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Noridian Part A Customer Service Contact and Hours of Operation

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<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interactive Voice Response (IVR)</td>
<td>877-908-8431</td>
</tr>
<tr>
<td>Provider Contact Center (PCC)</td>
<td></td>
</tr>
<tr>
<td>Provider Enrollment</td>
<td></td>
</tr>
<tr>
<td>Electronic Data Interchange Support</td>
<td></td>
</tr>
<tr>
<td>Services (EDISS)</td>
<td></td>
</tr>
<tr>
<td>User Security (including Endeavor)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>General IVR inquiries available 24/7</td>
</tr>
<tr>
<td></td>
<td>Claim-specific inquiries</td>
</tr>
<tr>
<td></td>
<td>Monday – Friday</td>
</tr>
<tr>
<td></td>
<td>8 a.m. – 4 p.m. (in respective time zones)</td>
</tr>
<tr>
<td>Text Teletype Calls (TTY)</td>
<td>877-261-4163</td>
</tr>
<tr>
<td></td>
<td>Monday – Friday</td>
</tr>
<tr>
<td></td>
<td>8 a.m. – 4 p.m. (in respective time zones)</td>
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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 those or any other claims.

Additional Information


Effective Date: January 1, 2005
Implementation Date: January 4, 2005

Telehealth Services

MLN Matters® Number: MM9428
Related Change Request (CR) #: CR 9428
Related CR Release Date: March 11, 2016
Effective Date: January 1, 2015
Related CR Transmittal #: R221BP and R3476CP
Implementation Date: April 11, 2016

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

What You Need to Know
Change Request (CR) 9428:
• Informs MACs that the list of telehealth services that were once available through the manual updates will now be displayed at http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/ on the Centers for Medicare & Medicaid Services (CMS) website.
• Adds Certified Registered Nurse Anesthetists (CRNAs) to the list of Medicare practitioners who may bill for covered telehealth services.
• Removes the telehealth language from Chapter 15, Section 270 of the “Medicare Benefit Policy Manual” and puts a reference in the text to see Chapter 12, Section 190 of the “Medicare Claims Processing Manual” for further information regarding telehealth service.

The text added to Chapter 12 of the “Medicare Claims Processing Manual” addresses the following topics:
• Payment for ESRD-Related Services as a Telehealth Service;
• Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services;
  • Payment for Diabetes Self-Management Training (DSMT) as a Telehealth Service;
  • Originating Site Facility Fee Payment Methodology; and
  • Payment Methodology for Physician/Practitioner at the Distant Site.

Several conditions must be met for Medicare to make payments for telehealth services under the Medicare Physician Fee Schedule (MPFS). The service must be on the list of Medicare telehealth services and meet all of the following additional requirements:
• The service must be furnished via an interactive telecommunications system;
• The service must be furnished by a physician or authorized practitioner;
• The service must be furnished to an eligible telehealth individual; and
• The individual receiving the service must be located in a telehealth originating site.

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

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

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

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

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

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

Additional Information
New Look and Website Address for Noridian Homepage


For those who have bookmarked the current homepage url, http://www.noridianmedicare.com/, a redirect will be provided.

We hope you enjoy the new look coming your way.
Noridian Medicare Portal Transition Dates

All Endeavor users are required to register for the Noridian Medicare portal. Important dates to know are listed below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/26/2016</td>
<td>Noridian Medicare Portal Registration Launches</td>
</tr>
<tr>
<td>3/10/2016</td>
<td>Last day for Endeavor registration/changes</td>
</tr>
<tr>
<td>2/26/2016 – 4/29/2016</td>
<td>Endeavor Users will need to register to Noridian Medicare Portal</td>
</tr>
<tr>
<td>4/29/2016</td>
<td>Final day Endeavor users will be able to be accessed</td>
</tr>
<tr>
<td>5/1/2016</td>
<td>Endeavor deactivated</td>
</tr>
</tbody>
</table>

Endeavor will be deactivated on May 1, 2016, and will no longer be available to the providers/suppliers to use. In preparation of this change, effective March 11, 2016, Noridian will no longer accept any new registrations or changes to your Endeavor registration. All registrations will need to be completed through the Noridian Medicare Portal at that time. To ensure you are able to maintain the current functionality that is utilized today for portal activity, complete the registration in Noridian Medicare Portal before April 29, 2016.

To learn more about the Noridian Medicare Portal, visit our website at https://med.noridianmedicare.com/. Select the appropriate Jurisdiction, line of business, and then navigate to “Browse by Topic” and select “Noridian Medicare Portal.”

Noridian Medicare Portal Roles

When registering for the Noridian Medicare Portal, it is important for each facility to determine who within the facility will hold the user roles. A Provider Administrator must be enrolled for the NPI/PTAN/TIN combination before any End Users or Vendor Administrators can register. The following table provides valuable information regarding each of the specific roles.

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
<th>Limit</th>
</tr>
</thead>
</table>
| Provider Administrator (PA) | • Responsible for approving and administering access for the Provider End Users and Vendor Administrators  
• Responsible for ensuring users are using the system appropriately  
• PA does not have access to functionality for portal inquiries unless requirements for dual role are met | Five PAs per TIN  
• Each PA administers only five TINs |
| Provider End User (PEU)    | • Access to functionality assigned to them by PA                             | No Limit                                  |
| Vendor Administrator (VA)  | • Responsible for approving administering access for the Vendor End Users  
• Responsible for ensuring users are using the system appropriately  
• VA does not have access to functionality for portal inquiries | Two Vendor Administrators per TIN/NPI/PTAN/Trading Partner ID Combination |
| Vendor End User (VEU)      | • Access to functionality assigned to them by VA                             | No Limit                                  |

To learn more, visit the Noridian Medicare Portal page of the Noridian website.
MLN Connects Provider eNews – January 7, 2016

In This Edition:

MLN Connects® Events
- ESRD QIP: Payment Year 2019 Final Rule Call — Register Now
- Collecting Data on Global Surgery as Required by MACRA Listening Session — Register Now
- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Register Now
- New Audio Recordings and Transcripts Available
- Stay Informed about Medicare Program Changes

Other CMS Events
- Comparative Billing Report on Home E/M Services Webinar

Medicare Learning Network® Publications and Multimedia
- FY 2017 and After Payments to Hospice Agencies That Do Not Submit Required Quality Data MLN Matters® Article — Released
- Remittance Advice Resources and FAQs Fact Sheet — New
- Medicare Overpayments Fact Sheet — Revised
- Medicare Vision Services Fact Sheet — Revised
- Screening, Brief Intervention, and Referral to Treatment Services Fact Sheet — Revised
- Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet — Revised
- Certificate of Medical Necessity Web-Based Training Course — Revised
- New Educational Web Guides Fast Fact

Announcements
- Medicare FFS Utilization and Payment Data Available for HHAs
- CMS Finalizes Rule Creating Prior Authorization Process for Certain DMEPOS Items
- CMS Quality Measure Development Plan
- Improving the Submission of Quality Data to CMS Quality Reporting Programs
- Pilot Project to Test Improving Patients’ Health by Addressing Their Social Needs
- EHR Incentive Programs: 2015 Program Year Attestation Begins January 4
- PQRS: Submission Timeframes for 2015 Data
- PQRS: Self-Nomination for 2016 Qualified Registries and QCDRs Open through January 31
- IRF Data Submission Deadline Extended to February 15
- LTCH Data Submission Deadline Extended to February 15
- LTCH QRP: FAQs and Provider Training Materials Available
- Hospice Item Set Timeliness Compliance Threshold Fact Sheet Available
- Improving the Documentation of Chiropractic Services Video

