medically reasonable and necessary based on the patient’s condition at the time of transport.

Additional Information


APPEALS

Reopenings Update – Changes to Chapter 34

MLN Matters® Number: MM9639
Related Change Request (CR) #: CR 9639
Related CR Release Date: July 29, 2016
Effective Date: September 30, 2016
Related CR Transmittal #: R3568CP
Implementation Date: September 30, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9639 provides updates to Chapter 34, Section 10 of the “Medicare Claims Processing Manual” to remove outdated contractor terminology, clarify remittance advice code reference and to add hyperlinks for regulation and statutory obligations. The updates enhance and clarify operating instructions and language in accordance with regulation and statute. CR9639 includes no policy changes. Make sure that your billing staffs are aware of these updates.

Background

A reopening is a remedial action taken to change a binding determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are different from adjustment bills in that adjustment bills are subject to normal claims processing timely filing requirements (that is, filed within 1 year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (for example, claim determinations may be reopened within 1 year of the date of the initial determination for any reason, or within 1 to 4 years of the date of the initial determination upon a showing of good cause).

The main clarification in CR9639 is to note that where Medicare medical review staff request documentation from a provider/supplier for a claim, but did not receive it, and issued a denial based on no documentation, the codes used for the denial are as follows:

• Group Code: CO – Contractual Obligation
• Claim Adjustment Reason Code (CARC) 50 – these are non-covered services because this is not deemed a ‘medical necessity’ by the payer
• Remittance Advice Remark Code (RARC) M127 – Missing patient medical record for this service.)
**APPEALS**

**Additional Information**


**Reconsideration Contractor Transitions to Maximus Federal Services Inc.**

CMS recently awarded the Qualified Independent Contractor (QIC) Part A West contract to Maximus Federal Services, Inc. (Maximus). Effective September 1, 2016, Maximus will be responsible for processing new reconsideration requests of initial Medicare claim determinations for Medicare Part A and Medicare Part B of A claim appeals in the following states:

Jurisdiction E: California, Nevada, Guam, Hawaii, and the territories of Northern Mariana Islands and American Samoa.


Reconsiderations requested in the above jurisdictions on or before August 31, 2016, will continue to be processed by the existing Part A West QIC, C2C Innovative Solutions, Inc. (C2C). Since C2C will be processing appeals received prior to September 1, 2016, there will be a short transition period during which both Maximus and C2C will be issuing decisions. MACs shall work with both QICs during this time.

Noridian is updating the Medicare Redetermination Notice (MRN), dismissal notice, reconsideration request form, websites, and related correspondence to contain the updated address and contractor information to reflect the following address:

Maximus Federal Services
3750 Monroe Ave
Part A West – Suite 706
Pittsford, NY 14534

Noridian will be working with both C2C and Maximus to ensure case files are coordinated and meet CMS expectations.

**BILLING**

**Enforcement of the PHP 20 Hours per Week Billing Requirement – Revised**

MLN Matters® Number: SE1607 Revised

Effective Date: July 1, 2016

Implementation Date: July 5, 2016

This article was revised on July 7, 2016, to add a notice on page 2 showing that Medicare is suspending enforcement of three new edits that were to begin on July 1, 2016, including the edit that enforces weekly billing requirements for PHPs.

**Provider Types Affected**

This MLN Matters® Special Edition Article is intended for Outpatient Prospective Payment System (OPPS) providers submitting Partial Hospitalization Program (PHP) claims to Medicare A/B Medicare Administrative Contractors (MACs) for Partial Hospitalization Program services to Medicare beneficiaries.

**What You Need to Know**

This article conveys enforcement editing requirements for the “Medicare Benefit Policy Manual,” (Internet-Only Manual 100-02) Chapter 6, and Section 70.3 which describes coverage of Partial Hospitalization Program (PHP) Services. Make sure your billing staff is aware of these changes. This guidance updates
the operational mechanism PHP providers should use to bill Medicare for PHP services furnished on or after July 1, 2016. New editing will be implemented in the July 2016 quarterly release of the Integrated Outpatient Code Editor (IOCE). This advance notice is being given to assist PHP providers to prepare for these changes.

**Background**

PHPs are structured to provide intensive outpatient psychiatric care through active treatment that utilizes a combination of the clinically recognized items and services described in §1861(ff) of the Social Security Act (the Act). The treatment program of a PHP closely resembles that of a highly structured, short-term hospital inpatient program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation. Programs providing primarily social, recreational, or diversionary activities are not considered partial hospitalization.

Patients must meet benefit requirements for receiving the partial hospitalization services as defined in §1861(ff) and §1835(a)(2)(F) of the Act. Patients admitted to a PHP must be under the care of a physician who certifies the need for partial hospitalization and require a minimum of 20 hours per week of therapeutic services, as evidenced by their plan of care. The patients also require a comprehensive, structured, multimodal treatment requiring medical supervision and coordination, provided under an individualized plan of care, because of a mental disorder which severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning. Such dysfunction generally is of an acute nature. In addition, PHP patients must be able to cognitively and emotionally participate in the active treatment process, and be capable of tolerating the intensity of a PHP program.

To enforce the required minimum of 20 hours per week of therapeutic services, the Centers for Medicare & Medicaid Services (CMS) is instituting three (3) new edits into the IOCE in its July 2016 quarterly release. CMS is giving this advance notice to PHP providers so they can prepare the systems to submit claims correctly and plan accordingly.

**These edits were scheduled to begin on July 1, 2016. CMS is suspending all three edits at this time, including the one that enforces weekly billing requirements for PHPs. CMS reminds PHPs that the 20 hours per week minimum PHP service requirement remains in effect, as described in regulation at 42 CFR 410.43(c).**

**July 2016 IOCE Editing**

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<td>Partial hospitalization services are required to be billed weekly</td>
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Initially, for the first quarter all edits will be set up to Return to Provider (RTP). After the first quarter, CMS will set edit 95 to deny claims.

**October 2016 IOCE Editing**

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<td>97</td>
<td>W7097</td>
<td>Partial hospitalization services are required to be billed weekly</td>
<td>RTP Claim</td>
</tr>
</tbody>
</table>
As a reminder, for claims received on or after July 1, 2016, PHP providers are instructed to submit “weekly” claims for Type of Bill 13x with condition code 41 and Type of Bill 76x. Interim billing requirements still apply.

Additional Information

Flu Resources for Health Care Professionals for 2016 – 2017
MLN Matters® Number: SE1622

Provider Types Affected
All health care professionals who order, refer, or provide flu vaccines and vaccine administration to Medicare beneficiaries.

What You Need to Know
• Keep this Special Edition MLN Matters® article and refer to it throughout the 2016 - 2017 flu season.
• Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
• Continue to provide the flu shot as long as you have vaccine available, even after the new year.
• Remember to immunize yourself and your staff.

Introduction
The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for flu vaccines and their administration. \textit{(Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)}

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of Medicare’s coverage of the annual flu shot.

As a reminder, please help prevent the spread of flu by immunizing yourself and your staff!

Know What to Do About the Flu!

Payment Rates for 2016-2017

Each year, CMS updates the Medicare Healthcare Common Procedure Coding System (HCPCS) and Current Procedure Terminology (CPT) codes and payment rates for personal influenza (flu) and pneumococcal vaccines. Payment allowance limits for such vaccines are 95 percent of the Average Wholesale Price (AWP), except where the vaccine is furnished in a hospital outpatient department, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). In these cases, the payment for the vaccine is based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners, and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Effective for services provided on August 1, 2016, through those provided on July 31, 2017, the following Medicare Part B payment allowances for HCPCS and CPT codes apply.
CPT Codes:

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<td>8/1/2016 – 7/31/2017</td>
<td>Pending</td>
</tr>
<tr>
<td>90672</td>
<td>8/1/2016 – 7/31/2017</td>
<td>Pending</td>
</tr>
<tr>
<td>90673</td>
<td>8/1/2016 – 7/31/2017</td>
<td>Pending</td>
</tr>
<tr>
<td>90674</td>
<td>8/1/2016 – 7/31/2017</td>
<td>Pending</td>
</tr>
<tr>
<td>90685</td>
<td>8/1/2016 – 7/31/2017</td>
<td>Pending</td>
</tr>
<tr>
<td>90686</td>
<td>8/1/2016 – 7/31/2017</td>
<td>Pending</td>
</tr>
<tr>
<td>90687</td>
<td>8/1/2016 – 7/31/2017</td>
<td>Pending</td>
</tr>
<tr>
<td>90688</td>
<td>8/1/2016 – 7/31/2017</td>
<td>Pending</td>
</tr>
</tbody>
</table>

HCPCS Codes:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Effective Dates</th>
<th>Payment Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2035</td>
<td>8/1/2016 – 7/31/2017</td>
<td>Pending</td>
</tr>
<tr>
<td>Q2036</td>
<td>8/1/2016 – 7/31/2017</td>
<td>Pending</td>
</tr>
<tr>
<td>Q2037</td>
<td>8/1/2016 – 7/31/2017</td>
<td>Pending</td>
</tr>
<tr>
<td>Q2038</td>
<td>8/1/2016 – 7/31/2017</td>
<td>Pending</td>
</tr>
<tr>
<td>Q2039</td>
<td>8/1/2016 – 7/31/2017</td>
<td>Flu Vaccine Adult – Not Otherwise Classified: Payment allowance is to be determined by the local claims processing contractor.</td>
</tr>
</tbody>
</table>

The above pricing, and any required updates, will be available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html).

Educational Products for Health Care Professionals

The Medicare Learning Network® (MLN) has developed a variety of educational resources to help you understand Medicare guidelines for seasonal flu vaccines and their administration.

1. MLN Influenza Related Products for Health Care Professionals
   - [Preventive Services chart](https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html)
   - [MLN Preventive Services Educational Products webpage](https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/ProviderResources.html)

2. Other CMS Resources
   - [Immunizations webpage](http://www.cms.gov/Medicare/Prevention/Immunizations/index.html)
   - [Prevention General Information](http://www.cms.gov/Medicare/Prevention/PreventionGenInfo/index.html)
BILLING


3. Other Resources
The following non-CMS resources are just a few of the many available in you may find useful information and tools for the 2016 – 2017 flu season:

- Other sites with helpful information include:
  - Centers for Disease Control and Prevention - http://www.cdc.gov/flu
  - Food and Drug Administration - http://www.fda.gov
  - Immunization Action Coalition - http://www.immunize.org
  - Indian Health Services - http://www.ihs.gov
  - National Alliance for Hispanic Health - http://www.hispanichealth.org
  - National Foundation For Infectious Diseases - http://www.nfid.org/influenza
  - National Vaccine Program - http://www.hhs.gov/nvpo
  - World Health Organization - http://www.who.int/en

Beneficiary Information
For information to share with your Medicare patients, please visit http://www.medicare.gov.

Mammography Services Reminder
Providers and suppliers that furnish and bill Medicare for film, digital, or 3-D mammography services are reminded that claims for these mammography services will either deny or reject as unprocessable if:

- There is no FDA certification number reported on the claim
- The facility is not certified for the type of mammogram submitted on the claim (film, digital, or 3-D)
- A facility’s certificate is suspended or revoked
- The HCPCS/CPT code billed does not match the certification on file for the facility, or
- There is no FDA certification number on the MQSA file for the facility listed on the claim.

For additional information, providers and suppliers that furnish and bill Medicare for film, digital, or 3-D mammography services can refer to Medicare’s Internet Only Manual (IOM) Publication 100-04, Chapter 18, Section 20 and its subsections found here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf.
CAH

CAH Claims Returned to Provider with DDE Reason Code E461J

Noridian has identified two issues with Critical Access Hospital (CAH) claims billed with Evaluation and Management (E/M) codes on the 0510 and professional revenue codes of 96X, 97X or 998X. Such claims have Returned to Provider (RTP’d) with Direct Data Entry (DDE) reason code E461J.

1. Claims have been incorrectly billed with a new E/M code on the 0510 revenue code and an established E/M code on the professional revenue code or vice versa.
   - To ensure proper processing, the E/M codes must be consistent on the revenue codes reported. Providers must submit both as new patient or both as established patient E/M codes.
2. Claims have RTP’d incorrectly as the A1 or B2 value codes were automatically added to the claim prior to finalization.
   - Providers who use DDE are encouraged to correct these RTP’d claims by removing the A1 or B2 value codes. If a claim is RTP’d back for the same reason code, contact the Provider Contact Center for further review.

CERT

CERT MAC Improper Payment Rates for 2014 and 2015

Noridian Healthcare Solutions is pleased to announce that the CMS recently published the Comprehensive Error Rate Testing (CERT) 2014 and 2015 improper payment rates by Medicare Administrative Contractor (MAC) Jurisdictions. Visit: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/MedicareFFSJurisdictionErrorRateContributionData.html to view interactive maps and learn more about: improper payments; error rate scoring; and corrective actions.

The national projected error rates have been provided below.

2014

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Projected Improper Payment</th>
<th>Improper Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMEPOS</td>
<td>$5.1</td>
<td>53.1%</td>
</tr>
<tr>
<td>Part A (Total)</td>
<td>$29.6</td>
<td>11.4%</td>
</tr>
<tr>
<td>Part A (Excluding IPPS)</td>
<td>$19.2</td>
<td>13.1%</td>
</tr>
<tr>
<td>Part A (Hospital IPPS)</td>
<td>$10.4</td>
<td>9.2%</td>
</tr>
<tr>
<td>Part B</td>
<td>$11.0</td>
<td>12.1%</td>
</tr>
</tbody>
</table>

2015

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Projected Improper Payment</th>
<th>Improper Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMEPOS</td>
<td>$3.2</td>
<td>39.9%</td>
</tr>
<tr>
<td>Part A (Total)</td>
<td>$28.7</td>
<td>11.0%</td>
</tr>
<tr>
<td>Part A (Excluding IPPS)</td>
<td>$21.7</td>
<td>14.7%</td>
</tr>
<tr>
<td>Part A (Hospital IPPS)</td>
<td>$7.0</td>
<td>6.2%</td>
</tr>
<tr>
<td>Part B</td>
<td>$11.5</td>
<td>12.7%</td>
</tr>
</tbody>
</table>

Note that the figures in the above tables have been adjusted for A to B rebilling and some totals may not appear to properly average due to rounding. Dollars displayed are in billions.

As the CMS stated in their July 21, 2016 publication, Medicare Fee For Service (FFS) Jurisdiction Error Rate Contribution Data, “Provider compliance is fundamental to reducing improper payment rates. Both
the CMS and MACs are engaged in a continuing process to identify and execute new and promising practices to improve provider compliance.”

Noridian Healthcare Solutions reminds providers and suppliers that they have a direct impact on the improper payment rates. The leading error category, as published in the Medicare Fee-for-Service 2015 Improper Payments Report, is Insufficient Documentation. Providers are encouraged to review intake processes and Local Coverage Determinations to ensure they have proper documentation on file for the items being billed.

To receive additional information on the educational products and services Noridian Healthcare Solutions offers, please contact the appropriate email addresses below.

- Part A: CERTPartAQuestion@noridian.com
- Part B: CERTQuestion@noridian.com
- JD DME: JDDMECERT@noridian.com
- JA DME: JADMECERT@noridian.com

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**CLARIFICATION**

**Revenue Code Clarification for Healthcare Common Procedure Coding System (HCPCS) Code Q4081**

Change Request (CR) 9501 will implement Phase 1 of the Part B Drug Payment Model on September 6, 2016. The HCPCS, Average Sales Price (ASP), Zip 5 and Zip 9 files will be used to apply pricing from the incoming Part B drug claim line. All new drug HCPCS billed will default to revenue code 0636.

The HCPCS file will be updated for HCPCS Q4081 (Injection, epoetin alfa, 100 units (for ESRD on dialysis) to reflect the correct revenue codes 0634 and 0635.

The official instructions issued regarding these changes are available at CR 9501 and CR 9509.

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**CODING**

**HPTC - October 2016 Code Set Update**

MLN Matters® Number: MM9659
Related Change Request (CR) #: CR 9659
Related CR Release Date: August 26, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3597CP
Implementation Date: January 3, 2017, except some MACs may implement on October 1, 2016

**Provider Types Affected**

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

**What You Need to Know**

CR9659 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference file. MACs that have the capability to do so will implement the October 2016 HPTC set as early as October 1, 2016, for claims received on or after October 1, 2016. All MACs will implement the HPTC set by January 3, 2017.
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims.