View this edition as a PDF
• Reporting the Diabetes: Hemoglobin A1c Measure for Program Year 2015
• CMS to Release a Comparative Billing Report on Domiciliary E/M Services in January
• January Quarterly Provider Update Available
• Get Your Patients Off to a Healthy Start in 2016
• Continue Seasonal Influenza Vaccination through January and Beyond

Claims, Pricers, and Codes
• Holding of 2016 Date-of-Service Claims for Services Paid Under the 2016 MPFS
• Provider Enrollment Application Fee Amount for CY 2016
• Clarification for Coding Relating to Cologuard
• January 2016 OPPS Pricer File Available
• January 2016 FQHC Pricer Files Available
• Transcatheter Mitral Valve Repair Claims Editing Incorrectly
• Pharmacogenomic Testing for Warfarin Responsiveness Claims Editing Incorrectly
• Adjustments to Correct Home Health Claim Payments

MLN Connects Provider eNews – January 14, 2016
MLN Connects® Provider eNews for January 14, 2016
View this edition as a PDF

In This Edition:

MLN Connects® Events
• ESRD QIP: Payment Year 2019 Final Rule Call — Last Chance to Register
• Collecting Data on Global Surgery as Required by MACRA Listening Session — Last Chance to Register
• IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Register Now

Medicare Learning Network® Publications and Multimedia
• Introduction to the IMPACT Act of 2014 Video — New
• Preventive Services Poster — New
• Drug Diversion: Schemes, Auditing, and Referrals Web-Based Training — New
• Medicare Parts C and D General Compliance Training Web-Based Training — New
• Combatting Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training — New
• Medicare Quarterly Provider Compliance Newsletter Educational Tool — New
• Hospice Payment System Fact Sheet — Revised
• ICD-10 Post-Implementation: Coding Basics Revisited Video — Reminder

Announcements
• Accountable Care Organization Initiatives Announced to Improve Health System Care Delivery
• Home Health Compare: Deadline to have Data Suppressed is January 25
• CMS to Release a Comparative Billing Report on Electrodiagnostic Testing in February
• Revised Two-Midnight Rule Guidelines
• PQRS Web-Based Measure Search Tool
• January is Cervical Health Awareness Month

Inpatient Hospital Payment Rate Impacted by the Consolidated Appropriations Act, 2016

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

CMS is currently revising the Inpatient Prospective Payment System (IPPS) FY 2016 Pricer to reflect the new payment calculation requirement. The amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges on or after January 1, 2016, will be based on 0 percent of the applicable Puerto Rico percentage and 100 percent of the applicable Federal percentage. In addition, the IPPS FY 2016 Pricer will include conforming changes to certain FY 2016 IPPS operating rates and factors that result from the application of the new Puerto Rico hospital payment calculation requirement, which are applicable to all IPPS hospital discharges on or after January 1, 2016. We will also incorporate the revised IPPS rates into the Long-Term Care Hospital (LTCH) Pricer, as they are used for certain LTCH claims payments.

To allow sufficient time to develop and test, we will implement the IPPS and LTCH Pricers on April 4, 2016. Medicare Administrative Contractors (MACs) will reprocess IPPS inpatient claims from Puerto Rico and all other IPPS hospitals with a discharge date on or after January 1, 2016. The MACs will also reprocess LTCH claims with a discharge date on or after January 1, 2016, due to the impact of this change. Puerto Rico hospitals (as well as all other IPPS and LTCH hospitals) do not need to take any action. We expect to reprocess claims no later than June 30, 2016.

MLN Connects Provider eNews – January 21, 2016

MLN Connects® Provider eNews for January 21, 2016

View this edition as a PDF

In This Edition:

MLN Connects® Events
• IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Register Now

Other CMS Events
• Comparative Billing Report on Domiciliary E/M Services Webinar

Medicare Learning Network® Publications and Multimedia
• PECOS FAQs Fact Sheet — Revised
• The Medicare Home Health Benefit Booklet — Revised

Announcements
• CMS Updates Open Payments Data and Improves Website
• Open Payments System Downtime from January 21 through 26
• LTCH Quality Reporting Program Data Submission Deadline: February 15
• IRF Quality Reporting Program Data Submission Deadline: February 15
• Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
• LTCH and IRF Dry Run Readmission Reports Available
• Update to IRF-PAI Training Manual V1.4
• Read More about What is Next for the EHR Incentive Programs
• Help Protect the Vision of Your Medicare Patients

Claims, Pricers, and Codes
• January 2016 OPPS Pricer File Update
MLN Connects Provider eNews – January 28, 2016
MLN Connects® Provider eNews for January 28, 2016
View this edition as a PDF

In This Edition:

MLN Connects® Events
• IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Last Chance to Register

Other CMS Events
• Special Open Door Forum: Understanding the IMPACT Act
• LTCH Quality Reporting Program Webinar
• Physician Compare Public Reporting Information Sessions

Medicare Learning Network® Publications and Multimedia
• CMS Provider Minute: Duplicate Professional Claims Video — New
• Medicare Advance Beneficiary Notices Booklet — Revised
• Skilled Nursing Facility Billing Reference Fact Sheet — Revised
• Suite of Products & Resources for Billers & Coders Educational Tool — Revised
• Suite of Products & Resources for Compliance Officers Educational Tool — Revised
• Suite of Products & Resources for Educators & Students Educational Tool — Revised
• Suite of Products & Resources for Inpatient Hospitals Educational Tool — Revised
• Updated MLN Matters® Search Indices
• New Educational Web Guides Fast Fact

Announcements
• CMS Releases Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries
• PQRS: Submission Timeframes for 2015 Data
• Comment Period for IMPACT Act Measures Extended to January 29
• PQRS: Self-Nomination for 2016 Qualified Registries and QCDRs Open through January 31
• CMS to Release a Comparative Billing Report on Modifier 25: Internal Medicine in February
• CMS Seeks Public Comments on Draft Quality Measure Development Plan by March 1
• Prior Authorization for Certain DMEPOS Items: FAQs on the Final Rule
• PEPPERs Available for SNFs, HHAs, Hospices, CAHs, LTCHs, IPFs, IRFs and PHPs
• Payment for Group 3 Power Wheelchair Cushions and Accessories
• Changes to the Medicare EHR Incentive Program Hardship Exception Process
• Testing QRDA I Release 2 and QRDA III Release 1 Files

Claims, Pricers, and Codes
• New Drug Testing Laboratory Codes Editing Incorrectly
MLN Connects Provider eNews – February 4, 2016
MLN Connects® Provider eNews for February 4, 2016
View this edition as a PDF

In This Edition:

MLN Connects® Events
• New Audio Recordings and Transcripts Available

Other CMS Events
• Medicare Quality Reporting Programs Webinar: What Eligible Providers Need to Know in 2016