The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

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

You should note that:

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

CR9659 implements the NUCC HPTC code set that is effective on October 1, 2016, and instructs MACs to obtain the most recent HPTC set at [http://www.wpc-edi.com/codes](http://www.wpc-edi.com/codes) and use it to update their internal HPTC tables and/or reference files.

When reviewing the HPTC code set online, you can identify revisions made since the last release by the color code:

- New items are green
- Modified items are orange, and
- Inactive items are red

Additional Information


Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM9680
Related Change Request (CR) #: CR 9680
Related CR Release Date: August 26, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3599CP
Implementation Date: January 3, 2017

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9680 updates, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgement transactions.
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 (NCMC) meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The NCMC allows the industry 6 months for implementation of newly added or changed codes. Codes sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/. 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 September/October 2016 committee meeting shall be posted on these sites on or about November 1, 2016. MACs will complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes, by the implementation of CR9680.

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 CR9680 is implemented.

MACs must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 Health Care Claim Status Request and Response. The MACs must use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Health Care Claim Status Responses. They must also use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Healthcare Claim Acknowledgments. References in this CR to “277 responses” and “claim status responses” encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

Additional Information

HCPCS Codes for SNF CB - 2017 Annual Update
MLN Matters® Number: MM9735
Related Change Request (CR) #: CR 9735
Related CR Release Date: August 26, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3603CP
Implementation Date: January 3, 2017

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 (HH&H) MACs and Durable Medical Equipment (DME) MACs, for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.

Provider Action Needed
If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in Change Request (CR) 9735 could impact your payments.
CR9735 provides the 2017 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for SNF Consolidated Billing (SNF CB) and explains how the updates affect edits in Medicare claims processing systems. By the first week in December 2016, the new code files for Part B processing, and the new Excel and PDF files for Part A processing, will be available at http://www.cms.gov/SNFConsolidatedBilling and will become effective on January 1, 2017.

The provider community should read the “General Explanation of the Major Categories” PDF file located at the bottom of each year’s MAC update in order to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

Background

The Common Working File (CWF) currently has edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. These edits allow only those services that are excluded from consolidated billing to be separately paid.

Changes to HCPCS codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow MACs to make appropriate payments in accordance with policy for SNF CB, found in the Chapter 6, Section 20.6 (Part A) and Section 110.4.1 (Part B) of the “Medicare Claims Processing Manual,” available for download at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf.

Additional Information


Coding Revisions to NCDs

MLN Matters® Number: MM9751
Related Change Request (CR) #: CR 9751
Related CR Release Date: August 19, 2016
Effective Date: January 1, 2017 - Unless otherwise noted
Related CR Transmittal #: R1708OTN
Implementation Date: January 3, 2017

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9751 is the 9th 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, CR9540, and CR9631; while others are the result of revisions required to other NCD-related CRs released separately. MLN Matters® Articles MM7818, MM8109, MM8197, MM8691, MM9087, MM9252, MM9540, and MM9631 contain information pertaining to these CR’s.

Background

The translations from ICD-9 to ICD-10 are not consistent 1-1 matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMS) mapping 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 the 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 as of October 1, 2015.
CODING

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. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed.

CR9751 makes adjustments to the following NCDs:

- NCD 20.7 Percutaneous Transluminal Angioplasty (PTA)
- NCD 20.19 Ambulatory Blood Pressure Monitoring (ABPM)
- NCD 20.33 Transcatheter Mitral Valve Repair (TMVR) Therapy
- NCD 40.1 Diabetes Self-Management Training (DSMT)
- NCD 160.18 Vagus Nerve Stimulation (VNS)
- NCD 180.1 Medical Nutrition Therapy (MNT)
- NCD 190.3 Cytogenetic Studies
- NCD 220.6.17 FDG PET for Solid Tumors
- NCD 220.6.20 PET Beta Amyloid in Dementia/Neurological/ Disorders
- NCD 230.18 Sacral Nerve Stimulation (SNS) for Urinary Incontinence
- NCD 260.1 Adult Liver Transplants


Remember that coding and payment are areas of the Medicare Program that are separate and distinct from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

Your MACs will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate:

- Remittance Advice Remark Codes (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; with
- Claim Adjustment Reason Codes (CARC)
  - 50 - These are non-covered services because this is not deemed a “medical necessity” by the payer;
  - 96 - Non-covered charge(s); or
  - 119 Benefit maximum for this time period has been reached.

Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32, or with occurrence code 32 and a GA modifier, indicating a signed Advance Beneficiary Notice (ABN) is on file). Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

Additional Information

Changes to the Laboratory NCD Edit Software for January 2017

MLN Matters® Number: MM9806
Related Change Request (CR) #: CR 9806
Related CR Release Date: September 23, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3614CP
Implementation Date: January 3, 2017

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) 9806 announces changes that will be included in the January 2017 quarterly release of the edit module for clinical diagnosis laboratory services. Make sure your billing staffs are aware of these changes to ensure proper billing to Medicare.

Background
The National Coverage Determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and the final rule was published on November 23, 2001. Medicare developed nationally uniform software that was incorporated in the Medicare shared systems so that laboratory claims subject to one of the 23 NCDs (Publication 100-03, Sections 190.12-190.34) were processed uniformly throughout the United States effective April 1, 2003.

CR9806 communicates requirements to Medicare system maintainers and the MACs regarding changes to the NCD code lists used for laboratory claims edit software for January 2017. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the ICD-10-CM codes. Please see Section II (Business Requirements Table) of CR9806 for the lengthy list of codes added or deleted. Note that where codes are deleted, the effective date of deletion is September 30, 2016 and the effective date for codes added is October 1, 2016.

Additional Information

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

MLN Matters® Number: MM9620 Revised
Related Change Request (CR) #: CR 9620
Related CR Release Date: July 1, 2016
Effective Date: January 27, 2016
Related CR Transmittal #: R193NCD and R3556CP
Implementation Date: October 3, 2016

This article was revised on September 26, 2016, to correct the language regarding the submission of professional claims on page 4 of the article. All other information remains the same.

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.

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:

- Chapter 32, Sections 69 and 90, of the “Medicare Claims Processing Manual,” available at https://www.
Please note, Chapter 1, Section 110.8.1 has been removed from the “NCD Manual” and incorporated into Chapter 1, Section 110.23.

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

- 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:
  - 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

**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:
  - 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
Professional Claims
For professional claims submitted 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:
  - 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

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

Physicians! Are You Ordering Glucose Monitors and Supplies For Your Patient?
Medicare will consider coverage of a glucose monitor and related supplies when the patient’s medical record shows the patient has diabetes and you have determined he/she or a caregiver is sufficiently trained to use the prescribed device appropriately. CMS publication 100-3, Section 40.2

For the glucose monitor only, the following is required prior to delivery:

<table>
<thead>
<tr>
<th>Glucose Monitor Documentation prior to delivery</th>
<th>Glucose Monitor Prescription prior to delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>An in person/face to face visit within six months prior to prescribing Documenting the patient was evaluated and/or treated for diabetes mellitus supporting need for the item(s) ordered</td>
<td>A five element order with the following: Patient name Item ordered National Provider Identifier (NPI) Date of the order Prescribing practitioner signature</td>
</tr>
</tbody>
</table>
For any item provided based on physician contact with a DME supplier to provide the service (i.e., dispensing order), the supplier must obtain a detailed written order before submitting a claim. The detailed written order must contain:

<table>
<thead>
<tr>
<th>Detailed Written Order Elements (DWO) prior to billing</th>
<th>Items provided on periodic basis, test strips and lancets DWO must include</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary’s name</td>
<td>Item(s) to be dispensed</td>
</tr>
<tr>
<td>Prescribing practitioner’s name</td>
<td>Frequency of use/testing frequency</td>
</tr>
<tr>
<td>Date of the order</td>
<td>Quantity to be dispensed</td>
</tr>
<tr>
<td>Detailed description of the item(s)</td>
<td>Number of refills</td>
</tr>
<tr>
<td>Prescribing practitioner’s signature and signature date</td>
<td></td>
</tr>
</tbody>
</table>

The DME MAC Glucose Monitors Local Coverage Determination (LCD) L33822 defines the quantity of test strips and lancets that are covered when the basic coverage criteria are met as follows:

<table>
<thead>
<tr>
<th>Treatment Regimen</th>
<th>Basic Coverage Test Strips and Lancets</th>
<th>Prescribed Testing Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin treated</td>
<td>300 per 3 months</td>
<td>3 times a day</td>
</tr>
<tr>
<td>Non-insulin treated</td>
<td>100 per 3 months</td>
<td>Once a day</td>
</tr>
</tbody>
</table>

Additional criteria must be met, documented in your patient’s medical record, and made available to the supplier (or review contractor) upon request when quantities of supplies ordered exceed utilization parameters indicated above. These additional documentation requirements are:

**Overutilization Documentation**

- Physician has seen and evaluated the beneficiary’s diabetes within six months of ordering quantities of supplies above the normal utilization and has documented in the medical record the specific reason for the additional supplies
- Medical records documenting frequency of actual testing by beneficiary
- Specific narrative that documents frequency beneficiary is actually testing; or,
- Copy of the beneficiary’s testing log (must be provided to physician by beneficiary)

Following this guidance will help your patients and the Medicare program by verifying that there is medical documentation to support the provision of a glucose monitor and supplies and allow your patient to receive the items needed to treat their condition. Your assistance will allow Medicare to pay claims appropriately and ensure that your patient receives the items you have prescribed.

Local Coverage Determinations for Glucose Monitors and Supplies

Jurisdiction A - [https://med.noridianmedicare.com/web/jadme/policies/lcd/active](https://med.noridianmedicare.com/web/jadme/policies/lcd/active)

Jurisdiction B - [http://www.cgsmedicare.com/jb/coverage/lcdinfo.html](http://www.cgsmedicare.com/jb/coverage/lcdinfo.html)

Jurisdiction C - [http://www.cgsmedicare.com/jc/coverage/lcdinfo.html](http://www.cgsmedicare.com/jc/coverage/lcdinfo.html)

Jurisdiction D - [https://med.noridianmedicare.com/web/jdme/policies/lcd/active](https://med.noridianmedicare.com/web/jdme/policies/lcd/active)

**Blepharoplasty, Eyelid Surgery, and Brow Lift JFA LCD Number Change - Effective August 17, 2016**

The following JF Local Coverage Determination (LCD) has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L36281

**LCD Title:** Blepharoplasty, Eyelid Surgery, and Brow Lift

**Effective Date:** August 17, 2016
Summary of Changes: LCD number L36281 for Jurisdiction F Part A (JFA) was retired on August 17, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L36286. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to [https://med.noridianmedicare.com/web/fb/policies/lcd/active](https://med.noridianmedicare.com/web/fb/policies/lcd/active)
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.

Chemotherapy Administration - R2 - Revised

The “Chemotherapy Administration - R2” article was originally published to Latest Updates on June 30, 2016. It is being republished to notify providers of the corrected CPT® code 95659 to 96549 for the description of unlisted chemotherapy procedure.

The Chemotherapy Administration (A52991) coverage article has been revised and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

Effective Date: July 1, 2016

Summary of Changes: Noridian made the following editorial revisions:

- Added Trademarks as needed.
- Added the following new C codes for OPPS claims effective July 1, 2016
  - C9476 – daratumumab (Darzalex™)
  - C9477 – elotuzumab (Empliciti™)
  - C9480 – trabectedin (Yondelis®)
- Added Q5102-ZB - infliximab, biosimilar 10 mg (infliximab, biosimilar 10 mg) is effective dates of service April 5, 2016 but processed July 1, 2016 and after.
- Corrected CPT® code 95659 to 96549 for the description of unlisted chemotherapy procedure.

View the complete Noridian coverage article.
- The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

Go to the Noridian Medicare Coverage Articles webpage to:
- Access the CMS MCD to view the Active or Future article and comprehensive revision history for this corresponding article
  - Scroll to bottom of webpage
  - Select state/contract of interest the Future column (This link will redirect you to the CMS website.)
  - Once in the CMS MCD, select corresponding article title

Circulating tumor Cell Marker Assay - JFA Number Changes - Effective August 17, 2016

The following JF Local Coverage Determination (LCD) has been retired under contractor 02101 (AK), 02201...
(ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L35096

**LCD Title:** Circulating Tumor Cell Marker Assay

**Effective Date:** August 17, 2016

**Summary of Changes:** LCD number L35096 for Jurisdiction F Part A (JFA) was retired on August 17, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L34066. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/active](https://med.noridianmedicare.com/web/jfa/policies/lcd/active)
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.

**Posterior Tibial Nerve Stimulation Coverage – R3**

The Posterior Tibial Nerve Stimulation Coverage article has been revised and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our Noridian website.

**Article Summary:** The article was revised to remove “for up to two years” and added “during and” in the 3rd paragraph under Coverage Guidelines in the article Text.

**Effective Date:** July, 01, 2016

**View the complete Noridian coverage article.**

- The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

Go to the [Noridian Medicare Coverage Articles](https://med.noridianmedicare.com/web/jfa/policies/lcd/active) webpage to:

- View complete list of Noridian coverage articles
- Access the CMS MCD to view a comprehensive revision history for this corresponding article
  - Scroll to bottom of webpage
  - Select state/contract of interest from Active, Future or Retired column (This link will redirect you to the CMS website.)
  - Once in the CMS MCD, select corresponding article title

**Self-Administered Drug Exclusion List – R7**

The Self-Administered Drug Exclusion List coverage article has been revised and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our Noridian website.

**Summary of Changes:** Removed HCPCS code J1575 from the excluded table. Claims denied with date of service 2/11/2016 and after will be adjusted to pay.

**Effective Date:** July 25, 2016

**View the complete Noridian coverage article.**
• The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

Go to the Noridian Medicare Coverage Articles webpage to:

• View complete list of Noridian coverage articles
• Access the CMS MCD to view a comprehensive revision history for this corresponding article
  – Scroll to bottom of webpage
  – Select state/contract of interest from Active, Future or Retired column (This link will redirect you to the CMS website.)
  – Once in the CMS MCD, select corresponding article title

**MolDX: 4q25-AF Risk Genotype Billing and Coding Guidelines**

The MolDX: 4q25-AF Risk Genotype Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary:** To notify the Provider community of the MolDX: 4q25-AF Risk Genotype Billing and Coding guidelines.

**Effective Date:** October 10, 2016

To access the MolDX Excluded Tests from our website, follow the instructions below.

  – The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
• On the “Excluded Tests” page, locate the above listed MolDx test title.

**MolDX: 9p21 Genotype Billing and Coding Guidelines**

The MolDX: 9p21 Genotype Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary:** To notify the Provider community of the MolDX: 9p21 Genotype Billing and Coding guidelines.

**Effective Date:** October 10, 2016

To access the MolDX Excluded Tests from our website, follow the instructions below.

  – The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
• On the “Excluded Tests” page, locate the above listed MolDx test title.

**MolDX: ApoE Genotype Billing and Coding Guidelines**

The MolDX: ApoE Genotype Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary:** To notify the Provider community of the MolDX: ApoE Genotype Billing and Coding guidelines.

**Effective Date:** October 10, 2016
To access the MolDX Excluded Tests from our website, follow the instructions below.

  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

- On the “Excluded Tests” page, locate the above listed MolDx test title.

**MolDX: Aspartoacyclase 2 Deficiency (ASPA) Testing Billing and Coding Guidelines**

The MolDX: Aspartoacyclase 2 Deficiency (ASPA) Testing Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary:** To notify the Provider community of the MolDX: Aspartoacyclase 2 Deficiency (ASPA) Testing Billing and Coding guidelines.

**Effective Date:** October 10, 2016

To access the MolDX Excluded Tests from our website, follow the instructions below.

  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

- On the “Excluded Tests” page, locate the above listed MolDx test title.

**MolDX: ATP7B Gene Tests Billing and Coding Guidelines**

The MolDX: ATP7B Gene Tests Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary:** To notify the Provider community of the MolDX: ATP7B Gene Tests Billing and Coding Guidelines.

**Effective Date:** October 17, 2016

To access the MolDX Excluded Tests from our website, follow the instructions below.

  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

- On the “Excluded Tests” page, locate the above listed MolDx test title.

**MolDX: BCKDHB Gene Test Billing and Coding Guidelines**

The MolDX: BCKDHB Gene Test Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary:** To notify the Provider community of the MolDX: BCKDHB Gene Test Billing and Coding guidelines.

**Effective Date:** October 17, 2016
To access the MolDX Excluded Tests from our website, follow the instructions below.

  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Excluded Tests” page, locate the above listed MolDx test title.

**MolDX: BLM Gene Analysis Billing and Coding Guidelines**

The MolDX: BLM Gene Analysis Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT) and 03602 (WY).

**Summary:** To notify the Provider community of the MolDX: BLM Gene Analysis Billing and Coding guidelines.

**Effective Date:** October 17, 2016

To access the MolDX Excluded Tests from our website, follow the instructions below.

  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Excluded Tests” page, locate the above listed MolDx test title.

**MolDX: BluePrint® Billing and Coding Guidelines**

The MolDX: BluePrint® Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary:** To notify the Provider community of the MolDX: BluePrint® Billing and Coding guidelines.

**Effective Date:** October 17, 2016

To access the MolDX Excluded Tests from our website, follow the instructions below.

  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Excluded Tests” page, locate the above listed MolDx test title.

**MolDX: CFTR Gene Analysis Billing and Coding Guidelines**

The MolDX: CFTR Gene Analysis Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary:** To notify the Provider community of the MolDX: CFTR Gene Analysis Billing and Coding guidelines.

**Effective Date:** October 17, 2016

To access the MolDX Excluded Tests from our website, follow the instructions below.

  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
• On the “Excluded Tests” page, locate the above listed MolDx test title.

**MolDX: CHD7 Gene Analysis Billing and Coding Guidelines**
The MolDX: CHD7 Gene Analysis Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary:** To notify the Provider community of the MolDX: CHD7 Gene Analysis Billing and Coding guidelines.

**Effective Date:** October 10, 2016

To access the MolDX Excluded Tests from our website, follow the instructions below.
• Go to https://med.noridianmedicare.com/web/faf/policies/moldx/excluded-tests.
  – The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
• On the “Excluded Tests” page, locate the above listed MolDx test title.

**MolDX: CYP2B6 Test Billing and Coding Guidelines**
The MolDX: CYP2B6 Test Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary:** To notify the Provider community of the MolDX: CYP2B6 Test Billing and Coding Guidelines.

**Effective Date:** October 24, 2016

To access the MolDX Covered Tests from our website, follow the instructions below.
• Go to https://med.noridianmedicare.com/web/faf/policies/moldx/covered-tests.
  – The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
• On the “Covered Tests” page, locate the above listed MolDX test title.

**MolDX: CYP2C9 and/or VKORC1 Gene Testing for Warfarin Response Billing and Coding Guidelines**
The MolDX: CYP2C9 and/or VKORC1 Gene Testing for Warfarin Response Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

**Summary:** To notify the Provider community of the MolDX: CYP2C9 and/or VKORC1 Gene Testing for Warfarin Response Billing and Coding Guidelines.

**Effective Date:** October 24, 2016

To access the MolDX Covered Tests from our website, follow the instructions below.
• Go to https://med.noridianmedicare.com/web/faf/policies/moldx/covered-tests.
  – The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
• On the “Covered Tests” page, locate the above listed MolDX test title.
MolDX: ENG and ACVRL1 Gene Tests Billing and Coding Guidelines

The MolDX: ENG and ACVRL1 Gene Tests Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

Summary: To notify the Provider community of the MolDX: ENG and ACVRL1 Gene Tests Billing and Coding Guidelines.

Effective Date: October 24, 2016

To access the MolDX Excluded Tests from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jfa/policies/holdx/excluded-tests
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Excluded Tests” page, locate the above listed MolDX test title.

MolDX: FANCC Genetic Testing Billing and Coding Guidelines

The MolDX: FANCC Genetic Testing Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

Summary: To notify the Provider community of the MolDX: FANCC Genetic Testing Billing and Coding Guidelines.

Effective Date: October 24, 2016

To access the MolDX Excluded Tests from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jfa/policies/holdx/excluded-tests
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Excluded Tests” page, locate the above listed MolDX test title.

MolDX: FDA Approved ALK Companion Diagnostic Tests Billing and Coding Guidelines

The MolDX: FDA Approved ALK Companion Diagnostic Tests Billing and Coding Guidelines coverage article has been published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD) and on our (Noridian) website.

Summary: To notify the Provider community of the MolDX: FDA Approved ALK Companion Diagnostic Tests Billing and Coding Guidelines.

Effective Date: October 24, 2016

To access the MolDX Covered Tests from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jfa/policies/holdx/covered-tests
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Covered Tests” page, locate the above listed MolDX test title.
2016 JF Part A Quarterly Ask-the-Contractor Teleconferences

Below is the listing of the 2015 Part A Quarterly Ask-the-Contractor Teleconferences (ACTs).

- January 21, 2016
- April 21, 2016
- July 21, 2016
- October 20, 2016

ACTs are designed to open communication between providers and Noridian, which allows for timely identification of problems, and sharing information in an informal and interactive question and answer (Q&A) format. No Personal Health Information (PHI) is allowed.

Noridian representatives from various Part A departments are available to address your Medicare questions and concerns. All questions are entertained and the Q&As are posted on our website for provider convenience.

To view ACT dates, times, toll-free number, and Q&As, go to [https://med.noridianmedicare.com/web/jfa/education/act](https://med.noridianmedicare.com/web/jfa/education/act).

No registration is required for these calls. Please call in 10 minutes prior, all calls start promptly at the time designated in the schedule listing.

By completing and submitting the Noridian “Ask the Contractor Teleconference Question Submission Form,” providers may ask question(s), up to five (5) days prior, to be answered during the next ACT. Questions submitted with this form will be answered first. Lines will then be opened for additional questions, as time permits. Do not include any Personal Health Information (PHI) or claim specific inquiries on this form. If you have claim specific questions, contact the Provider Contact Center. Providers will need to have Version 7 or higher of Adobe Reader to use this form.

We look forward to your participation in these important calls.

**Medicare Part A ACTs do not address Medicare Part B or Durable Medical Equipment (DME) inquiries.** If you are interested in attending a Part B or a DME ACT, select the appropriate link below for more information.

<table>
<thead>
<tr>
<th>ACT</th>
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<tbody>
<tr>
<td>DME</td>
<td><a href="https://med.noridianmedicare.com/web/jddme/education/act">https://med.noridianmedicare.com/web/jddme/education/act</a></td>
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**CERT A/B MAC Education Resources – Now Available**

CMS has a web page dedicated to education developed by the CERT A/B MAC Outreach & Education Task Force. The Task Force is a joint collaboration of all A/B MACs to communicate national issues. The goal is to reduce improper payments to the Medicare program.

Providers can access education on the following common billing errors below on the [CERT A/B MAC Outreach & Education Task Force](https://www.noridianmedicare.com) web page. The links will take you to an external website.

- Complying with Documentation Requirements for Laboratory Services (April 2016) [PDF, 1MB]
- Caring for Medicare Patients is a Partnership (June 2016) [PDF, 481KB]
- Inpatient Rehabilitation Facilities (IRFs): Improving Documentation Positively Impacts CERT (Web-based Training (WBT)) (July 2016)
  - *WBT requires login or creating an MLN Learning Management and Product Ordering System (LM/POS) account, then search for “IRF” in the Training Catalog

**National Correct Coding Initiative (NCCI) Self-Paced Trainings - Now Available**
New National Correct Coding Initiative (NCCI) Self-Paced Trainings have been created by the Noridian Provider Outreach and Education Department. Providers can access the below trainings on the Event Materials and Tutorials web page.

- Add-On Code Edits
- Billing units in Excess of Medically Unlikely Edit (MUE)
- Identifying Procedure to Procedure (PTP) Edit Claim Errors
- Locating Medically Unlikely Edits (MUEs)
- Medically Unlikely Edit (MUE) Overview
- National Correct Coding Initiative (NCCI)
- Procedure to Procedure (PTP) Edits

**OCE, MCE and Addendum A and B Self-Paced Training Tutorials Available**

New Outpatient Code Editor (OCE), Medicare Code Editor (MCE), and Addendum A and B Self-Paced Trainings have been created by the Noridian Provider Outreach and Education Department. Providers can access the below tutorials on the Integrated Outpatient Code Editor (OCE) and Medicare Code Editor (MCE) webpage.

- Locating the Medicare Code Editor (MCE)
- Locating the Outpatient Code Editor (OCE)
- Medicare Code Editor (MCE) Overview
- Outpatient Code Editor (OCE) Overview
- Outpatient Code Editor (OCE) Status Indicators
- Addendums A and B

**Modifier Self-Paced Training Tutorials Updated**

Revised Modifier Self-Paced Trainings have been created by the Noridian Provider Outreach and Education Department. Providers can access the below tutorials on the Modifiers webpage.

- Ambulance Modifiers
- Anatomical Modifiers
- Clinical Trial and Drug Modifiers
- CAH Modifiers
- ESRD Modifiers
- E&M Modifiers
- Laboratory Modifiers
- Modifier Basics and Other Modifiers
- Outpatient Rehabilitation Modifiers
- Preventive Modifiers
- Waiver of Liability Modifiers

**New PEPPER Available for Home Health Agencies**

The Centers for Medicare & Medicaid Services (CMS) have made available free provider-specific comparative data reports for home health agencies (HHAs) nationwide. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) summarizes HHA claims data statistics for areas that may be
at risk for improper Medicare payments:

1. Average Case Mix
2. Average Number of Episodes
3. Episodes with 5 or 6 Visits
4. Non-LUPA Payments
5. High Therapy Utilization Episodes
6. Outlier Payments

HHAs can use the data to support internal auditing and monitoring activities. PEPPER is a free report comparing an HHA’s Medicare billing practices with other HHAs in the nation, Medicare Administrative Contractor (MAC) jurisdiction and state. CMS has contracted with TMF® Health Quality Institute to develop and distribute the reports. To access the HHA PEPPER:

1. Visit the Distribution Schedule - Get Your PEPPER page at PEPPERresources.org.
2. Review the instructions and obtain the information required to authenticate access through the PEPPER Resources Portal (the HHA’s CMS certification number and a medical record number or patient control number from a paid traditional Medicare fee-for-service claim for services with a “from” or “through” date between December 1-31, 2015).
3. Access the PEPPER Resources Portal.
4. Complete all the fields.
5. Download the PEPPER.

For more information on the HHA PEPPER, such as the HHA PEPPER User’s Guide and a sample HHA PEPPER, please visit PEPPERresources.org. A WebEx training session reviewing the PEPPER is scheduled for July 28; for more information see here. Questions about PEPPER may be submitted through the Help Desk.

New PEPPER Available for Partial Hospitalization Programs

The Centers for Medicare & Medicaid Services (CMS) have made available free provider-specific comparative data reports for partial hospitalization programs (PHPs) nationwide. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) summarizes PHP claims data statistics for areas that may be at risk for improper Medicare payments. PHPs can use the data to support internal auditing and monitoring activities. PEPPER is a free report comparing a PHP’s Medicare billing practices with other PHPs in the nation, Medicare Administrative Contractor (MAC) jurisdiction and state. CMS has contracted with TMF® Health Quality Institute to develop and distribute the reports.

Free-standing PHPs can access their PEPPER via the PEPPER Resources Portal:

1. Visit the Distribution Schedule - Get Your PEPPER page at PEPPERresources.org.
2. Review the instructions and obtain the information required to authenticate access through the PEPPER Resources Portal (the PHP’s CMS certification number and a medical record number or patient control number from a paid traditional Medicare fee-for-service claim for services with a “from” or “through” date between December 1-31, 2015).
3. Access the PEPPER Resources Portal.
4. Complete all the fields.
5. Download the PEPPER.

PHPs administered by short-term acute care hospitals or inpatient psychiatric facilities received their PEPPER via the QualityNet secure portal. The PEPPER file was uploaded to the inbox of QualityNet account administrators and those with user accounts with the PEPPER recipient roles.

Updated in this release:
1. The “Days of Service with 4 Units Billed” target area has been discontinued.
EDUCATIONAL

2. A new target area on “Outlier Payments” has been added.
3. The report now summarizes the most recent three calendar years (instead of fiscal years).
4. The “Top Diagnosis” report now reflects the top 10 Clinical Classification System diagnoses (instead of the top 20 diagnosis codes).

For more information on the PHP PEPPER, such as the PHP PEPPER User’s Guide and a sample PHP PEPPER, please visit PEPPERresources.org. A WebEx training session reviewing the PEPPER is scheduled for July 26; for more information see here. Questions about PEPPER may be submitted through the Help Desk.

ENROLLMENT

Do Not Forward Initiative Reminder

The Internet Only Manual (IOM) Medicare Claims Processing Manual, Publication 100-04 instructs Part A and Part B Medicare Administrative Contractors (A/B MACs) and carriers to use “return service requested” envelopes when mailing paper checks and remittance advices to providers.

When the post office returns a “return service requested” envelope, the A/B MAC/carrier applies a “do not forward” (DNF) flag to the provider’s Medicare enrollment file. The A/B MAC/carrier will not generate any additional checks for that provider until the provider sends a properly completed change of address form back to the A/B MAC/carrier. We are not required to contact the provider to notify them that the flag has been added to their file.

Upon verifying the new address, the A/B MAC/carrier removes the DNF flag and can again generate payments for the provider. Electronic Funds Transfer (EFT) is required; therefore, when the address change update is completed, the provider will be set up to use EFT and will no longer receive paper checks.

NOTE: Because many providers get paid through EFT, there may be cases where a provider does not have a correct address on file, but the A/B MAC/carrier continues to pay the provider through EFT. It is still the provider’s responsibility to submit and address change update so that remittance notices and special checks would be sent to the proper address.

Noridian encourages providers to enroll or make changes using Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for faster processing time. Applications and changes completed online currently have an average processing time of 10 days. All Medicare providers may use the new enrollment process on the CMS website https://pecos.cms.hhs.gov. To log into this internet-based PECOS, providers will use their NPI Userid and password.

Policy

Effective October 1, 2002, A/B MACs/carriers must use “return service requested” envelopes for hardcopy remittance advices and checks, with respect to providers that have elected to receive hardcopy remittance advices. (PM B-02-023, CR 2038 dated April 12, 2002; Transmittal 1794, CR 2684 dated May 2, 2003)

Implementation Process

1. “Return service requested” envelopes are used for all hardcopy remittance advices starting October 1, 2002. These envelopes will be used for all providers.
2. “Return service requested” envelopes will not be used for beneficiary correspondence, such as Medicare Summary Notices (MSNs) or for overpayment demand letters.
3. When the post office returns a remittance advice due to an incorrect address, A/B MACs/carriers will follow the same procedures as followed for returned checks, that is:
   • Flag the provider’s file DNF.
   • A/B MAC/carrier staff will notify provider enrollment team.
ENROLLMENT

• A/B MAC/carriers will cease generating any further payments or remittance advice to that provider or supplier until furnished with a new, verified address.

4. When the provider establishes a new, verified address, A/B MACs/carriers will remove the DNF flag and pay the provider any funds which are still being held due to a DNF flag. A/B MAC/carriers must also reissue any remittance advices, which have been held.

5. Previously, CMS only required corrections to the “pay to” address. However, with the implementation of this initiative, CMS requires corrections to all addresses before the contractor can remove the DNF flag and begin paying the provider or supplier again. Therefore, A/B MAC/carriers cannot release any payments to DNF providers until the provider enrollment department has verified and updated all addresses for that provider’s location.

IRS-1099 Reporting

Provider or supplier checks returned and voided during the same year they were issued are not reported on the Internal Revenue Service (IRS) Form 1099 until the returned check is reissued (i.e., the DNF flag is removed and the A/B MAC/carrier reissues payment to the provider.) Checks returned and voided in the current year that were issued in prior years are not netted from the current year’s IRS Form 1099.