Medicare Learning Network® Publications and Multimedia
• Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters® Article — Revised
• Implementation of Fingerprint-Based Background Checks MLN Matters Article — Revised
• The Medicare Home Health Benefit Web-Based Training Course — Revised
• Remittance Advice Information: An Overview Fact Sheet — Revised
• Medicare Advance Beneficiary Notices Booklet — Revised
• How to Use the Searchable Medicare Physician Fee Schedule Booklet — Revised

Announcements
• CMS Announces Proposed Improvements to Medicare Shared Savings Program
• CMS Releases Home Health Patient Experience of Care Star Ratings
• New Proposal to Give Providers and Employers Access to Information to Drive Quality and Patient Care Improvement
• Comment Period for IMPACT Act Measures Extended to February 5
• Comment Period for RFI on Reporting of Quality Measures Extended to February 16
• Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
• Register in Open Payments System to Review and Dispute 2015 Data
• 2015 PQRS Data: Submission Deadlines
• Applying for an EHR Hardship Exception: FAQs
• Temporary Moratoria Extended on Enrollment of New Home Health Agencies and Part B Ambulance Suppliers
• Stop Hepatitis C Virus Transmission in Patients Undergoing Hemodialysis
• Flu Season Begins: Severe Influenza Illness Reported
• February is American Heart Month
MLN Connects Provider eNews – February 11, 2016
MLN Connects® Provider eNews for February 11, 2016
View this edition as a PDF

In This Edition:

MLN Connects® Events
• Provider Enrollment Revalidation Call — Registration Now Open

Other CMS Events
• Physician Compare Public Reporting Information Sessions

Medicare Learning Network® Publications and Multimedia
• Telehealth Services Fact Sheet — Revised
• Ambulance Fee Schedule Fact Sheet — Revised
• Reading a Professional Remittance Advice Booklet — Reminder

Announcements
• 39 Million Medicare Beneficiaries Utilized Free Preventive Services in 2015
• Nursing Facility Initiative Annual Report
• EHR Incentive Programs: Clinical Decision Support Interventions
• EHR Incentive Programs: New Tipsheet on Eligibility for Broadband Access Exclusions
• Implementation of Section 2 of the Patient Access and Medicare Protection Act
• Influenza Activity Continues

Claims, Pricers, and Codes
• Qualifiers for ICD-10 Diagnosis Codes on Electronic Claims

FYI

MLN Connects Provider eNews – February 18, 2016
MLN Connects® Provider eNews for February 18, 2016
View this edition as a PDF

In This Edition:

MLN Connects® Events
• Provider Enrollment Revalidation Call — Register Now
• New Audio Recording and Transcript Available

Other CMS Events
• Comparative Billing Report on Electrodiagnostic Testing Webinar

Medicare Learning Network® Publications and Multimedia
• Medicare Basics Commonly Used Acronyms Educational Tool — Revised
• PECOS Technical Assistance Contact Information Fact Sheet — Reminder
• Medicare Enrollment for Physicians and Other Part B Suppliers Fact Sheet — Reminder
Announcements
- Medicare Reporting and Returning of Self-Identified Overpayments
- IMPACT Act Technical Expert Panel Call for Nominations through February 26
- Submitting Comments on MACRA Episode Groups: Deadline Extended to March 1
- 2015 PQRS EHR Submission Deadline Extended to March 11
- EHR Incentive Programs Attestation Deadline Extended to March 11
- Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
- EHR Incentive Programs: Updated FAQs Available

MLN Connects Provider eNews – February 25, 2016
MLN Connects® Provider eNews for February 25, 2016
View this edition as a PDF

In This Edition:
MLN Connects® Events
- Provider Enrollment Revalidation Call — Last Chance to Register
- Medicare Shared Savings Program Listening Session: Proposed Rule on Revised Benchmark Rebasing Methodology — New

Medicare Learning Network® Publications and Multimedia
- Guidance on the PQRS 2014 Reporting Year and 2016 Payment Adjustment for RHCs, FQHCs, and CAHs MLN Matters® Article – Released
- Ambulatory Surgical Center Fee Schedule Fact Sheet — Revised
- New Educational Web Guides Fast Fact

Announcements
- Alignment and Simplification of Quality Measures
- CMS Publishes Medicare FFS Provider and Supplier Lists
- Strengthening Provider and Supplier Enrollment Screening
- CMS Seeks Public Comments on Draft Quality Measure Development Plan by March 1
- Quality of Patient Care Star Ratings TEP: Nomination Period Open through March 18
- EHR Hardship Exception Application: New FAQ

MLN Connects Provider eNews – March 3, 2016
MLN Connects® Provider eNews for March 3, 2016
View this edition as a PDF

In This Edition:
MLN Connects® Events
- Medicare Shared Savings Program Listening Session: Proposed Rule on Revised Benchmark Rebasing Methodology — Reminder

Medicare Learning Network® Publications and Multimedia
- Provider Enrollment Revalidation: Cycle 2 MLN Matters® Article — New
- CMS Quality Conference 2015: Industry Leaders Discuss IMPACT Act Video — New
• CMS Provider Minute: Multiple Same Day Surgeries and Modifier 51 Video — New
• Home Health Prospective Payment System Booklet — Revised
• Suite of Products & Resources for Rural Health Providers Educational Tool — Revised
• DMEPOS Quality Standards Booklet — Reminder

Announcements
• Major Commitments from Healthcare Industry to Make Electronic Health Records Work Better
• Program Integrity Enhancements to the Provider Enrollment Process
• CMS to Release a Comparative Billing Report on Non-invasive Vascular Studies in March
• EHR Incentive Program Hardship Application Deadline Extended to July 1
• EHR Incentive Programs: FAQs on Public Health Reporting Requirements
• ICD-10 Next Steps Toolkit
• Antipsychotic Drug use in Nursing Homes: Trend Update
• “Savor the Flavor of Eating Right” During National Nutrition Month® and Beyond

Claims, Pricers, and Codes
• Mandatory Payment Reduction of 2% Continues until Further Notice for the Medicare FFS Program — “Sequestration”

MLN Connects Provider eNews – March 10, 2016
MLN Connects® Provider eNews for March 10, 2016
View this edition as a PDF

In This Edition:
MLN Connects® Events
• Medicare Shared Savings Program ACO: Preparing to Apply for 2017 Call — Registration Opening Soon
• IMPACT Act: Data Element Library Call — Registration Now Open
• Medicare Shared Savings Program ACO Application Process Call — Registration Opening Soon

Medicare Learning Network® Publications and Multimedia
• Videos on Medicare Quality Reporting — New
• Swing Bed Services Fact Sheet — Revised
• Rural Health Clinic Fact Sheet — Revised
• Diagnosis Coding: Using the ICD-9 Web-Based Training — Revised

Announcements
• CMS Proposes to Test New Medicare Part B Prescription Drug Models
• HHS Reaches Goal of Tying 30 Percent of Medicare Payments to Quality Ahead of Schedule
• 2016 Value Modifier Results and Upward Payment Adjustment Factor
• Open Payments System Registration for Physicians and Teaching Hospitals
• 2015 PQRS Data Submission Deadlines
• EHR Incentive Programs: Attest to 2015 Program Requirements by March 11
• Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
• Quality of Patient Care Star Ratings TEP Call for Nominations through March 18
• Home Health Agencies: Register for HHCAHPS before April 1
• Next Generation ACO Model Second Application Cycle: Letter of Intent due May 2
• New ST PEPPER Available
• Five Ways Patients Can Become Informed Medicare Consumers
• March is Colorectal Cancer Awareness Month