Monies withheld because a DNF flag exists on a provider or supplier record are not reported on IRS-1099s until the calendar year in which payment is made (i.e., the point at which the A/B MAC/carrier pays the provider once the DNF flag is removed.) If DNF amounts are erroneously included on IRS-1099 forms, A/B MACs/carriers will issue corrected IRS Form 1099s to affected providers.

Source: IOM Medicare Claims Processing Manual, Publication 100-04, Chapter 22, Section 50.1

Timely Reporting of Provider Enrollment Information Changes

MLN Matters® Number: SE1617

Provider Types Affected

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

Provider Action Needed

Failure to comply with the requirements to report changes in your Medicare enrollment information could result in the revocation of your Medicare billing privileges. This article does not establish any new or revised policy, but serves as a reminder to comply with existing policy. MLN Matters® Article SE1617 reinforces the importance of the timely reporting of changes in your Medicare enrollment information. Comply with the reporting requirements for changes in your enrollment information and avoid disruption of your Medicare claims payments.

Background

In accordance with 42 Code of Federal Regulations (CFR) Section 424.516(d), all physicians, non-physician practitioners (for example, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals) and physician and non-physician practitioner organizations must report the following changes in their enrollment information to your MAC via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) or the CMS 855 paper enrollment application within 30 days of the change:

• A change in ownership
• An adverse legal action, or
• A change in practice location.

You must report all other changes to your MAC within 90 days of the change.
ENROLLMENT

If you are a supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), you must report any changes in information supplied on the enrollment application within 30 days of the change to the National Supplier Clearinghouse (NSC) (42 CFR §424.57(c)(2)).

Independent Diagnostic Testing Facilities must report changes in ownership, location, general supervision, and adverse legal actions to your MAC either online, or via the appropriate CMS-855 form, within 30 calendar days of the change. You must report all other changes to your enrollment information within 90 days of the change (42 CFR §410.33(g)(2)).

All providers and suppliers not previously identified must report any changes of ownership, including a change in an authorized or delegated official, within 30 days; and all other informational changes within 90 days (42 CFR §424.516(e)).

It is very important that you comply with these reporting requirements. Failure to do so could result in the revocation of your Medicare billing privileges.

HOSPITAL

IPPS Hospitals, IRFs, and LTCHs - Supplemental Security Income/Medicare Beneficiary Data for 2014

MLN Matters® Number: MM9648
Related Change Request (CR) #: CR 9648
Related CR Release Date: July 15, 2016
Effective Date: August 16, 2016
Related CR Transmittal #:RI681OTN
Implementation Date: August 16, 2016

Provider Types Affected
This MLN Matters® Article is intended for Inpatient Prospective Payment System (IPPS) hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 9648 provides updated data for determining the disproportionate share adjustment for IPPS hospitals and the Low Income Patient (LIP) adjustment for IRFs as well as payments as applicable for LTCH discharges (for example, discharges paid the IPPS comparable amount under the short-stay outlier payment adjustment).

Background
The Supplemental Security Income (SSI)/Medicare beneficiary data for hospitals are available electronically and contain the:
- Name of the hospital
- Centers for Medicare & Medicaid Services (CMS) certification number
- SSI days
- Total Medicare days, and
- The ratio of Medicare Part A patient days attributable to SSI recipients

The files are located on the CMS website addresses as follows:
- IPPS Hospitals: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html)
The data are used for settlement purposes for IPPS hospitals and IRFs with cost reporting periods beginning during Fiscal Year (FY) 2014 (cost reporting periods beginning on or after October 1, 2013, and before October 1, 2014), except when explicitly directed otherwise by CMS.

CMS expects hospitals will express interest in revising the worksheet S-10 submitted with their FY 2014 cost reports. MACs are working on separate instructions to provide you with guidance for responding to and reviewing hospitals’ worksheet S-10 data. MACs shall accept a hospital’s request to amend its FY 2014 worksheet S-10, but hold off on settlement of FY 2014 cost reports until CMS issues further instructions.

Additional Information


**SSP ACO Qualifying Stay Edits – Revised**

MLN Matters® Number: MM9568 Revised
Related Change Request (CR) #: CR 9568
Related CR Release Date: July 1, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R1679OTN
Implementation Date: January 3, 2017

This article was revised on July 5, 2016, due to an updated Change Request (CR). That CR revised Shared System Maintainer (SSM) responsibility. The transmittal number, CR release date and link to the transmittal also changed. All other information remains the same.

**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**

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 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) 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**


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. To learn more about the SNF 3-Day Waiver, visit the SSP webpage and click on Statutes/Regulations/Guidance.

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**Part A SNF PPS Pricer – Update 2017**

MLN Matters® Number: MM9712
Related Change Request (CR) #: CR 9712
Related CR Release Date: July 1, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3555CP
Implementation Date: October 3, 2016

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 9712 announces the availability of the payment rates used under the PPS for SNFs for Fiscal Year (FY) 2017, as required by statute. Make sure that your billing staffs are aware of these changes.

**Background**

Annual updates to the PPS rates are required by Section 1888(e) of the Social Security Act as amended by the Medicare, Medicaid, and the State Children’s Health Insurance Plan (SCHIP) Balanced Budget Refinement Act of 1999 (the BBRA), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (the BIPA), and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), relating to Medicare payments and consolidated billing for SNFs.
Each July, the Centers for Medicare & Medicaid Services (CMS) publishes the SNF payment rates for the upcoming fiscal year (that is, October 1, 2016, through September 30, 2017) in the Federal Register.

The update methodology is identical to that used in the previous year, which includes a forecast error adjustment whenever the difference between the forecasted and actual change in the SNF market basket exceeds 0.5 percentage point. The statute mandates an update to the Federal rates using the latest SNF full market basket adjusted for productivity. The payment rates will be effective October 1, 2016.

Additional Information

The CNF payment rates for FY2017 are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/List-of-SNF-Federal-Regulations.html.

New ST PEPPER now available
A new release of the Short-Term (ST) Program for Evaluating Payment Patterns Electronic Report (PEPPER), with statistics through the second quarter of fiscal year 2016, is available for short-term acute care hospitals nationwide. PEPPER files were recently distributed through a QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER recipient role.

About PEPPER
PEPPER summarizes hospital-specific data statistics for Medicare severity diagnosis-related groups and discharges at risk for improper payments. It is distributed by TMF® Health Quality Institute under contract with the Centers for Medicare & Medicaid Services. Visit PEPPERresources.org to access resources for using PEPPER, including the PEPPER user’s guide, recorded training sessions, information about QualityNet accounts, frequently asked questions and examples of how other hospitals are using PEPPER.

Do you have questions or comments about PEPPER or need help obtaining your report? Visit our Help Desk. Provide feedback or suggestions regarding PEPPER through our feedback form.

INCENTIVE PROGRAMS

Overview of the Skilled Nursing Facility Value-Based Purchasing Program
MLN Matters® Number: SE1621

Provider Types Affected
This article is intended for physicians, clinical staff, and administrators of Skilled Nursing Facilities (SNFs) submitting claims under the SNF Prospective Payment System (PPS) to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries during a SNF stay.

What You Need to Know
The Centers for Medicare & Medicaid Services (CMS) SNF Value-Based Purchasing (VBP) Program is one of many VBP programs that aims to reward quality and improve health care. Beginning October 1, 2018, SNFs will have an opportunity to receive incentive payments based on performance on the specified quality measure.

Background
The Protecting Access to Medicare Act (PAMA) of 2014, enacted into law on April 1, 2014, authorized the SNF VBP program. PAMA requires CMS to adopt a VBP payment adjustment for SNFs beginning October 1, 2018. By law, the SNF VBP Program is limited to a single readmission measure at a time.
INCENTIVE PROGRAMS

PAMA requires CMS, among other things, to:

- Furnish value-based incentive payments to SNFs for services beginning October 1, 2018.
- Develop a methodology for assessing performance scores.
- Adopt performance standards on a quality measure that include achievement and improvement.
- Rank SNFs based on their performance from low to high. The highest ranked facilities will receive the highest payments, and the lowest ranked 40 percent of facilities will receive payments that are less than what they otherwise would have received without the Program.

CMS will withhold 2 percent of SNF Medicare payments starting October 1, 2018, to fund the incentive payment pool and will then redistribute 50-70 percent of the withheld payments back to SNFs through the SNF VBP Program.

Readmissions Measures

Skilled Nursing Facility 30-Day All Cause Readmission Measure (SNFRM)

In the Fiscal Year (FY) 2016 SNF Prospective Payment System (PPS) final rule, CMS adopted the SNFRM as the first measure for the SNF VBP Program. The measure is defined as the risk-standardized rate of all-cause, unplanned hospital readmissions of Medicare beneficiaries within 30 days of discharge from their prior hospitalization. Hospital readmissions are identified through Medicare hospital claims (not SNF claims) so no readmission data is collected from SNFs and there are no additional reporting requirements for the measure. This measure is endorsed by the National Quality Forum.

Readmissions to a hospital within the 30-day window are counted regardless of whether the beneficiary is readmitted directly from the SNF or after discharge from the SNF as long as the beneficiary was admitted to the SNF within 1 day of discharge from a hospital stay. The measure excludes planned readmissions because they do not indicate poor quality of care. The measure is risk-adjusted based on patient demographics, principal diagnosis from the prior hospitalization, comorbidities, and other health status variables that affect probability of readmission.

Other exclusions include patients who were hospitalized for medical treatment of cancer, do not have Medicare Part A coverage for the full 30-day window, and do not have Part A coverage for the 12 months preceding the prior hospital discharge. Additional exclusions include SNF stays with:

- An intervening post-acute care admission within the 30-day window,
- Patient discharge from the SNF against medical advice,
- Principal diagnosis in prior hospitalization was for rehabilitation, fitting of prosthetics, or adjustment of devices,
- Prior hospitalization for pregnancy, and
- Other reasons documented in the measure’s technical specifications.

Skilled Nursing Facility 30-Day Potentially Preventable Readmission (SNFPPR) Measure

On July 29, 2016, CMS adopted the SNFPPR measure for future use in the SNF VBP Program. The SNFPPR measure assesses the risk-standardized rate of unplanned, Potentially Preventable Readmissions (PPRs) for Medicare Fee-For-Service SNF patients within 30 days of discharge from a prior hospitalization.

Potentially preventable hospital readmissions for post-acute care are defined using the existing evidence, empirical analysis, and technical expert panel input. However, the key difference between the SNFRM and SNFPPR measures is that the SNFPPR focuses on potentially preventable readmissions rather than all-cause readmissions. As required by the Program’s statute, CMS will replace the SNFRM with the SNFPPR as soon as practicable.

Performance Scoring

CMS has adopted these scoring methodologies to measure SNF performance that includes levels of achievement and improvement:

- **Achievement scoring** compares a SNF’s performance rate in a performance period against all SNFs’ performance during the baseline period
**INCENTIVE PROGRAMS**

- **Improvement scoring** compares a SNF’s performance during the performance period against its own prior performance during the baseline period.

For FY 2019 of the SNF VBP Program, achievement scoring will compare SNFs’ 2017 performance to the performance of all facilities during Calendar Year (CY) 2015. Improvement scoring methodology will compare a SNFs’ 2017 performance to its own performance during CY 2015. For more information about the SNF VBP Program’s scoring methodology, refer to the [FY 2017 SNF PPS final rule](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html).

**Quality Feedback Reports**

On October 1, 2016, SNFs will begin receiving quarterly confidential feedback reports about their performance in the SNF VBP Program via the Certification and Survey Provider Enhanced Reporting (CASPER) system.

**Additional Information**

For more information about the SNF VBP Program, visit [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html) and refer to the [FY 2016 SNF PPS final rule](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html) and the [FY 2017 SNF PPS final rule](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html).

If you have additional questions, please email them to: SNFVBPinquiries@cms.hhs.gov.

**MEDICAL POLICIES**

**Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) Final LCD – Effective September 15, 2016**

The following Local Coverage Determination (LCD) has completed the Open Public and Contractor Advisory Committee (CAC) comment period and is now finalized under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

**Medicare Coverage Database (MCD) Number/Contractor Determination Number:** L33979

**LCD Title:** Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs)

**Effective Date:** September 15, 2016

**Summary of LCD:** This LCD discusses the medically necessary indications and treatment of benign skin lesions excluding actinic keratosis and those treated with MOHS.

To access the Noridian Future Effective LCDs from our website, follow the instructions below.

- Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/future](https://med.noridianmedicare.com/web/jfa/policies/lcd/future)
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

- On the “Future LCDs” page, select the coordinating state and locate the above listed CMS MCD number or LCD title.
  - This link will redirect you to the state specific Future Effective LCD on the CMS website.

**Cardiovascular Stress Testing, Including Exercise and/or Pharmacological Stress and Stress Echocardiography Studies Draft LCD Published for Review and Comments**

The following draft Local Coverage Determination (LCD) has been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

**Medicare Coverage Database Number:** DL36889

**LCD Title:** Cardiovascular Stress Testing, Including Exercise and/or Pharmacological Stress and Stress Echocardiography Studies

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*Medicare A News | Noridian Medicare A Jurisdiction F | October 2016 | Issue No. 2129*
MEDICAL POLICIES

Comment period: October 6 – December 15, 2016


When sending comments, providers must reference the specific policy to which they are related and email or mail them to:

- policya.drafts@noridian.com
- Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

Chest X-Ray Draft LCD Published for Review and Comments

The following draft Local Coverage Determination (LCD) has been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

Medicare Coverage Database Number: DL34052

LCD Title: Chest X-Ray Policy

Comment period: October 6 – December 15, 2016


When sending comments, providers must reference the specific policy to which they are related and email or mail them to:

- policya.drafts@noridian.com
- Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

Incident to Clarification for OPPS and CAH Outpatient JFA and JFB Coverage Article Number Change - Effective August 4, 2016

The following JF Medicare Coverage Article has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: A55214

Article Title: Incident to Clarification for Outpatient Prospective Payment System (OPPS) and Critical Access Hospital (CAH) Outpatient

Effective Date: August 4, 2016

Summary of Changes: Article number A52734 for Jurisdiction F Part A (JFA) was retired on 10/01/2015 and combined into Jurisdiction F Part B (JFB) Article number A55214. JFA and JFB contract numbers will have the same final MCD Article number and remain an Active Medicare Coverage Article. Coverage will remain the same.

To access the Noridian Coverage Articles from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jfa/policies/coverage-articles
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Medicare Coverage Articles” page, locate the above listed coverage article title.
Diagnostic and Therapeutic Colonoscopy Draft LCD Published for Review and Comments

The following draft Local Coverage Determination (LCD) has been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

Medicare Coverage Database Number: DL36868

LCD Title: Diagnostic and Therapeutic Colonoscopy

Comment period: October 6, 2016 – December 15, 2016


When sending comments, providers must reference the specific policy to which they are related and email or mail them to:

• policya.drafts@noridian.com
• Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

Flow Cytometry LCD – R3

The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L36094

LCD Title: Flow Cytometry

Effective Date: October 1, 2015

Summary of Changes: Updated the following information in this LCD:

• ICD-10-CM codes
  – D46.4 - Refractory anemia, unspecified, and
  – D49.9 - Myelodysplastic syndrome, unspecified
• Changed JF A LCD number from L36093 to L36094. The same policy content for JF Part A and JF Part B is combined to L36094.
  – LCD number L36093 for JFA will be retired on 07/22/2016.

To access the Noridian Active LCDs from our website, follow the instructions below.

• Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/active
  – The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
• On the “Active [Future] LCDs” page, locate the above listed LCD title.
  – This link will direct you to the locally hosted copy of the LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.
GlycoMark Testing for Glycemic Control Draft LCD Published for Review and Comments

The following draft Local Coverage Determination (LCD) has been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

**Medicare Coverage Database Number:** DL36866  
**LCD Title:** GlycoMark Testing for Glycemic Control  
**Comment period:** October 6 – December 15, 2016


When sending comments, providers must reference the specific policy to which they are related and email or mail them to:

- policya.drafts@noridian.com
- Noridian Medicare JF Part A  
  Attention: Draft LCD Comments  
  PO Box 6781  
  Fargo, ND 58103-6781

**Total Hip Arthroplasty Final LCD – Effective September 7, 2016**

The following Local Coverage Determination (LCD) has completed the Open Public and Contractor Advisory Committee (CAC) comment period and is now finalized under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

**Medicare Coverage Database (MCD) Number/Contractor Determination Number:** L36573  
**LCD Title:** Total Hip Arthroplasty  
**Effective Date:** September 7, 2016  
**Summary of LCD:** View coverage criteria supporting the medical necessity prior to performing a Total Hip Arthroplasty along with applicable diagnosis codes.