Claims, Pricers, and Codes
• April 2016 Average Sales Price Files Available

MLN Connects Provider eNews – March 17, 2016
MLN Connects® Provider eNews for March 17, 2016
View this edition as a PDF

In This Edition:

MLN Connects® Events
• Medicare Shared Savings Program ACO: Preparing to Apply for 2017 Call — Registration Now Open
• Open Payments 2016: Prepare to Review Reported Data Call — Registration Now Open
• IMPACT Act: Data Element Library Call — Register Now
• Medicare Shared Savings Program ACO Application Process Call — Registration Now Open
• New Audio Recording and Transcript Available

Other CMS Events
• Comparative Billing Report on Modifier 25: Internal Medicine Webinar
• Comparative Billing Report on Non-invasive Vascular Studies Webinar

Medicare Learning Network® Publications and Multimedia
• February 2016 Catalog Available
• Dual Eligible Beneficiaries Fact Sheet and MLN Matters® Article — Revised
• Health Professional Shortage Area Physician Bonus Program Fact Sheet — Revised
• SNF Consolidated Billing Web-Based Training Course — Reminder
• HIPAA EDI Standards Web-Based Training Course — Reminder
• Medicare-Required SNF PPS Assessments Educational Tool — Reminder

Announcements
• Medicare SNF Transparency Data for CY 2013
• DMEPOS Competitive Bidding Payment Amounts and Contract Offers for Round 2 Recompete and the National Mail-Order Recompete
• Eligible Professionals and Hospitals: Submitting QRDA Files in the 2016 Reporting Period
• ICD-10: Track and Improve Your Progress
• CMS Acting Administrator Andy Slavitt’s Comments at HIMSS
• HCAHPS: Measurement of the Patient Experience in Hospitals
• It Is Still Influenza Season
MLN Connects Provider eNews – March 24, 2016
MLN Connects® Provider eNews for March 24, 2016
View this edition as a PDF

In This Edition:
MLN Connects® Events
• Medicare Shared Savings Program ACO: Preparing to Apply for 2017 Call — Register Now
• Open Payments 2016: Prepare to Review Reported Data Call — Register Now
• IMPACT Act: Data Element Library Call — Register Now
• Medicare Shared Savings Program ACO Application Process Call — Register Now
• New Audio Recording and Transcript Available

Other CMS Events
• March ICD-10 Coordination and Maintenance Committee: Comments on Proposals due April 8

Medicare Learning Network® Publications and Multimedia
• Series of MLN Matters® Special Edition Articles for Chiropractors — New
• Medicare Costs at a Glance: 2016 Educational Tool — Revised
• PECOS for Physicians and Non-Physician Practitioners — Reminder
• Medicare Enrollment for Institutional Providers Fact Sheet — Reminder
• New Educational Web Guides Fast Fact

Announcements
• CMS Releases Interactive Mapping Medicare Disparities Tool
• Delivery System Reform: Making Health Care Work Better
• CMS to Release a CBR on Subsequent Nursing Facility E/M Services in April
• Next Generation ACO Model Second Application Cycle: LOI due May 2
• 2016 PQRS Educational Materials Available
• DMEPOS Suppliers: List of HCPCS Codes Affected by Section 2 of PAMPA

Claims, Pricers, and Codes
• Update to the RHC Qualifying Visit List

MLN Connects Provider eNews – March 31, 2016
MLN Connects® Provider eNews for March 31, 2016
View this edition as a PDF

In This Edition:
MLN Connects® Events
• Medicare Shared Savings Program ACO: Preparing to Apply for 2017 Call — Last Chance to Register
• Open Payments 2016: Prepare to Review Reported Data Call — Register Now
• IMPACT Act: Data Element Library Call — Register Now
• Medicare Shared Savings Program ACO Application Process Call — Register Now
• 2016 PQRS Reporting: Avoiding 2018 Negative Payment Adjustments Call — Registration Now Open
• National Partnership to Improve Dementia Care and QAPI Call — Registration Now Open
• New Video Slideshow Available

**Medicare Learning Network® Publications and Multimedia**
• Basics of Medicare Series of Web-Based Training Courses — New
• Long-Term Care Hospital Prospective Payment System Booklet — Revised
• Medicare Ambulance Transports Booklet — Revised
• Clinical Laboratory Fee Schedule Fact Sheet — Revised
• Hospital Outpatient Prospective Payment System Fact Sheet — Revised

**Announcements**
• CMS Launches New Effort to Improve Care for Nursing Facility Residents
• Advance Care Planning: New FAQs

**Claims, Pricers, and Codes**
• Modifications to HCPCS Code Set
• Medicare Payment for PAP Devices

**Noridian Medicare Portal Offers Diagnosis Codes and Pointers within Claim Status Functionality**
Effective March 24, 2016, the Noridian Medicare Portal will display all diagnoses submitted on a claim and identify which diagnosis is indicated as the primary diagnosis per line item on a claim.

When a claim or line item denies diagnosis code related (specificity, medical necessity, etc.), users will have the ability to research at a line item level. All applicable diagnosis code(s) and pointer(s) will display.

Instructions on submitting primary diagnosis codes per claim line-item are available in the CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 25.
LCD Reconsideration Requests to Include Additional ICD-10-CM Codes

Noridian has received numerous Reconsideration requests to add additional ICD-10-CM codes to the existing active Local Coverage Determinations (LCDs). The efforts made by our provider community to make certain LCDs contained the necessary diagnoses codes upon the ICD-9-CM to ICD-10-CM transition is appreciated.

As providers continue to request additions, Noridian is encouraging that a single request be submitted that contain all suggested codes for all LCDs of interest to the requesting party. This will help ensure we are able to respond to the requester and make all necessary changes at the same time.

**NOTE:** When determining if it is appropriate to request that an ICD-10-CM be added to an LCD, review the policy to confirm the code is not already included. Because most ICD-10-CM codes included within the LCDs are more specific ICD-10-CM, not otherwise classified (NOC) codes, with few exceptions, have not and will not be added to policies.

ASC X12 Healthcare Claims Acknowledgement (277CA) Flat File Update

**MLN Matters® Number:** MM9454  
**Related Change Request (CR) #:** CR 9454  
**Related CR Release Date:** February 4, 2016  
**Effective Date:** July 1, 2016  
**Related CR Transmittal #:** R1609OTN  
**Implementation Date:** July 5, 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) 9454 updates the Accredited Standards Committee (ASC) X12 Healthcare Claims Acknowledgement (277CA) flat file to allow for larger monetary amounts to meet Medicare’s needs. The 277CA amount fields are currently the same size as the size used for the input files.

**Additional Information**  
Correction to Applying Therapy Caps to Maryland Hospitals and Billing Requirement for Rehabilitation Agencies and CORFs

MLN Matters® Number: MM9489
Related Change Request (CR) #: CR 9489
Related CR Release Date: February 4, 2016
Effective Date: Dates of service on or after January 1, 2016 for Maryland hospitals; Dates of service on or after July 1, 2016, for rehabilitation agencies and CORFs
Related CR Transmittal #: R3454CP
Implementation Date: July 5, 2016

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

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

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

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

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

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

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

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

MLN Matters® Number: MM9115 Revised
Related Change Request (CR) #: CR 9115
Related CR Release Date: December 30, 2015
Effective Date: October 9, 2014
Related CR Transmittal #: R188NCD and R3319CP
Implementation Date: September 8, 2015 for non-shared MAC edits; January 4, 2016 for shared systems changes

This article was revised on January 5, 2016, to reflect the revised CR9115 issued on December 30, 2015. The CR was revised to show that HCPCS code G0464 expired on December 31, 2015, and is replaced in the 2016 Clinical Laboratory Fee Schedule with CPT code 81528. The article is revised to reflect this change. Also, the CR release date, transmittal number, and the Web address for accessing the CR are changed. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for physicians, providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs) for colorectal screening tests provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 9115 which announces effective October 9, 2014, the Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is sufficient to cover Cologuard™ – a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, aged 50 to 85 years.

CR9115 instructs the MACs that effective for claims with dates of service on or after October 9, 2014, Medicare will recognize new Healthcare Common Procedure Coding System (HCPCS) code G0464, (Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (for example, KRAS, NDRG4 and BMP3)) as a covered service. Only laboratories authorized by the manufacturer to perform the Cologuard™ test may bill for this service. Make sure that your billing staff are aware of these changes.

Background
The Social Security Act (the Act) (Sections 1861(s)(2)(R) and 1861(pp) - see http://www.ssa.gov/Oact/OP_Home/ssact/title18/1861.htm and regulations at 42 CFR 410.37 (see http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-37.pdf) authorize coverage for screening colorectal cancer (CRC) tests under Medicare Part B. The statute and regulations authorize the Secretary to add other tests and procedures (and modifications to such tests and procedures for colorectal cancer screening) as the Secretary determines appropriate in consultation with appropriate experts and organizations.

As part of the CMS – Food and Drug Administration (FDA) Parallel Review Pilot Program, CMS finalized a NCD for Screening for CRC Using Cologuard™ - A Multitarget Stool DNA Test. After considering public comments and consulting with appropriate organizations, effective October 9, 2014, CMS has determined that the evidence is sufficient to cover Cologuard™ - a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, who are ages 50 to 85 years.

Effective for claims with dates of service on or after October 9, 2014, MACs will recognize the new HCPCS code G0464 as a covered service. Be aware that claims for HCPCS code G0464 must also include ICD-9 diagnosis codes V76.41 and V76.51. Once ICD-10 is implemented, the claim must reflect ICD-10 diagnosis codes Z12.12 and Z12.11.
MACs will only pay for HCPCS code G0464 when it is submitted on Types of Bill (TOB) 13X hospital outpatient departments, 14X (hospital non-patient laboratories), or 85X (critical access hospitals. Payments will be made on TOB 13X and 14X based on the clinical laboratory fee schedule (CLFS). Payment for TOB 85X will be based on reasonable cost.

HCPCS code G0464 is in the January 1, 2015 CLFS and Integrated Outpatient Code Editor (IOCE) updates with an effective date of October 9, 2014. Therefore, MACs shall apply contractor pricing to claims containing HCPCS G0464 with dates of service October 9, 2014, through December 31, 2014. However, in the 2016 CLFS, G0464 expires effective December 31, 2015, and effective January 1, 2016, CPT code 81528 replaces G0464.

You can refer to the revised Pub. 100-03, Medicare NCD Manual, Chapter 1, Section 210.3, Colorectal Cancer Screening Tests, for coverage policy. For claims processing instructions, refer to revised Pub. 100-04, Medicare Claims Processing Manual, Chapter 18, Section 60, Colorectal Cancer Screening. Both of these revised manuals are included as attachments to CR9115.

Effective for dates of service on or after October 9, 2014, Medicare Part B will cover the Cologuard™ test once every 3 years for Medicare beneficiaries that meet all of the following criteria:

- Age 50 to 85 years;
- Asymptomatic (no signs or symptoms of colorectal disease including but not limited to lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test); and
- At average risk of developing colorectal cancer (no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease, including Crohn’s Disease and ulcerative colitis; no family history of colorectal cancers or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer).

There is no coinsurance or deductible for tests paid under the CLFS. Therefore, there is no coinsurance or deductible for HCPCS code G0464.

Medicare will pay for this service for eligible beneficiaries only once every 3 years. Next eligible dates will be displayed on all Common Working File (CWF) provider query screens. Subsequent claim lines for HCPCS code G0464 received in the same 3-year period will be denied using the following:

- Claim Adjustment Reason Code (CARC) 119 – “Benefit maximum for this time period has been reached;”
- 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 www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD;” and
- Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed Advance Beneficiary Notice (ABN) is on file.

To be eligible for this service, beneficiaries must be aged 50-85 or the claim line item will be denied with the following messages:

- CARC 6 – “The procedure/revenue code is inconsistent with the patient’s age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- RARC N129 – “Not eligible due to the patient’s age.”
- Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.
Failure to include the required ICD-9 or ICD-10 codes on the claim line will result in denial of the claim line with the following messages:

- **CARC 167** – “This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- **RARC N386** – “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp) on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- **Group Code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

Claim line items submitted on TOBs other than 13X, 14X, or 85X will be denied with the following messages:

- **CARC 170**: “Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- **RARC N95** – “This provider type/provider specialty may not bill this service.”
- **Group Code CO** assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

All other indications for colorectal cancer screening not otherwise specified in the Act and regulations, or otherwise specified in Section 210.3 of the NCD Manual, remain nationally non-covered.

**Additional Information**


**NCD for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Second Revision**

**MLN Matters® Number: MM9078 Revised**
**Related Change Request (CR) #: CR 9078**
**Related CR Release Date: December 10, 2015**
**Effective Date: August 13, 2013**
**Related CR Transmittal #: R3421CP and R187NCD**
**Implementation Date: July 6, 2015**

This article was revised on January 27, 2016, to note that the NCD for Cardiac Pacemakers, “Single Chamber and Dual Chamber Permanent Cardiac Pacemakers” (NCD20.8.3) was effective on August 13, 2013, and remains in effect. In order to address claims processing issues, the Centers for Medicare & Medicaid Services has instructed Medicare Administrative Contractors (MACs) to implement this NCD at the local level until CMS is able to revise the formal claims processing instructions. All aspects of the NCD policy in the “NCD Manual”, Section 20.8.3, remain in effect. Additionally, CMS is temporarily removing the corresponding “Medicare Claims Processing Manual”, Chapter 32, Section 320, and all but two business requirements, to avoid confusion and better clarify that the MACs will use their discretionary authority to process these claims.
Provider Types Affected
This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to MACs for single chamber and dual chamber permanent cardiac pacemaker services provided to Medicare beneficiaries.