To access the Noridian Future Effective LCDs from our website, follow the instructions below.

- Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/future](https://med.noridianmedicare.com/web/jfa/policies/lcd/future)  
  – The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Future LCDs” page, select the coordinating state and locate the above listed CMS MCD number or LCD title.  
  – This link will redirect you to the state specific Future Effective LCD on the CMS website.

**Total Knee Arthroplasty Final LCD – Effective September 7, 2016**

The following Local Coverage Determination (LCD) has completed the Open Public and Contractor Advisory Committee (CAC) comment period and is now finalized under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

**Medicare Coverage Database (MCD) Number/Contractor Determination Number:** L36177  
**LCD Title:** Total Knee Arthroplasty  
**Effective Date:** September 7, 2016  
**Summary of LCD:** View coverage criteria supporting the medical necessity prior to performing a Total Knee Arthroplasty along with applicable diagnosis codes.
To access the Noridian Future Effective LCDs from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/future
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Future LCDs” page, select the coordinating state and locate the above listed CMS MCD number or LCD title.
  - This link will redirect you to the state specific Future Effective LCD on the CMS website.

**Intensity Modulated Radiation Therapy (IMRT) JFA and JFB LCD Number Changes - Effective August 24, 2016**

The following JF Local Coverage Determination (LCD) has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L34241

**LCD Title:** Intensity Modulated Radiation Therapy (IMRT)

**Effective Date:** August 24, 2016

**Summary of Changes:** LCD number L34251 for Jurisdiction F Part A (JFA) was retired on August 24, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L34080. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Effective October 1, 2015, the combined LCD is also revised to correct a typographical error for Group 2 diagnoses to clarify that Z764.09 OR Z78.9 must be used as a secondary diagnosis. The instruction previously read, “and”. Coverage will remain the same.

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/active
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.

**Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton’s Neuroma Draft LCD Published for Review and Comments**

The following draft Local Coverage Determination (LCD) has been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

**Medicare Coverage Database Number:** DL34076

**LCD Title:** Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton’s Neuroma

**Comment period:** October 6 – December 15, 2016


When sending comments, providers must reference the specific policy to which they are related and email or mail them to:
Measurement of Salivary Hormones Draft LCD Published for Review and Comments

The following draft Local Coverage Determination (LCD) has been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

Medicare Coverage Database Number: DL36857

LCD Title: Measurement of Salivary Hormones

Comment period: October 6 – December 15, 2016


When sending comments, providers must reference the specific policy to which they are related and email or mail them to:

- policya.drafts@noridian.com
- Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

Mohs Micrographic (MMS) Surgery JFA and JFB LCD Number Changes – Effective September 7, 2016

The following JF Local Coverage Determination (LCD) has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database Number: L35703

LCD Title: Mohs Micrographic (MMS) Surgery

Effective Date: September 7, 2016

Summary of Changes: LCD number L35703 for Jurisdiction F Part A (JFA) was retired on September 7, 2016 and was combined into Jurisdiction F Part B (JFB) LCD number L35704. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/active
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.
**MEDICAL POLICIES**

**Non Covered Services LCD – R16**

The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L35008

**LCD Title:** Non Covered Services

**Effective Date:** July 1, 2016

**Summary of Changes:** LCD revised to add the following Category III codes:

- 0437T – 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)
- 0438T – Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance
- 0439T – 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)
- 0440T – Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve
- 0441T – Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve; lower extremity distal/peripheral nerve
- 0442T – Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve; lower extremity distal/peripheral nerve; nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)
- 0443T – Real time spectral analysis of prostate tissue by fluorescence spectroscopy
- 0444T – Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/active](https://med.noridianmedicare.com/web/jfa/policies/lcd/active)
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.

**Non Covered Services LCD – R17**

The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L35008

**LCD Title:** Non Covered Services

**Effective Date:** August 8, 2016

**Summary of Changes:** Removed CPT code 86352 from Group 1. 86352 - Cellular function assay involving stimulation (e.g., mitogen or antigen) and detection of biomarker (e.g., ATP)

To access the Noridian Active Effective LCDs from our website, follow the instructions below.

- Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/active](https://med.noridianmedicare.com/web/jfa/policies/lcd/active)
MEDICAL POLICIES

- The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

- On the “Active” LCDs page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.

Non Covered Services JFA LCD Number Change – Effective July 14, 2016

The following JF Local Coverage Determination (LCD) has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database Number: L34886

LCD Title: Non-Covered Services

Effective Date: July 14, 2016

This LCD number L34886 for Jurisdiction F Part A (JFA) was retired effective May 31, 2016 and was combined into the Jurisdiction F Part B (JFB) LCD number L35008. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/active
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

- On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.

Percutaneous Endovascular Cardiac Assist Procedures and Devices – R3

The “Percutaneous Endovascular Cardiac Assist Procedures and Devices – R4” article was originally published to Latest Updates on May 19, 2016; however, the R number within the title was incorrect. This article is being published to correct the title to read “Percutaneous Endovascular Cardiac Assist Procedures and Devices – R3.” No additional changes within the article have been made.

The following Noridian coverage requirements for the Percutaneous Endovascular Cardiac Assist Procedures and Devices National Coverage Determination (NCD) have been published under contract numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY) in the CMS Medicare Coverage Database (MCD and on our (Noridian) website.

NCD Title: Percutaneous Endovascular Cardiac Assist Procedures and Devices (NCD 20.9.1)

Effective Date: October 1, 2015

Article Summary of Changes: The following revisions were made to this article:

- Changed ICD-10-PCS code from 02HL3DZ back to 5A0221D in Group 1 Paragraph for Part A Providers.
- Change article number from A52944 to A52967. Same article number and content for Jurisdiction F (JF) Part A and Part B.
  - Article number A52944 will be retired on 5/15/16.

Read the complete National Coverage Determination requirements article

- The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
To view a complete list of all Noridian NCD coverage articles, go to the National Coverage Determination (NCD) and select the title of interest.

To view a complete list of all CMS NCDs available, go to National Coverage Determinations (NCDs) Alphabetical Index.

**Percutaneous Vertebral Augmentation – JFA and JFB LCD Number Changes - Effective July 14, 2016**

The following JF Local Coverage Determination (LCD) has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L34168

**LCD Title:** Percutaneous Vertebral Augmentation

**Effective Date:** July 14, 2016

Summary of Changes: LCD number L34168 for Jurisdiction F Part A (JFA) was retired on July 14, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L34106. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/active](https://med.noridianmedicare.com/web/jfa/policies/lcd/active)
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).

- On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.

**Polysomnography and Other Sleep Studies Draft LCD Published for Review and Comments**

The following draft Local Coverage Determination (LCD) has been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

**Medicare Coverage Database Number:** DL34040

**LCD Title:** Polysomnography and Other Sleep Studies

**Comment period:** October 6 – December 15, 2016


When sending comments, providers must reference the specific policy to which they are related and email or mail them to:

- policya.drafts@noridian.com
- Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781
MEDICAL POLICIES

Trigger Point Injections Draft LCD Published for Review and Comments

The following draft Local Coverage Determination (LCD) has been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

**Medicare Coverage Database Number:** DL36859

**LCD Title:** Trigger Point Injections

**Comment period:** October 6 – December 15, 2016


When sending comments, providers must reference the specific policy to which they are related and email or mail them to:

- policya.drafts@noridian.com
- Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

Treatment of Ulcers and Symptomatic Hyperkeratoses – R7

The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L34199

**LCD Title:** Treatment of Ulcers and Symptomatic Hyperkeratoses

**Effective Date:** October 1, 2015

**Summary of Changes:** Corrected the typographical error referencing Wagner of 1 to Wagner 0.

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/active](https://med.noridianmedicare.com/web/jfa/policies/lcd/active)
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.

Treatment of Ulcers and Symptomatic Hyperkeratoses – R8

The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database (MCD) Number:** L34199

**LCD Title:** Treatment of Ulcers and Symptomatic Hyperkeratoses

**Effective Date:** October 1, 2015

**Summary of Changes:** Added the following ICD-10-CM codes:

- I87.011-I87.013 - Postthrombotic syndrome with ulcer of right, left & bilateral lower extremity;
- I87.031-I87.033 - Postthrombotic syndrome with ulcer and inflammation of right left & bilateral lower extremity;
MEDICAL POLICIES

- L05.01 - Pilonidal cyst with abscess;
- L08.0 – Pyoderma;
- L12.0 - Bullous pemphigoid;
- L78.8 - Other specified follicular disorders;
- S31.819 Unspecified open wound of right buttock, initial, subsequent encounter and sequela;
- S31.829 Unspecified open wound of left buttock, initial, subsequent encounter and sequela;
- T31.33 - Burns involving 30-39% of body surface with 30-39% third degree burns; and
- T87.51-T87.54 - Necrosis of amputation stump, right, left and bilateral upper extremity and right, left and bilateral lower extremity

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/active.
- The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Active LCDs” page, locate the above listed LCD title.
- This link will direct you to the locally hosted copy of the LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.

Urinalysis LCD Retirement – Effective April 29, 2016

The following JF Local Coverage Determination (LCD) has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database Number: L34060

LCD Title: Urinalysis

Effective Date: April 29, 2016

LCDs are retired due to lack of evidence of current need(s) for the education and/or edits or in some cases because the material is addressed by a National Coverage Determination (NCD), a coverage provision in a CMS interpretative manual, another LCD or an article. Retirement does not mean that medical necessity has changed or that the LCD no longer reflects appropriate criteria. The guidance in the retired LCD may be helpful in assessing medical necessity.

To access the Noridian Retired LCDs from our website, follow the instructions below.

Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/retired.

- The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Retired LCDs” page, select the state of interest.
- This link will redirect you to the CMS website.
- Select “Noridian Healthcare Solutions, LLC.” Locate the above listed CMS Medicare Coverage Database (MCD) number and LCD title and select the title of interest.

Treatment of Varicose Veins of the Lower Extremities JFA LCD Number Change - Effective August 11, 2016

The following JF Local Coverage Determination (LCD) has been retired under contractor 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L36599

LCD Title: Treatment of Varicose Veins of the Lower Extremities
**Effective Date:** August 11, 2016

**Summary of Changes:** LCD number L36599 for Jurisdiction F Part A (JFA) was retired on August 11, 2016 and combined into Jurisdiction F Part B (JFB) LCD number L34010. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD. Coverage will remain the same.

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/active](https://med.noridianmedicare.com/web/jfa/policies/lcd/active)
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.

**MolDX: APC and MUTYH Gene Testing Draft LCD Published for Review and Comments**

The following draft Local Coverage Determination (LCD) has been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

**Medicare Coverage Database Number:** DL36844

**LCD Title:** MolDX: APC and MUTYH Gene Testing

**Comment period:** October 6 – December 15, 2016


When sending comments, providers must reference the specific policy to which they are related and email or mail them to:

- [policya.drafts@noridian.com](mailto:policya.drafts@noridian.com)
- Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

**MolDX - CDD Percepta Bronchial Genomic Classifier Draft LCD Published for Review and Comments**

The following draft Local Coverage Determination (LCD) has been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

**Medicare Coverage Database Number:** DL36891

**LCD Title:** MolDX - CDD Percepta Bronchial Genomic Classifier Draft LCD Published for Review and Comments

**Comment period:** October 6 – December 15, 2016

MEDICAL POLICIES

When sending comments, providers must reference the specific policy to which they are related and email or mail them to:

- policya.drafts@noridian.com
- Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

MolDX - CDD: Oncotype DX Breast Cancer for DCIS (Genomic Health)
Draft LCD Published for Review and Comments

The following draft Local Coverage Determination (LCD) has been published for review and comment on the Noridian website for the following contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA) and 03601 (WY).

Medicare Coverage Database Number: DL36947

LCD Title: MolDX - CDD: Oncotype DX® Breast Cancer for DCIS (Genomic Health ™)

Comment period: October 6 – December 30, 2016


When sending comments, providers must reference the specific policy to which they are related and email or mail them to:

- policya.drafts@noridian.com
- Noridian Medicare JF Part A
  Attention: Draft LCD Comments
  PO Box 6781
  Fargo, ND 58103-6781

MolDX: Genetic Testing for BCR-ABL Negative Myeloproliferative Disease – R2

The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L36186

LCD Title: MolDX: Genetic Testing for BCR-ABL Negative Myeloproliferative Disease

Effective Date: April 19, 2016

Summary of Changes: The acronym for myeloproliferative disease was previously noted primarily as MPL with a few notations as MPD. LCD was revised to consistently use MPD to describe myeloproliferative disease.

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/active.
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.
MolDX: HLA-DQB1*06:02 Testing for Narcolepsy Final LCD – Effective September 22, 2016

The following Local Coverage Determination (LCD) has completed the Open Public and Contractor Advisory Committee (CAC) comment period and is now finalized under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT) and 03601 (WY).

Medicare Coverage Database (MCD) Number/Contractor Determination Number:  L36551

LCD Title: MolDX: HLA-DQB1*06:02 Testing for Narcolepsy

Effective Date: September 22, 2016

Summary of LCD: LCD describes non-coverage of HLA-DQB1*06:02 typing.

To access the Noridian Future Effective LCDs from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/future
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Future LCDs” page, select the coordinating state and locate the above listed CMS MCD number or LCD title.
  - This link will redirect you to the state specific Future Effective LCD on the CMS website.

MolDX: Molecular Diagnostic Tests (MDT) LCD – R1

The following JF Local Coverage Determination (LCD) has been revised under contractor numbers 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database (MCD) Number: L36256

LCD Title: MolDX: Molecular Diagnostic Tests (MDT)

Effective Date: April 21, 2016

Summary of Changes: Replaced Palmetto GBA reference with MolDX under “Unique Test Identifier Requirement” and removed instruction to register services via Z-Code Identifier Application and Palmetto GBA Test Identifier (PTI) Application. Under “Payment Rules”, removed suspension of claims that omit Z-Code IDs. Under “Covered Tests”, updated the point of contact for McKesson and MolDX. JFA LCD L36255 is retired and JFA contract numbers are added to the JFB LCD so that JFA and JFB have the same MCD LCD number.

To access the Noridian Active LCDs from our website, follow the instructions below.

- Go to https://med.noridianmedicare.com/web/jfa/policies/lcd/active
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).
- On the “Active LCDs” page, locate the above listed LCD title.
  - This link will direct you to the locally hosted copy of the Active LCD. You may also view the LCD on the CMS MCD by selecting the appropriate state link on the left side of the page and locating the LCD title.
I/OCE Specifications Version 17.3 – October 2016

MLN Matters® Number: MM9754
Related Change Request (CR) #: CR 9754
Related CR Release Date: August 12, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3591CP
Implementation Date: October 3, 2016

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

What You Need to Know
Change Request (CR) 9754 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Integrated OCE that will be used under the Outpatient Prospective Payment System (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes.

The I/OCE specifications will be posted at http://www.cms.gov/OutpatientCodeEdit/. These specifications contain the appendices mentioned in the table below.