Additional Information

Rural Health Clinics – Required Billing Updates – Third Revision
MLN Matters® Number: MM9269 Revised
Related CR Release Date: March 23, 2016
Related Transmittal #: R16370TN
Change Request (CR) #: CR 9269
Implementation Date: April 1, 2016
Effective Date: April 4, 2016

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

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

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

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

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

Provisions of the Affordable Care Act of 2010 further modified the billing requirements for RHCs. Effective January 1, 2011, Section 4104 of the Affordable Care Act waived the coinsurance and deductible for the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and other Medicare covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. In accordance with this provision, RHCs have been required to report HCPCS codes when furnishing certain preventive services since January 1, 2011.
CMS regulations require covered entities to report standard medical code sets for electronic health care transactions, although CMS program instructions have directed RHCs to submit HCPCS codes only for preventive services. Such standard medical code sets are defined as Level I and Level II of the HCPCS.

In the CY 2016 Physician Fee Schedule (PFS) proposed rule (80 FR 41943), CMS proposed that all RHCs, including RHCs exempt from electronic reporting under Section 424.32(d)(3), be required to submit HCPCS and other codes as required on claims for services furnished. The requirements for RHCs to submit HCPCS codes were finalized in the CY 2016 PFS final rule with comment period (80 FR 71088).

CR9269 Changes

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

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

Qualified preventive health services include the IPPE, the AWV, and other Medicare covered preventive services recommended by the USPSTF with a grade of A or B. For a complete list of preventive services and their coinsurance and deductible requirements, see the “RHC Preventive Services Chart” on the CMS RHC center webpage.

Beginning on April 1, 2016, RHCs are required to report the appropriate HCPCS code for each service line along with a revenue code on their Medicare claims. Services furnished through March 31, 2016, should be billed without a HCPCS code under the previous guidelines.

A RHC visit must include one of the services listed on the RHC Qualifying Visit List, which is shown below. RHC qualifying medical visits are typically Evaluation and Management (E/M) type of services or screenings for certain preventive services. RHC qualifying mental health visits are typically psychiatric diagnostic evaluation, psychotherapy, or psychoanalysis. Updates to the qualifying visit list are generally made on a quarterly basis and posted on the CMS RHC center webpage. RHCs can subscribe to the center page for email updates.

Service Level Information:

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

Billing Qualifying Visits under the HCPCS Reporting Requirement

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

NOTE: The examples listed below include form locators (FL) from the UB-04.
**Example 1: Medical Services**

RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the *RHC Qualifying Visit List*. Payment and applicable coinsurance and/or deductible shall be based upon the qualifying medical visit line. All other RHC services furnished during the encounter are also reported with the charge for the service.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>99213(^1)</td>
<td>04/01/2016</td>
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<td>AIR</td>
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<tr>
<td>0300</td>
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<td>04/01/2016</td>
<td>1</td>
<td>$3.00(^3)</td>
<td>Included in the AIR</td>
<td>No</td>
</tr>
</tbody>
</table>

\(^1\)HCPCS code from the *RHC Qualifying Visit List*  
\(^2\)Total charges for the encounter  
\(^3\)Charge for the service

**Example 2: Medical Services and Preventive Services**

If an approved preventive service is furnished with a medical visit, the RHC shall report the preventive service on an additional 052X service line with the associated charges. The qualifying medical visit line should include the total charges for the visit and payment and coinsurance will be based upon this line. All other RHC services furnished during the encounter are also reported with the charge for the service. Preventive services furnished with a medical visit are ineligible to receive an additional encounter payment at the AIR, except for the IPPE.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied</th>
</tr>
</thead>
<tbody>
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<td>052X</td>
<td>99213(^1)</td>
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</table>

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

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

**Example 3: Preventive Service Only Encounter**

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

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
<th>Payment</th>
<th>Coinsurance/Deductible Applied</th>
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</table>

\(^1\)Preventive service HCPCS code from the *RHC Qualifying Visit List*  
\(^2\)Total charges for encounter  
\(^3\)Coinsurance and deductible are waived when appropriate
Example 4: Mental Health Services

RHCs shall report one service line per mental health encounter/visit with revenue code 0900 and a qualifying mental health visit from the RHC Qualifying Visit List. The qualifying mental health visit line should include the total charges for the visit and payment and coinsurance will be based upon this line. All other RHC services furnished during the encounter are also reported with the charge for the service.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
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¹HCPCS code from the RHC Qualifying Visit List
²Total charge for the encounter
³Charge for the service

Example 5: Multiple Medical Services

RHCs shall report one service line per encounter/visit with revenue code 052X and a qualifying medical visit from the RHC Qualifying Visit List. Each additional medical service furnished should be reported with revenue code 052X. The qualifying medical visit line should include the total charges for the visit and payment and coinsurance will be based upon this line.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
<th>FL 47 Total Charges</th>
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</table>

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

Example 6: Medical Services and Incident to Services

Services and supplies furnished incident to a RHC visit are considered RHC services. They are included in the payment of a qualifying visit and are not separately payable as stand-alone services. The qualifying visit line must include the total charges for all the services provided during the encounter/visit. RHCs can report incident to services using all valid revenue codes except 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x. RHCs should report the most appropriate revenue code for the services being performed.

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL 44 HCPCS</th>
<th>FL 45 Service Date</th>
<th>FL 46 Service Units</th>
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<td>No</td>
</tr>
</tbody>
</table>

¹HCPCS code from the RHC Qualifying Visit List
²Total charge for the encounter
³Charge for the service
For any service line included in the AIR payment, the following remittance codes will be received:

- Group code CO – Contractual obligation;
- CARC 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present; and
- RARC M15 – Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

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

Encounters with more than one RHC practitioner on the same day, or multiple encounters with the same RHC practitioner on the same day, constitute a single RHC visit and is payable as one visit, except for the following circumstances:

- The patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day, (for example, a patient sees their practitioner in the morning for a medical condition and later in the day has a fall and returns to the RHC for treatment). The subsequent medical service should be billed using a qualifying visit, revenue code 052X, and modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day and that the condition being treated was not present during the visit earlier in the day. This is the only circumstance in which modifier 59 should be used.
- The patient has a qualifying medical visit and a qualifying mental health visit on the same day. The RHC shall follow the guidelines in the Billing Qualifying Visits under the HCPCS Reporting Requirement section of this article to bill for a medical and mental health visit. The qualifying medical visit line should include the total charges for the medical services and the qualifying mental health visit line should include the total charges for the mental health services.
- The patient has an IPPE and a separate medical and/or mental health visit on the same day. IPPE is a once in a lifetime benefit and is billed using HCPCS code G0402 and revenue code 052X. The beneficiary coinsurance and deductible are waived.

**Coinsurance**

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

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

**Returned Claims**

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

**Additional Information**

Physicians, Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists – Are You Ordering PAP Devices For Your Patient?

Medicare can make payment for Positive Airway Pressure (PAP) equipment and supplies when the patient’s medical record shows the patient has Obstructive Sleep Apnea and meets medical documentation, test results, and health conditions as specified in the CMS Internet-Only Manual (IOM) Publication 100-03, Section 240.4.

Medical record documentation determines whether your patient can receive the PAP equipment and supplies you have prescribed and the amount of the patient’s out of pocket expenses.