Key Changes for October 2016 I/OCE
The modifications of the I/OCE for the October 2016 release are summarized in the table below. Readers should also read through the entire document and note the highlighted sections, which also indicate changes from the prior release of the software. Some I/OCE modifications may be retroactively added to prior releases. If so, the retroactive date appears in the ‘Effective Date’ column.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/1/2016</td>
<td>1, 2, 3, 86</td>
<td>Updated diagnosis code editing for validity, age, gender, and manifestation based on the FY 2017 ICD-10-CM code revisions to the Medicare Code Editor (MCE).</td>
</tr>
<tr>
<td>10/1/2016</td>
<td>29</td>
<td>Updated the mental health diagnosis list based on the FY 2017 ICD-10-CM code revisions.</td>
</tr>
</tbody>
</table>
| 1/1/2016       | 99             | Implement new edit 99: Claim with pass-through or non-pass-through drug or biological lacks OPPS payable procedure (Return to Provider (RTP)).
Criteria: There is a pass-through drug or biological HCPCS code present on a claim without an associated OPPS procedure with Status Indicator (SI) = J1, J2, P, Q1, Q2, Q3, R, S, T, U, V.
Note: refer to special OPPS processing logic and Appendix P. |
<p>| 1/1/2016       | 98             | Revise the logic for edit 98 to remove the pass-through drugs and biologics; editing for pass-through devices remains. The revised description is “Claim with pass-through device lacks required procedure (RTP)” (refer to special OPPS processing logic and Appendix P). |</p>
<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/2016</td>
<td>95, 96, 97</td>
<td>Deactivate edits 95, 96, and 97 retroactive to the implementation date (refer to special OPPS processing logic and Appendix C for weekly Partial Hospitalization Program (PHP) processing).</td>
</tr>
<tr>
<td>10/1/2013</td>
<td>41</td>
<td>Add revenue code 953 (Chemical Dependency) to the list of valid revenue codes.</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Assign payment adjustment flag 10 (Coinsurance not applicable) for pass-through drugs and biologicals when reported with an OPPS payable procedure that is not subject to payment offset (refer to Appendix G).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the Payment Indicator assignment for pass-through (SI=G) and non-pass-through (SI=K) drugs to a value of 2 (Services not paid under OPPS; paid under fee schedule or other payment system); update the Payment Method Flag assignment to a value of 2 (refer to special OPPS processing logic, Table 7 and Appendix E).</td>
</tr>
<tr>
<td>1/1/2015</td>
<td></td>
<td>Update the conditional Ambulatory Payment Classification (APC) processing logic for STV-packaged (SI=Q1) and T-packaged (SI=Q2) codes to ignore already packaged codes from the selection of highest paying service for the day (refer to special OPPS processing logic).</td>
</tr>
<tr>
<td>1/1/2015</td>
<td></td>
<td>Correct the program logic to remove complexity-adjusted comprehensive APC values from the claim output of non-OPPS claims (OPPS flag = 2).</td>
</tr>
<tr>
<td>1/1/2015</td>
<td></td>
<td>Update the comprehensive APC exclusion list to correct the omission of certain laboratory and non-covered services (see quarterly data files).</td>
</tr>
<tr>
<td>10/1/2016</td>
<td>20, 40</td>
<td>Implement version 22.3 of the NCCI (as modified for applicable outpatient institutional providers).</td>
</tr>
<tr>
<td>10/1/2016</td>
<td></td>
<td>Make all HCPCS/APC/SI changes as specified by the Centers for Medicare &amp; Medicaid Services (CMS) (quarterly data files).</td>
</tr>
</tbody>
</table>
| 10/1/2016     |               | Updated the following lists for the release (see quarterly data files):  
|               |               | • Deductible/coinsurance not applicable (see also Appendix O)  
|               |               | • Comprehensive APC exclusions  
|               |               | • Federally Qualified Health Center (FQHC) preventive and FQHC qualifying visit code pairs (see also Appendix M)  
|               |               | • Conditional bilateral list  
|               |               | • PHP duration list  
|               |               | • Valid revenue codes |

**Additional Information**

Hospital OPSS - October 2016 Update

MLN Matters® Number: MM9768
Related Change Request (CR) #: CR 9768
Related CR Release Date: August 26, 2019
Effective Date: October 1, 2016
Related CR Transmittal #: R3602CP
Implementation Date: October 3, 2016

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) 9768 describes changes to and billing instructions for various payment policies implemented in the October 2016 OPPS update. It identifies the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, Status Indicators (SIs), and Revenue Code additions, changes, and deletions that are reflected in the October 2016 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer. Make sure that your billing staffs are aware of these changes.

Key Points of CR9768
Key changes to and billing instructions for various payment policies implemented in the July 2016 OPPS updates are as follows:

New Separately Payable Procedure Code
Effective October 1, 2016, a new HCPCS code C9744 has been created. See Table 1 below.

Table 1 – New Separately Payable Procedure Code Effective October 1, 2016

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>OPPS APC</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9744</td>
<td>Abd us w/contrast</td>
<td>Ultrasound, abdominal, with contrast</td>
<td>S</td>
<td>5571</td>
<td>10/01/2016</td>
</tr>
</tbody>
</table>

Smoking Cessation Codes
Effective September 30, 2016, HCPCS codes G0436 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and G0437 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes) are deleted. The services previously represented by HCPCS codes G0436 and G0437 should be billed under existing CPT codes 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and 99407 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes) respectively. See Table 2 below.

Table 2 – Deleted Smoking Cessation HCPCS Codes and the Existing Replacement CPT Codes


### OPPS

<table>
<thead>
<tr>
<th>Deleted HCPCS Code</th>
<th>Long Description</th>
<th>Add Date</th>
<th>Termination Date</th>
<th>Existing Replacement CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0436</td>
<td>Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes</td>
<td>01/01/2008</td>
<td>09/30/2016</td>
<td>99406</td>
</tr>
<tr>
<td>G0437</td>
<td>Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes</td>
<td>01/01/2008</td>
<td>09/30/2016</td>
<td>99407</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**

Non-therapy outpatient department services are services such as physical therapy, occupational therapy, and speech-language pathology provided during the perioperative period (of a Comprehensive APC (C-APC) procedure) without a certified therapy plan of care. These are not therapy services as described in Section 1834(k) of the Social Security Act (the Act), regardless of whether the services are delivered by therapists or other non-therapist health care workers. Therapy services are those provided by therapists under a plan of care in accordance with Section 1835(a)(2)(C) and Section 1835(a)(2)(D) of the Act and are paid for under Section 1834(k) of the Act, subject to annual therapy caps as applicable (78 FR 74867 and 79 FR 66800). Because these services are outpatient department services and not therapy services, the requirement for functional reporting under the regulations at 42 CFR 410.59(a)(4) and 42 CFR 410.60(a)(4) does not apply.

The comprehensive APC payment policy packages payment for adjunctive items, services, and procedures into the most costly primary procedures under the OPPS at the claim level. When non-therapy outpatient department services are included on the same claim as a C-APC procedure (status indicator (SI) = J1) (see 80 FR 70326) or the specific combination of services assigned to the Observation Comprehensive APC 8011 (SI = J2), these services are considered adjunctive to the primary procedure. Payment for non-therapy outpatient department services is included as a packaged part of the payment for the C-APC procedure.

Effective for claims received on or after October 1, 2016, with dates of service on or after January 1, 2015, providers may report non-therapy outpatient department services (that are similar to therapy services) that are adjunctive to a C-APC procedure (SI = J1) or the specific combination of services assigned to the Observation Comprehensive APC 8011 (SI = J2), in one of two ways:

1. Without using the therapy CPT codes and instead reporting these non-therapy services with Revenue Code 0940 (Other Therapeutic Services); or
2. Reporting non-therapy outpatient department services that are adjunctive to J1 or J2 services with the appropriate occurrence codes, CPT codes, modifiers, revenue codes and functional reporting requirements.

**Advanced Care Planning (ACP)**

Effective January 1, 2016, payment for the service described by CPT code 99497 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate) is conditionally packaged under the OPPS and is consequently assigned to a conditionally packaged payment status indicator of “Q1.” When this service is furnished with another service paid under the OPPS, payment is packaged; when it is the only service furnished, payment is made separately. CPT code 99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)) is an add-on code and therefore payment for the service described by this code is unconditionally packaged (assigned status indicator “N”) in the OPPS in accordance with 42 CFR 419.2(b)(18).
Drugs, Biologicals, and Radiopharmaceuticals

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

Payment for separately payable nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals (status indicator “K”) is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In addition, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals (status indicator “G”) is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective October 1, 2016, and drug price restatements are available in the October 2016 update of the OPPS Addendum A and Addendum B at http://www.cms.gov/HospitalOutpatientPPS/.

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 day of the quarter at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html. Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

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

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

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

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9139</td>
<td>Injection, Factor IX, albumin fusion protein (recombinant), Idelvion, 1 i.u.</td>
<td>G</td>
<td>9171</td>
</tr>
<tr>
<td>C9481</td>
<td>Injection, reslizumab, 1 mg</td>
<td>G</td>
<td>9481</td>
</tr>
<tr>
<td>C9482</td>
<td>Injection, sotalol hydrochloride, 1 mg</td>
<td>G</td>
<td>9482</td>
</tr>
<tr>
<td>C9483</td>
<td>Injection, atezolizumab, 10 mg</td>
<td>G</td>
<td>9483</td>
</tr>
</tbody>
</table>

Revised Status Indicator for Biosimilar Biological Product

On April 5, 2016, a biosimilar biological product, Inflectra®, was approved by the Food and Drug Administration (FDA).

Due to the unavailability of pricing information, Inflectra®, described by CPT code Q5102 (Injection, Infliximab, Biosimilar, 10 mg), is assigned SI= E (Not paid under OPPS or any other Medicare payment system.) Inflectra® was previously assigned SI= K (Separately paid nonpass-through drugs and biologicals, including therapeutic radiopharmaceuticals) in the July 2016 update of the OPPS. This change is effective July 1, 2016.

Below, Table 4 lists the code and the effective date for the status indicator change.

Table 4 – Drugs and Biologicals with Revised Status Indicators

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5102</td>
<td>Injection, Infliximab, Biosimilar, 10 mg</td>
<td>E</td>
<td>07/01/2016</td>
</tr>
</tbody>
</table>

Billing Guidance for the Topical Application of Mitomycin During or Following Ophthalmic Surgery
Hospital outpatient departments should only bill HCPCS code J7315 (Mitomycin, ophthalmic, 0.2 mg) or HCPCS code J7999 (Compounded drug, not otherwise classified) for the topical application of mitomycin during or following ophthalmic surgery. J7315 may be reported only if the hospital uses mitomycin with the trade name Mitosol®. Any other topical mitomycin should be reported with J7999. Hospital outpatient departments are not permitted to bill HCPCS code J9280 (Injection, mitomycin, 5 mg) for the topical application of mitomycin.

**Changes to OPPS Pricer Logic**

**ASP Fee Amounts Moves from the OPPS Pricer to the Fiscal Intermediary Shared System (FISS)**

OPPS drug pricing will now apply the ASP fee schedule amounts from the FISS standard system and not the OPPS Pricer. OPPS covered drugs with allowed payment amounts will continue to have Status Indicators “G” and “K” applied. Drugs that are listed as packaged under OPPS will continue to be packaged with this change of payment application systems.

**Outpatient Coinsurance Cap Logic as ASP Payment for Drugs Moves from the OPPS Pricer to the Fiscal Intermediary Shared System (FISS)**

Outpatient procedure coinsurance is capped to the inpatient deductible limit (IP Limit). The cap is calculated by adding the highest wage adjusted national coinsurance amount for the procedure line (identified by status indicators S, T, V, P, J1 or J2) plus the coinsurance for the blood products (identified by status indicator “R”) and comparing to the inpatient Part A deductible. The difference is the amount of coinsurance to be applied to the ASP drug lines. The coinsurance of the ASP drug lines with the same dates of service as the procedure code are added together. The coinsurance reduction percentage is calculated by dividing the amount of coinsurance to be applied to the ASP drug lines by the total coinsurance of the ASP drug lines. The coinsurance amount for each of ASP drug lines should be reduced by the multiplication of the drug line coinsurance and the coinsurance reduction percentage. The difference between the original coinsurance and the reduced coinsurance is then added to the payment. CMS’ shared system will cap the coinsurance for the drugs with status indicator G or K (except for Pass-Through drugs with a Payment Adjustment Flags (PAF) 10, or 18-20 [indicating no coinsurance applies]) that was not assigned to the IP Limit for the calendar year. Several claim examples are as follows:

**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:**
OPPS

• 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.

Example 3 of inpatient deductible capped amount with procedure, blood, and drug lines:
• 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 $800.00.
• Coinsurance on blood line is 88.00.
• $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 4 of inpatient deductible capped amount equals procedure, blood, and drug line coinsurance:
• Drug Line A has a fee of $200.00, a payment of $160.00, and coinsurance of $40.00.
• Drug Line B has a fee of $100.00, a payment of $80.00, and coinsurance of $20.00.
• Drug Line C has a fee of $50.00, a payment of $40.00 and coinsurance of $10.00.
• Drug Line D has a fee of $50.00, a payment of $40.00 and coinsurance of $10.00.
• Highest wage adjusted national coinsurance amount for a procedure line is $1,120.00.
• Coinsurance on blood line is $88.00.
• The Inpatient Part A deductible is $1,288.00 for 2016.
• $1,288.00 - $1,288.00 = $0.00 remaining coinsurance to be applied toward inpatient deductible cap.
• Drug Lines A-D coinsurance is $800.00.
• $800.00 cap remaining - $800.00 drug line(s) coinsurance = reduction to coinsurance due to inpatient deductible cap does not apply
• 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.

Example 5 of procedure and blood coinsurance equal inpatient deductible cap:
• 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 $1,200.00.
• Coinsurance on blood line is $88.00.
• The Inpatient Part A deductible is $1,288.00 for 2016.
• $1,288.00 - $1,288.00 = $0.00 remaining coinsurance to be applied toward inpatient deductible cap.
• Drug Lines A-D coinsurance is $800.00.
• $0.00 cap remaining / $800.00 drug line(s) coinsurance = 100% reduction to coinsurance due to inpatient deductible cap.
• Apply 100% reduction of the coinsurance amounts for each line and add the remaining 100% back into the payment amount.
• Drug Line A has a final payment of $2,000.00, and coinsurance of $0.00.
• Drug Line B has a final payment of $1,000.00, and coinsurance of $0.00.
• Drug Line C has a final payment of $500.00, and coinsurance of $0.00.
• Drug Line D has a final payment of $500.00, and coinsurance of $0.00.

Example 6 of part B deductible applies to drug charges prior to inpatient deductible capped amount:
• Drug Line A has a fee of $2,166.00, a deductible of $166.00, 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 deductible of $166.00, 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.

Pass-through Drug Offset Moves from the OPPS Pricer to the FISS Shared System

Outpatient Pass-Through drugs with offsets will be identified by the I/OCE payer only value codes (QR, QS, and QT) when appropriate pairings are found on the claim. Offsets will continue to be wage-adjusted prior to application and will apply to the drug line(s) payment amount. Pass-Through Drugs with are eligible for an offset continue to not have coinsurance applied whether the off-set is made or not.

Coverage Determinations

As a reminder, 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.

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

Additional Information


REIMBURSEMENT

Influenza Vaccine Payment Allowances - Annual Update for 2016-2017 Season

MLN Matters® Number: MM9758
Related Change Request (CR) #: CR 9758
Related CR Release Date: September 9, 2016
Effective Date: August 1, 2016
Related CR Transmittal #: R3611CP
Implementation Date: No later than November 1, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9758 inform MACs about the payment allowances for seasonal influenza virus vaccines. These payment allowances are updated on August 1 of each year. The Centers for Medicare & Medicaid Services (CMS) will post the payment allowances for influenza vaccines that are approved
REIMBURSEMENT

after the release of CR9758 at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html. Make sure that your billing staffs are aware that the payment allowances are being updated.

Background

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the Average Wholesale Price (AWP) as reflected in the published compendia except when the vaccine is furnished in a hospital outpatient department, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). In these instances, payment for the vaccine is based on reasonable cost.

The Medicare Part B payment allowances for the following Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes below apply for the effective dates of August 1, 2016-July 31, 2017:

- CPT 90653 Payment allowance is pending
- CPT 90655 Payment allowance is pending
- CPT 90656 Payment allowance is pending
- CPT 90657 Payment allowance is pending
- CPT 90661 Payment allowance is pending
- CPT 90685 Payment allowance is pending
- CPT 90686 Payment allowance is pending
- CPT 90687 Payment allowance is pending
- CPT 90688 Payment allowance is pending
- HCPCS Q2035 Payment allowance is pending
- HCPCS Q2036 Payment allowance is pending
- HCPCS Q2037 Payment allowance is pending
- HCPCS Q2038 Payment allowance is pending

Payment for the following CPT/HCPCS codes may be made if your MAC determines their use is reasonable and necessary for the beneficiary, for the effective dates of August 1, 2016-July 31, 2017:

- CPT 90630 Payment allowance is pending
- CPT 90654 Payment allowance is pending
- CPT 90662 Payment allowance is pending
- CPT 90672 Payment allowance is pending
- CPT 90673 Payment allowance is pending
- CPT 90674 Payment allowance is pending
- HCPCS Q2039 Flu Vaccine Adult - Not Otherwise Classified payment allowance is to be determined by your MAC with effective dates of August 1, 2016-July 31, 2017

The Centers for Medicare & Medicaid Services (CMS) will publish the approved payment allowances on the CMS Seasonal Influenza Vaccines Pricing webpage after CR9758 is released and as the information becomes available. Please note that the effective dates for these vaccines will be the date of FDA approval.