Medical record documentation must show an in-person or face-to-face interaction with your patient within six (6) months prior to prescribing the item, specifically to document the patient was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered. For the initial evaluation, the report would commonly document pertinent information such as – signs and symptoms of sleep disordered breathing including snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches; the duration of those symptoms and a validated sleep hygiene inventory, but may include other details as well. Also a pertinent physical examination assessing – e.g., body mass index, neck circumference, upper airway exam and cardiopulmonary exam. It is not necessary for all of the above to be present, however it is critical that there be detailed information that identifies symptoms commonly associated with Obstructive Sleep Apnea. Multiple treating practitioners may be involved in patient care. The practitioner conducting the face-to-face visit may be different than the ordering practitioner, however the ordering practitioner must have access to evaluate the medical record.

Your patient must have a facility-based polysomnogram or a Type II, III, or IV home sleep study after your in-person evaluation, demonstrating an Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) greater than or equal to 15 events per hour with a minimum of 30 events per hour or an AHI or RDI greater than or equal to five and less than or equal to 14 events per hour with a minimum of 10 events and documentation of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia or hypertension, ischemic heart disease or history of stroke. This sleep study must take place on the same date or after the in-person or face-to-face interaction documenting signs and symptoms of OSA.

The prescription must include a detailed description of the item(s) being ordered. The order must also include the order date, patient name, your name, National Provider Identifier (NPI), signature and signature date. You must supply this signed order and the medical record documentation of your face-to-face evaluation to the supplier before they can deliver the PAP device to your patient. Please note that while PAP accessories may be provided from a dispensing order, this must be followed up with an order containing a detailed description for each item provided to your patient.

Your medical record documentation must also show a face-to-face re-evaluation with your patient between the 31st and 91st day after initiating therapy with a notation that the patient’s symptoms of Obstructive Sleep Apnea are improving. Your medical record documentation must also demonstrate the patient is adhering to the therapy and that you have reviewed this adherence. Adherence to therapy is defined as use of the PAP greater than or equal to 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

Following this guidance will help your patients and the Medicare program by verifying that there is medical documentation to support the provision of a Positive Airway Pressure Device and allow your patient to receive the therapy needed to treat their condition. Your assistance will allow Medicare to pay claims appropriately and ensure that your patient receives the device and accessories you have prescribed.
Skilled Nursing Facility (SNF) – ID Service Specific Probe Review Notification

Noridian Healthcare Solutions (Noridian) is initiating a service specific probe review for original SNF Prospective Payment System (PPS) claims with Resource Utilization Group (RUG) level RV*. This will affect ID claims containing this RUG level. Part A Medical Review has analyzed national and local data to identify atypical billing.

View the Skilled Nursing Facility (SNF) – ID Service Specific Probe Review Notification

Skilled Nursing Facility (SNF) – MT Service Specific Targeted Review Notification

Noridian Healthcare Solutions (Noridian) is initiating a service specific targeted review for Skilled Nursing Facility (SNF) Resource Utilization Grouper (RUG) RU*. This will affect MT claims containing this original SNF Prospective Payment System (PPS) claims with Resource Utilization Group (RUG) level RU*. Part A Medical Review has identified errors in a service specific probe resulting in the initiation of this review.

View the Skilled Nursing Facility (SNF) - MT Service Specific Targeted Review Notification

Additional Documentation Request: Submit Documentation to Avoid Claim a Denial

Noridian Medical Review (MR) has identified an increase in claims denying due to missing or late submissions of requested documentation.

Although providers are encouraged to monitor their Additional Documentation Requests (ADRs), the Noridian Medical Review staff may, as workloads allow, make a courtesy call to providers with claims pending 30 days or more. This call will help providers identify claims missed during routine review of their ADRs.

Note: Whether a call is made or not, providers are required, per CMS guidelines, to submit requested documentation to Noridian within 45 days of the date of the ADR.

View more information on Additional Documentation Request (ADR) Submissions.

View more information on Reason Code 56900.

Clarification on Patient’s Reason for Visit Necessary to Capture HIPAA Compliant Fields

MLN Matters® Number: MM9450
Related Change Request (CR) #: CR 9450
Related CR Release Date: December 31, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3435CP
Implementation Date: March 31, 2016

Provider Types Affected
This MLN Matters® Article is intended for clinical diagnostic laboratories submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
What You Need to Know
In order for Medicare to process Health Insurance Portability and Accountability Act (HIPAA) compliant claim information located on the UB-04, or 837I transactions, the Centers for Medicare & Medicaid Services (CMS) needs to clarify the usage of the Patient’s Reason for Visit used for processing claims. Change Request (CR) 9450 ensures correct education and editing for institutional claims processing system fields. Make sure that your billing staffs are aware of these instructions.

Background
Institutional providers are required to submit HIPAA compliant claims, and CMS is continuing with their application of the HIPAA, V5010. The National Uniform Billing Committee (NUBC) has provided clarified direction on the Patient’s Reason for Visit Form Locator (FL) in the 2016 “Data Specifications Manual.” The Administrative Simplification provisions of HIPAA require the Secretary of HHS to adopt standard electronic transactions and code sets for administrative health care transactions. The Secretary may also modify these standards periodically.

The Patient’s Reason (FL 70a-c) is a “Situational” reported field. The requirement for reporting Patient’s Reason for Visit is restricted to the outpatient Type of Bills 013x and 085x. It is required for these TOBs for Medicare institutional claims processing when:

a. Form Locator 14 (Priority (Type) of Admission or Visit) codes 1, 2, or 5 are reported; and
b. Revenue Codes 045x, 0516, or 0762 are reported.

If the Patient’s Reason for Visit is not required, it may be reported on other 013x and 085x bill types that fail to meet the criteria in a) or b) above at the provider’s discretion when this information substantiates the medical necessity of services.

Additional Information

Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the QMB Program – Second Revision
MLN Matters® Number: SEII28 Revised
This article was revised on February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under Important Clarifications Concerning QMB Balance Billing Law on page 3. All other information is the same.

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

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

The QMB program is a State Medicaid benefit that covers Medicare deductibles, coinsurance, and copayments, subject to State payment limits. (States may limit their liability to providers for Medicare deductibles, coinsurance and copayments under certain circumstances.) Medicare providers may not balance bill QMB individuals for Medicare cost-sharing, regardless of whether the State reimburses providers for the full Medicare cost-sharing amounts. Further, all original Medicare and MA providers— not only those that accept Medicaid—must refrain from charging QMB individuals for Medicare cost-sharing. Providers who inappropriately balance bill QMB individuals are subject to sanctions.
Refer to the Background and Additional Information Sections of this article for further details and resources about this guidance. Please ensure that you and your staffs are aware of the federal balance billing law and policies regarding QMB individuals. Contact the Medicaid Agency in the States in which you practice to learn about ways to identify QMB patients in your State and procedures applicable to Medicaid reimbursement for their Medicare cost-sharing. If you are a Medicare Advantage provider, you may also contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

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

Balance Billing of QMBs Is Prohibited by Federal Law

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

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

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

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

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

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

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

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

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

- If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare Remittance Advice.

- Understand the processes you need to follow to request reimbursement for Medicare cost-sharing amounts if they are owed by your State. You may need to complete a State Provider Registration Process and be entered into the State payment system to bill the State.