Providers should note that:

- All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- The annual Part B deductible and coinsurance amounts do not apply.
- While your MACs will not search their files either to retract payment for claims already paid or to retroactively pay claims, they will adjust claims that you bring to their attention.
Annual Clotting Factor Furnishing Fee Update 2017

MLN Matters® Number: MM9759
Related Change Request (CR) #: CR 9759
Related CR Release Date: August 26, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3607CP
Implementation Date: January 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for physicians and other providers billing Medicare Administrative Contractors (MACs) for services related to the administration of clotting factors provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9759 updates the clotting factor furnishing fee for 2017, and announces that for 2017 it is $0.209 per unit. Make sure that your billing staffs are aware of this update to the annual clotting factor furnishing fee for 2017.

Background
The Centers for Medicare and Medicaid Services (CMS) includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. The clotting factor furnishing fee is updated each calendar year based on the percentage increase in the Consumer Price Index (CPI) for medical care for the 12-month period ending with June of the previous year.

Effective for dates of service from January 1, 2017, through December 31, 2017, the clotting factor furnishing fee of $0.209 per unit is included in the published payment limit for clotting factors, and it will be added to the payment for a clotting factor when no payment limit for the clotting factor is published either on the Average Sales Price (ASP) Medicare Part B Drug Pricing File or the Not Otherwise Classified (NOC) Pricing File.

Additional Information
RHCs HCPCS Reporting Requirement and Billing Updates – Revised
MLN Matters® Number: SE1611 Revised
Effective Date: October 1, 2016
Implementation Date: October 3, 2016

This article was revised on August 2, 2016 to show in Table 1 that codes G0436 and G0437 are replaced by 99406 and 99407, respectively, on October 1, 2016. All other information remains the same.

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.

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/CPT 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>99406</td>
<td>Tobacco-use counsel 3-10 min</td>
</tr>
<tr>
<td>99407</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>
</tbody>
</table>
### RHC

<table>
<thead>
<tr>
<th>HCPCS/CPT Code</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<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>

HCPCS code G0436 and G0437 will be discontinued effective 10/1/2016. CPT codes 99406 and 99407 are the remaining codes for tobacco cessation counseling. The beneficiary copayment is waived for CPT codes 99406 and 99407.

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.

### UPDATES

**Home and Self-Dialysis Training, Retraining, and Nocturnal Hemodialysis – Updates to the 72X Type of Bill**

**MLN Matters® Number: MM9609**

**Related Change Request (CR) #: CR 9609**

**Effective Date: January 1, April 1, or July 1, 2017 as noted below.**

**Related CR Release Date: September 16, 2016**

**Related CR Transmittal #: R1715OTN**

**Implementation Date: January 3, April 3, or July 3, 2017**

**Provider Types Affected**

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

**Provider Action Needed**

Change Request (CR) 9609 implements condition code 87 that can be used on the 72X type of bill for ESRD facilities to indicate that the ESRD beneficiary is receiving a retraining treatment. CR9609 also introduces the UJ modifier to show the provision of nocturnal hemodialysis. Make sure your billing staffs are aware of these changes.

**Background**

Effective January 1, 2011, The Centers for Medicare & Medicaid Services (CMS) implemented the ESRD Prospective Payment System (PPS) based on the requirements of Section 1881(b)(14) of the Social Security
Act (the Act) as amended by Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA). The ESRD PPS provides a single per-treatment payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment.

The ESRD PPS provides a home and self-dialysis training add-on payment adjustment when the beneficiary is training for home or self-dialysis. The training add-on payment adjustment is applied to a maximum of 25 treatments for hemodialysis and 15 treatments for peritoneal dialysis. After the initial training is completed, ESRD facilities can receive the training add-on payment adjustment when ESRD beneficiaries are retraining. Currently, ESRD facilities report the 73 condition code for both training and retraining.

Nocturnal Hemodialysis - Effective January 1, 2017
Nocturnal hemodialysis is performed either at home or in a dialysis facility while the patient is sleeping. It is a longer and slower form of hemodialysis that can be >5 hours per treatment, 3 to 7 days a week.

Currently under the ESRD PPS, there is no claims processing mechanism for ESRD facilities to recognize that an ESRD beneficiary is receiving nocturnal hemodialysis. CR9609 implements the UJ modifier – services provided at night, for ESRD facilities to append on the dialysis line to indicate that the treatment furnished is nocturnal hemodialysis, that is, longer and slower hemodialysis that can be performed at home or in-facility for >5 hours per treatment, 3-7 days a week.

Home and Self-Dialysis Training Add-on Payment Adjustment - Effective April 1, 2017
There are no changes to the home and self-dialysis training policy discussed in the “Medicare Benefit Policy Manual,” Chapter 11, Section 30.2. CR9609 does implement a treatment cap for the number of training treatments furnished to ESRD beneficiaries. ESRD beneficiaries that receive training for hemodialysis should not receive more than 25 training treatments. ESRD beneficiaries that receive training for continuous cycling peritoneal dialysis and continuous ambulatory peritoneal dialysis should not receive more than 15 training treatments.

Home and Self-Dialysis Retraining - Effective July 1, 2017
There are no changes to the home and self-dialysis retraining policy discussed in the “Medicare Benefit Policy Manual,” Chapter 11, Section 30.2.E. CR9069 does implement condition code 87 (ESRD Self Care Retraining) that can be used on the 72X type of bill for ESRD facilities to indicate that the ESRD beneficiary is receiving a retraining treatment.

Additional Information

IRF Annual Update: PPS Pricer Changes for FY 2017
MLN Matters® Number: MM9669
Related Change Request (CR) #: CR 9669
Related CR Release Date: August 5, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3576CP
Implementation October 3, 2016

Provider Types Affected
This MLN Matters® Article is intended for Inpatient Rehabilitation Facilities (IRFs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
Provider Action Needed
Change Request (CR) 9669 provides updated rates used to pay IRF Prospective Payment System (PPS) claims for FY 2017. A new IRF PRICER software package will be released prior to October 1, 2016, and will contain the updated rates that are effective for claims with discharges that fall within October 1, 2016, through September 30, 2017. Make sure your billing staff is aware of these changes.

Background

Key Points
Take note of the phase out of the rural adjustment:
CMS will implement a 3 year budget neutral phase out of the rural adjustment for those IRFs that meet the definition in section 412.602 as rural in FY 2015 and became urban under the FY 2016 Core-Based Statistical Area (CBSA) designations. CMS will afford existing IRFs designated in FY 2015 as rural IRFs (pursuant to section 412.602) and re-designated as an urban facility in FY 2016 (pursuant to section 412.602) a 3 year phase out in order to mitigate the payment effect upon a rural facility that is re-designated as an urban facility (effective FY 2016) and thereby loses the rural adjustment of 1.149.

PRICER Updates: For IRF PPS FY 2017
(October 1, 2016 – September 30, 2017)

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Standard Federal rate</td>
<td>$15,708</td>
</tr>
<tr>
<td>Adjusted standard Federal rate</td>
<td>$15,399</td>
</tr>
<tr>
<td>Fixed loss amount</td>
<td>$7,984</td>
</tr>
<tr>
<td>Labor-related share</td>
<td>0.709</td>
</tr>
<tr>
<td>Non-labor related share</td>
<td>0.291</td>
</tr>
<tr>
<td>Urban national average Cost to charge Ratio (CCR)</td>
<td>0.421</td>
</tr>
<tr>
<td>Rural national average CCR</td>
<td>0.522</td>
</tr>
<tr>
<td>Low Income Patient (LIP) Adjustment</td>
<td>0.3177</td>
</tr>
<tr>
<td>Teaching Adjustment</td>
<td>1.0163</td>
</tr>
<tr>
<td>Rural Adjustment</td>
<td>1.149</td>
</tr>
</tbody>
</table>

The Social Security Act (section 1886(jj)(7)(A)(i)) requires application of a 2 percentage point reduction of the applicable market basket increase factor for IRFs that fail to comply with the quality data submission requirements. The mandated reduction will be applied in FY 2017 for IRFs that failed to comply with the data submission requirements during the data collection period January 1, 2015, through December 31, 2015. Thus, in compliance with section 1886(jj)(7)(A)(i) of the Act, CMS will apply a 2 percentage point reduction to the applicable FY 2017 market basket increase factor (1.65 percent) in calculating an adjusted FY 2017 standard payment conversion factor to apply to payments for only those IRFs that failed to comply with the data submission requirements.

Application of the 2 percentage point reduction may result in an update that is less than 0.0 for a fiscal year and in payment rates for a fiscal year being less than such payment rates for the preceding fiscal year. Also, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the FY involved.

The adjusted FY 2017 standard payment conversion factor that will be used to compute IRF PPS payment rates for any IRF that failed to meet the quality reporting requirements for the period from January 1, 2015, through December 31, 2015, will be $15,399.
RARC, CARC, MREP and PC Print Update

MLN Matters® Number: MM9695
Related Change Request (CR) #: CR 9695
Related CR Release Date: July 15, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3562CP
Implementation Date: October 3, 2016

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

Provider Action Needed
Change Request (CR) 9695 informs MACs about the changes that update the Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) lists, and CR9695 calls for an update to the Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes. If you use the MREP and/or PC Print software, be sure to obtain the latest version that is released on or before October 3, 2016.

Background
The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times a year – around March 1, July 1, and November 1.

CR9695 is a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Medicare’s Standard System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in CR9695, MACs must implement on the date specified on the WPC website at http://wpc-edi.com/Reference/

A discrepancy between the dates may arise as the WPC website is only updated 3 times a year and may not match the CMS release schedule.

Additional Information
Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule - Update from CAQH CORE

MLN Matters® Number: MM9696
Related Change Request (CR) #: CR 9696
Related CR Release Date: July 1, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3558CP
Implementation Date: October 3, 2016

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

Provider Action Needed
This article is based on Change Request (CR) 9696 which instructs MACs and Medicare’s Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule publication. These system updates reflect the Committee on Operating Rules for Information Exchange (CORE) Code Combination List for June 2016. Make sure that your billing staff is aware of these changes. In addition, if you use the PC Print or Medicare Remit Easy Print (MREP) software supplied by your MAC, be sure to obtain the updated version of that software when it is available.

Background
The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that was implemented on January 1, 2014, under the Affordable Care Act.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of HHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to Electronic Data Interchange (EDI) from paper has been slow and disappointing.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions by mandating the adoption of a set of operating rules for each of the HIPAA transactions.

CAQH CORE lists the June 2016 version on the Code Combination List website. This update includes CARC and RARC updates as posted at the Washington Publication Company (WPC) website on or about March 1, 2016. This will also include updates based on Market Based Review (MBR) that the CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them.

Medicare can use any code combination if the business scenario is not one of the 4 CORE defined business scenarios. With the 4 CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional Information

The WPC website is at http://www.wpc-edi.com/reference/.
The CAQH CORE Code Combination List is available at http://www.caqh.org/CORECodeCombinations.php.

Screening for Sexually Transmitted Infections - Editing Update - Revised

MLN Matters® Number: MM9719
Related Change Request (CR) #: CR 9719
Effective Date: For claims with dates of service on or after October 1, 2015
Related CR Release Date: September 1, 2016
Related CR Transmittal #: R1713OTN
Implementation Date: January 3, 2017

This article was revised on September 8, 2016, due to an updated Change Request (CR). The CR modified the effective date and made changes to the Background section to reflect that change. The transmittal number CR release date and link to the transmittal also changed. All other information remains the same.

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 to Medicare beneficiaries.

Provider Action Needed
CR 9719 informs MACs about the changes to certain edits that should have been written as line level denials rather than claim denials if you do not report the appropriate diagnosis code. Make sure that your billing staffs are aware of these changes.

Background
CR7610, Transmittal 2476, provided billing instructions for Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling to Prevent STIs. It was brought to Centers for Medicare & Medicaid Services (CMS) attention that 072X Type of Bill (TOB) claims containing STI codes and diagnosis V74.5 or V73.89, with dates of service on or after October 1, 2015, were incorrectly being denied. Per CR7610, current editing would deny a claim for STI services submitted with diagnosis code V74.5 or V73.89 on a TOB other than 13X, 14X, or 85X (without revenue code 096X, 097X, or 098X).

To correct these problems, CR9719 instructs the MACs to modify existing editing to deny line items on claims for STIs (HCPCS 86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87800, 87590, 87591, 87850, 86592, 86593, 86780, 87340, or 87341) containing ICD-9 code V74.5 or V73.89 (for claims with dates of service before October 1, 2015) and ICD-10 code Z11.3 or Z11.59 (with dates of service on or after October 1, 2015) when submitted on a TOB other than 13X, 14X, or 85X (without revenue code 096X, 097X, or 098X). When denying these line items, MACs will use the following messages:

- CARC170: “Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N95: “This provider type/provider specialty may not bill this service.”
- Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with a GA modifier indicating a signed Advance Beneficiary Notice (ABN) is on file).
- Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier indicating no signed ABN is on file).

CR9719 represents no change in policy. CMS is modifying existing editing to ensure correct payment for claims related to STIs.
Additional Information


IPF PPS – 2017 Update

MLN Matters® Number: MM9732
Related Change Request (CR) #: CR 9732
Related CR Release Date: August 1, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3575CP
Implementation October 3, 2016

Provider Types Affected

This MLN Matters® Article is intended for Inpatient Psychiatric Facilities (IPFs) that submit claims to Medicare Administrative Contractors (MACs) for services provided to inpatient Medicare beneficiaries and are paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS).

What You Need to Know

Change Request (CR) 9732 identifies changes required as part of the annual IPF PPS update from the FY 2017 IPF PPS Notice displayed on July 28, 2016. These changes are applicable to IPF discharges occurring from October 1, 2016, through September 30, 2017. In addition, CR9732 removes two ICD-10 PCS Electroconvulsive Therapy (ECT) codes, GZB1ZZZ and GZB3ZZZ, in accordance with Nation Coverage Determination (NCD) 160.25. Make sure your billing staffs are aware of these IPF PPS changes for FY 2017.

Background

Payments to IPFs under the IPF PPS are based on a federal per diem base rate that includes both inpatient operating and capital-related costs (including routine and ancillary services), but excludes certain pass-through costs (bad debts, and graduate medical education). The Centers for Medicare & Medicaid Services (CMS) is required to make updates to this prospective payment system annually.

CR9732 identifies changes required by the annual IPF PPS update from the IPF PPS FY 2017 Notice. These changes are applicable to IPF discharges occurring during the FY October 1, 2016, through September 30, 2017.

Key Points of CR9732

Market Basket Update

For FY 2017, CMS is using the 2012-based IPF market basket to update the IPF PPS payments (that is, the Federal per diem base rate and ECT payment per treatment). The 2012-based IPF market basket update for FY 2017 is 2.8 percent. However, this 2.8 percent is subject to two reductions required by the Social Security Act (the Act), as described below.

Section 1886(s)(2)(A)(i) of the Act (http://www.ssa.gov/OP_Home/ssact/title18/1886.htm) requires the application of an “Other Adjustment” that reduces any update to the IPF market basket update by percentages specified in Section 1886(s)(3) of the Act for Rate Year (RY) beginning in 2010 through the FY beginning in 2019. For the FY beginning in 2016 (that is, FY 2017), Section 1886(s)(3)(C) of the Act requires the reduction to be 0.2 percentage point. CMS implemented that provision in the FY 2017 IPF PPS Notice.

In addition, the Act Section 1886(s)(2)(A)(ii) requires the application of the Productivity Adjustment described in the Act (Section 1886(b)(3)(B)(xii)(II)) to the IPF PPS for the RY beginning in 2012 (that is, a RY
that coincides with a FY), and each subsequent FY. For the FY beginning in 2016 (that is, FY 2017), the reduction is 0.3 percentage point. CMS implemented that provision in the FY 2017 IPF PPS Notice.

Specifically, CMS updated the IPF PPS base rate for FY 2017 by applying the adjusted market basket update of 2.3 percent (which includes the 2012-based IPF market basket update of 2.8 percent, the required 0.2 percentage point “other adjustment” reduction to the market basket update, and the required productivity adjustment reduction of 0.3 percentage point) and the wage index budget neutrality factor of 1.0007 to the FY 2016 Federal per diem base rate of $743.73 to yield a FY 2017 Federal per diem base rate of $761.37. Similarly, applying the adjusted market basket update of 2.3 percent and the wage index budget neutrality factor of 1.0007 to the FY 2016 ECT payment per treatment of $320.19 yields an ECT payment per treatment of $327.78 for FY 2017.

IPF Quality Reporting Program (IPFQR)

Section 1886(s)(4) of the Act requires the establishment of a quality data reporting program for the IPF PPS beginning in FY 2014. CMS finalized requirements for quality reporting for IPFs in the “Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Fiscal Year 2013 Rates” Final Rule (August 31, 2012) (77 FR 53258, 53644 through 53360). Section 1886(s)(4)(A)(i) of the Act requires that, for FY 2014 and each subsequent fiscal year, the Secretary of Health and Human Services reduce any annual update to a standard Federal rate for discharges occurring during the FY by two percentage points for any IPF that does not comply with the quality data submission requirements with respect to an applicable year. Therefore, CMS applies a two percentage point reduction to the Federal per diem base rate and the ECT payment per treatment as follows:

- For IPFs that fail to submit quality reporting data under the IPFQR program, CMS applies a 0.3 percent annual update (an update consisting of 2.3 percent reduced by 2.0 percentage points) and the wage index budget neutrality factor of 1.0007 to the FY 2016 Federal per diem base rate of $743.73, yielding a Federal per diem base rate of $746.48 for FY 2017.
- Similarly, CMS applies a 0.3 percent annual update and the 1.0007 wage index budget neutrality factor to the FY 2016 ECT payment per treatment of $320.19, yielding an ECT payment per treatment of $321.38 for FY 2017.

IPF PPS Pricer Updates for FY 2017

- The Federal per diem base rate is $761.37 for IPFs complying with quality data submission requirements.
- The Federal per diem base rate is $746.48 for IPFs that do not comply with quality data submission requirements.
- The fixed dollar loss threshold amount is $10,120.00.
- The IPF PPS wage index is based on the FY 2016 pre-floor, pre-reclassified acute care hospital wage index.
- The labor-related share is 75.1 percent.
- The non-labor related share is 24.9 percent.
- The ECT payment per treatment is $327.78 for IPFs that complied with quality data submission requirements.
- The ECT payment per treatment is $321.38 for IPFs that failed to comply with quality data submission requirements.

Cost-to-Charge Ratios (CCR) for the IPF PPS FY 2017

<table>
<thead>
<tr>
<th>Cost to Charge Ratios</th>
<th>Median</th>
<th>Ceiling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>0.4455</td>
<td>1.6374</td>
</tr>
<tr>
<td>Rural</td>
<td>0.5960</td>
<td>1.9315</td>
</tr>
</tbody>
</table>

CMS is applying the national CCRs to the following situations:

- New IPFs that have not yet submitted their first Medicare cost report. For new facilities, CMS is using these national ratios until the facility’s actual CCR can be computed using the first tentatively settled or
final settled cost report, which will then be used for the subsequent cost report period.

- The IPFs whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean (that is, above the ceiling).
- Other IPFs for whom the MAC obtains inaccurate or incomplete data with which to calculate either an operating or capital CCR or both.

**IPF PPS ICD-10 CM/PCS Updates**

The adjustment factors are unchanged for the FY 2017 IPF PPS. However, CMS updated the ICD-10-CM/PCS code set as of October 1, 2016. These updates affected the ICD-10-CM/PCS codes which underlie the IPF PPS MS-DRG categories and the IPF PPS comorbidity categories. The updated FY 2017 IPF PPS comorbidity categories and code first lists are available at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/tools.html).

**FY 2017 IPF PPS Wage Index**

The FY 2017 final IPF PPS wage index is available online at: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex.html). This FY 2017 IPF PPS final wage index fully incorporates the Office of Management and Budget statistical area delineations that were adopted in the FY 2016 IPF PPS transitional wage index.

**Cost Of Living (COLA) Adjustment for the IPF PPS 2017**

<table>
<thead>
<tr>
<th>Alaska</th>
<th>Cost of Living Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Anchorage and 80-kilometer (50-mile) radius by road</td>
<td>1.23</td>
</tr>
<tr>
<td>City of Fairbanks and 80-kilometer (50-mile) radius by road</td>
<td>1.23</td>
</tr>
<tr>
<td>City of Juneau and 80-kilometer (50-mile) radius by road</td>
<td>1.23</td>
</tr>
<tr>
<td>Rest of Alaska</td>
<td>1.25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hawaii</th>
<th>Cost of Living Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>City and County of Honolulu</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Hawaii</td>
<td>1.19</td>
</tr>
<tr>
<td>County of Kauai</td>
<td>1.25</td>
</tr>
<tr>
<td>County of Maui and County of Kalawao</td>
<td>1.25</td>
</tr>
</tbody>
</table>

**Rural Adjustment**

Due to the Office of Management and Budget (OMB) Core Based Statistical Area (CBSA) changes implemented in FY 2016, several rural IPFs had their status changed to “urban” as of FY 2016. As a result, these rural IPFs were no longer eligible for the IPF PPS 17 percent rural adjustment. Rather than ending the adjustment abruptly, CMS is phasing out the adjustment for these providers over a three year period.

- In FY 2016, the adjustment for these newly-urban providers is two-thirds of 17 percent, or 11.3 percent.
- For FY 2017, the adjustment for these providers will be one-third of 17 percent, or 5.7 percent.
- No rural adjustment will be given to these providers after FY 2017.

**Additional Information**


**SNF Correct Errors and Omissions – Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04**

MLN Matters® Number: MM9748
Related Change Request (CR) #: CR 9748
Related CR Release Date: September 16, 2016
Effective Date: October 18, 2016
Related CR Transmittal #: R101GI, R227BP and R3612CP
Implementation Date: October 18, 2016

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

Provider Action Needed
Change Request (CR) 9748 revises the following Medicare manuals to correct various minor technical errors and omissions:

• “Medicare General Information, Eligibility, and Entitlement Manual”
• “Medicare Benefit Policy Manual” and
• “Medicare Claims Processing Manual”

The revisions of these manuals are intended to clarify the existing content, and no policy, processing, or system changes are anticipated.

Key Points of CR9748
CR9748 includes all revisions as attachments, and selected extracts from these attachments are as follows:

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

• Chapters 4 and 5 of this manual are revised to include references to another manual with related information and a reference to a related regulation.

“Medicare Benefit Policy Manual” Summary of Key Revisions

• In several sections, references to related material in other manuals are included.
• Language is added to refer providers to a list of exclusions from consolidated billing (CB, the SNF “bundling” requirement), which is available at http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html.
• Language is added to state that “Medicare’s post-hospital extended care benefit is not designed to provide broad coverage in SNFs of what is commonly regarded as “nursing home” care; that is, long-term, relatively low-level assistance with activities of daily living (see Chapter 16, §110 of the “Medicare Benefit Policy Manual” for a discussion of Medicare’s general coverage exclusion of “custodial” care). Rather, Congress originally enacted this benefit in order to achieve savings in Medicare expenditures on inpatient hospital stays, by creating a less expensive institutional substitute for what would otherwise be the final, convalescent portion of the hospital stay itself. Accordingly, the post-hospital extended care benefit focuses specifically on care that serves as a fairly brief and highly skilled “extension” of a beneficiary’s inpatient hospital stay. In this context, the 3-day qualifying hospital stay requirement serves to target more effectively the limited population that this benefit was originally created to cover: specifically, those beneficiaries who require a relatively intensive but also fairly brief course of SNF care as a continuation of their inpatient hospital stay.”

“Medicare Claims Processing Manual” Key Revision Summary

• In several sections, references to related material in other manuals are included.

Additional Information
The official instruction, CR9748, issued to your MAC regarding this change is available via three transmittals:

UPDATES


MPFSDB - October 2016 Quarterly Update – Revised

MLN Matters® Number: MM9749 Revised
Related Change Request (CR) #: CR 9749
Related CR Release Date: August 24, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R3595CP
Implementation Date: October 3, 2016

This article was revised on August 24, 2016, due to a revised Change Request (CR). The transmittal number, CR release date and link to the CR also changed. All other information remains unchanged.

Provider Types Affected

This MLN Matters® Article is intended for physicians, provider and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries and subject to the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed

This article is based on CR 9749, which informs you that payment files were issued to MACs based upon the Calendar Year (CY) MPFS Final Rule. This change request amends those payment files. Make sure that your billing staffs are 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. Unless otherwise stated, the changes included in the October update to the 2016 MPFSDB are effective for dates of service on and after January 1, 2016.

The key changes for the October update are the following:

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0436</td>
<td>Procedure Status = I (Effective for services on or after 10-1-2016.)</td>
</tr>
<tr>
<td>G0437</td>
<td>Procedure Status = I (Effective for services on or after 10-1-2016.)</td>
</tr>
<tr>
<td>44799</td>
<td>Procedure Status = C; Global Surgery Days = YYY</td>
</tr>
<tr>
<td>32666</td>
<td>Bilateral Indicator = 1</td>
</tr>
</tbody>
</table>

The HCPCS codes listed below have been added to the MPFSDB effective for dates of service on and after October 1, 2016. All of these new codes were communicated through other instructions. Please consult those instructions for the description and other information.

<table>
<thead>
<tr>
<th>Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0490</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
</tr>
<tr>
<td>G9679</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
</tr>
<tr>
<td>G9680</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
</tr>
<tr>
<td>G9681</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
</tr>
<tr>
<td>G9682</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
</tr>
</tbody>
</table>
UPDATES

<table>
<thead>
<tr>
<th>Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>G9683</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
</tr>
<tr>
<td>G9684</td>
<td>Procedure Status = X; there are no RVUs; all policy indicators = concept does not apply</td>
</tr>
<tr>
<td>G9685</td>
<td>Procedure Status = A; RVUs = Work 3.86, Non-Facility 1.55, Facility 1.55, MP 0.29</td>
</tr>
<tr>
<td>G9686</td>
<td>Procedure Status = A; RVUs = Work 1.50, Non-Facility 0.61, Facility 0.61, MP 0.10</td>
</tr>
</tbody>
</table>

The following payment policy indicators apply to G9685 and G9686: 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 = XXX.

New code G0498, listed below, has been added to the MPFSDB effective for dates of service on and after January 1, 2016. The Procedure Status is C and there are no RVUs. The following payment policy indicators apply to G0498: Multiple Surgery = 0, Bilateral Surgery = 0, Assistant at Surgery = 0, Co-Surgeons = 0, Team Surgeons = 0, PC/TC = 5, Physician Supervision of Diagnostic Procedures = 09, and Diagnostic Imaging Family = 99. The Global Surgery Days = YYY.

<table>
<thead>
<tr>
<th>Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0498</td>
<td>Chemo extend iv</td>
<td>Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/other outpatient setting using office/other outpatient setting pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/other outpatient setting, includes follow up office/other outpatient visit at the conclusion of the infusion</td>
</tr>
</tbody>
</table>

Additional Information

DMEPOS Fee Schedule - October 2016 Quarterly Update
MLN Matters® Number: MM9756
Related Change Request (CR) #: CR 9756
Related CR Release Date: August 26, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3598CP
Implementation: October 3, 2016

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

What You Need to Know
Change Request (CR) 9756 advises providers of fee schedule amounts for codes in effect on October 1, 2016. Make sure your billing staffs are aware of these updates.

Key Points
The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedules on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the “Medicare Claims Processing Manual,” Chapter 23, Section 60.
UPDATES

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural fee schedule amounts. ZIP codes for non-continental Metropolitan Statistical Areas (MSA) are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis as necessary.

October quarterly updates are only required for the DMEPOS Rural ZIP Code file containing Quarter 4, 2016 Rural ZIP Code changes. MACs will process claims for DMEPOS items using the Rural ZIP code file for dates of service on or after October 1, 2016.

The October 2016 DMEPOS Rural ZIP Code Public Use File (PUF), containing the rural ZIP codes effective for Quarter 4, 2016, will be available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/ for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the above PUF.

Additional Information

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule - Update from CAQH CORE

MLN Matters® Number: MM9766
Related Change Request (CR) #: CR 9766
Related CR Release Date: August 26, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3600CP
Implementation Date: January 3, 2017

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

Provider Action Needed
Change Request (CR) 9766 informs MACs of the regular update in the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule. Make sure that your billing staffs are aware of these changes.

Background
The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that was implemented on January 1, 2014, under the Patient Protection and Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating...
rules in relation to the standards.

CR9766 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about October 1, 2016. This update is based on the Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC) updates as posted at the WPC website on or about July 1, 2016. This will also include updates based on Market Based Review (MBR) that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them.


Note: Per ACA mandate all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/Group Code for a minimum set of 4 Business Scenarios. Medicare can use any code combination if the business scenario is not one of the 4 CORE defined business scenarios. With the 4 CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

**Additional Information**


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**Hepatitis B Deductible and Coinsurance and Screening Pap Smears Claims Processing Information Update**

**MLN Matters® Number:** MM9778  
**Related Change Request (CR) #:** CR 9778  
**Related CR Release Date:** September 23, 2016  
**Effective Date:** December 27, 2016  
**Related CR Transmittal #:** R3615CP  
**Implementation Date:** December 27, 2016

**Provider Types Affected**

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

**What You Need to Know**

Change Request (CR) 9778 informs MACs about the updates to language regarding coinsurance and deductible for hepatitis B in the Chapter 18, Section 10 of the “Medicare Claims Processing Manual” to show that coinsurance and deductible for hepatitis B virus vaccine are waived. This is not a change in current policy and the CR only updates the manual to show current policy. CR9778 also removes subsection D from Sections 30.8 and 30.9 of Chapter 18 of the manual, which contained incorrect claims processing instructions regarding processing claims with HCPCS code G0476, HPV screening, when submitted on a Type of Bill other than 12X, 13X, 14X, 22X, 23x, and 85X.

**Additional Information**

HPSA Bonus Payments - 2017 Annual Update

MLN Matters® Number: MM9781
Related Change Request (CR) #: CR 9781
Related CR Release Date: September 9, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3610CP
Implementation Date: January 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for physicians submitting claims to Medicare Administrative Contractors (MACs) for services provided in Health Professional Shortage Areas (HPSAs) to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9781 alerts you that the annual Health Professional Shortage Area (HPSA) bonus payment file for 2017 will be made available by the Centers for Medicare & Medicaid Services (CMS) to your MAC and will be used for HPSA bonus payments on applicable claims with dates of service on or after January 1, 2017, through December 31, 2017. You should review Physician Bonuses webpage at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses each year to determine whether you need to add modifier AQ to your claim in order to receive the bonus payment, or to see if the ZIP code in which you rendered services will automatically receive the HPSA bonus payment. Make sure that your billing staffs are aware of these changes.

Background
Section 413(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 mandated an annual update to the automated HPSA bonus payment file. CMS automated HPSA ZIP code file shall be populated using the latest designations as close as possible to November 1 of each year. The HPSA ZIP code file shall be made available to contractors in early December of each year. MACs will implement the HPSA ZIP code file and for claims with dates of service January 1 to December 31 of the following year, shall make automatic HPSA bonus payments to physicians providing eligible services in a ZIP code contained on the file.

Additional Information

Prompt Payment Interest Rate – July 2016 Update

The Treasury Department notified Noridian that the new Prompt Payment Interest Rate is 1.875% effective July 1, 2016. Claim Processing Timeliness (CPT) Interest Rate is updated on January 1 and July 1 of every year.

The Prompt Payment Interest Rate is available at https://www.fiscal.treasury.gov/fsservices/gov/pmt/promptPayment/rates.htm