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

**QMB Eligibility and Benefits**

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

**Additional Information**

For more information about dual eligible categories and benefits, please visit [http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf](http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf) on the Internet. Also, for more information about QMBs and other individuals who are dually eligible to receive Medicare and Medicaid benefits, please refer to the Medicare Learning Network® publication titled “Medicaid Coverage of Medicare Beneficiaries [Dual Eligibles],” which is available on the CMS website.
Remittance Advice Messages Update – Pub. 100-04, Medicare Claims Processing Manual, Chapters 4 and 5
MLN Matters® Number: MM9424
Related Change Request (CR) #: CR 9424
Related CR Release Date: March 4, 2016
Effective Date: June 6, 2016
Related CR Transmittal #: R3475CP
Implementation Date: June 6, 2016

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

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

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

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

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

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

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

Additional Information
HPTCs Code Set Update – April 2016

MLN Matters® Number: MM9461
Related Change Request (CR) #: CR 9461
Related CR Release Date: February 19, 2016
Effective Date: April 1, 2016
Implementation Date: As soon as April 1, 2016, but no later than July 5, 2016
Related CR Transmittal #: R3467CP

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

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

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

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

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

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

When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by the color code:
- New items are green;
- Modified items are orange; and
- Inactive items are red.

Additional Information
HCPCS Codes Used for SNF CB Enforcement – July 2016 Quarterly Update

MLN Matters® Number: MM9561
Related Change Request (CR) #: CR 9561
Related CR Release Date: March 4, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R3473CP
Implementation Date: July 5, 2016

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

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

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

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

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


CR 9561 adds HCPCS Codes 93600, 93602, 93603, 93609, 93610, 93612, 93613, 93615, 93616, 93618-93624, 93631, 93640 - 93642, 93644, 93650, 93653, 93654, 93655, 93656, 93657, 93660, and 93662 to the Major Category 1.B Coding List for SNF Consolidated Billing, effective for dates of service on or after January 1, 2016.

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

Additional Information
Screening for the HIV Infection

MLN Matters® Number: MM9403
Related Change Request (CR) #: CR 9403
Related CR Release Date: February 5, 2016
Effective Date: April 13, 2015
Related CR Transmittal #: R190NCD and R3461CP
Implementation Date: March 7, 2016 (non-shared A/B MAC edits); July 5, 2016 (CWF analysis and design); October 3, 2016 (CWF Coding, Testing, Implementation, MCS, FISS Implementation; January 3, 2017 - Requirement 9403-04.9 July 5, 2016 - For CWF and January 1, 2017, for full implementation

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

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

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


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

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

1. Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual, voluntary screening for all adolescents and adults between the ages of 15 and 65, without regard to perceived risk.
2. Except for pregnant Medicare beneficiaries addressed below, a maximum of one, annual, voluntary screening for adolescents younger than 15 and adults older than 65 who are at increased risk for HIV infection. Increased risk for HIV infection is defined as follows:

- Men who have sex with men;
- Men and women having unprotected vaginal or anal intercourse;
- Past or present injection drug users;
- Men and women who exchange sex for money or drugs, or have sex partners who do;
- Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users;
- Persons who have acquired or request testing for other sexually transmitted infectious diseases;
- Persons with a history of blood transfusions between 1978 and 1985;
- Persons who request an HIV test despite reporting no individual risk factors;
- Persons with new sexual partners; or
- Persons who, based on individualized physician interview and examination, are deemed to be at increased risk for HIV infection. The determination of “increased risk” for HIV infection is identified by the health care practitioner who assesses the patient’s history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical recommendation should be a reflection of the service provided.

3. A maximum of three voluntary HIV screenings of pregnant Medicare beneficiaries:

- When the diagnosis of pregnancy is known;
- During the third trimester; and
- At labor, if ordered by the woman’s clinician.

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

**Billing Requirements**

Effective for claims with dates of service on or after April 13, 2015, MACs will recognize new HCPCS code G0475 (HIV antigen/antibody, combination assay, screening) as a new covered service for HIV screening. HCPCS G0475 will appear in the January 1, 2017, CLFS; in the January 1, 2016, Integrated Outpatient Code Editor (IOCE); in the January 2016 Outpatient Prospective Payment System (OPPS); and in the January 1, 2016, Medicare Physician Fee Schedule (MPFS). HCPCS Code G0475 will be effective retroactive to April 13, 2015, in the IOCE and OPPS.

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

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>V22.0</td>
<td>Supervision of normal first pregnancy</td>
</tr>
<tr>
<td>V22.1</td>
<td>Supervision of other normal pregnancy</td>
</tr>
<tr>
<td>V23.9</td>
<td>Supervision of unspecified high-risk pregnancy</td>
</tr>
<tr>
<td>V69.8</td>
<td>Other problems related to lifestyle</td>
</tr>
<tr>
<td>V73.89</td>
<td>Special screening examination for other specified viral diseases</td>
</tr>
<tr>
<td>V69.2</td>
<td>High risk sexual behavior</td>
</tr>
</tbody>
</table>
**COVERAGE**

For dates of service on or after October 1, 2015, the diagnosis codes are:

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

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

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

- **Claim Adjustment Reason Code (CARC) 119**: “Benefit maximum for this time period or occurrence has been reached.”

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

- **Group Code: CO (Contractual Obligation).**

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

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

- **CARC 167** – “This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

- **RARC N386** – “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp) on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.”

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

- **CARC 6:** “The procedure/revenue code is inconsistent with the patient’s age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- **RARC N129:** “Not eligible due to the patient’s age.”
- **Group Code:** CO (Contractual Obligation).

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

- **CARC 11:** “The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”
- **RARC N386:** “This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp) on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.”
- **Group Code:** CO (Contractual Obligation).

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

**Additional Information**


**Screening for Cervical Cancer with HPV Testing – NCD 210.2.1**

**MLN Matters® Number:** MM9434

**Related Change Request (CR) #:** CR 9434

**Related CR Release Date:** February 5, 2016

**Effective Date:** July 9, 2015

**Related CR Transmittal #:** R189NCD and R3460CP

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

**Provider Types Affected**

This MLN Matters® Article is intended for physicians and other providers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
Provider Action Needed
Change Request (CR) 9434 announces that the Centers for Medicare & Medicaid Services (CMS) has determined that, effective for dates of service on or after July 9, 2015, evidence is sufficient to add Human Papillomavirus (HPV) testing under specified conditions. Make sure that your billing staffs are aware of this change.

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

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

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

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

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

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

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

In addition, you should be aware of the following:

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

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

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

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

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

- CARC 6 – “The procedure/revenue code is inconsistent with the patient’s age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;”
- RARC N129 – “Not eligible due to the patient’s age;”
- Group Code “CO” if the claim contains a GZ modifier to denote a signed Advance Beneficiary Notice (ABN) is not on file or with Group Code “PR” (Patient Responsibility) if the claim has a GA modifier to show a signed ABN is on file.

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

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

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

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

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

**Additional Information**


**MolDX: CYP Gene Evidence Analysis**

The MolDX: CYP Gene Evidence Analysis 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.

**Article Summary:** The MolDX LCD CYP2D6, CYP2C19, CYP2C9 and VKORC1 Genetic Testing limits coverage to specific populations where the evidence supports genotyping will lead to proven clinical management changes and result in improved patient outcomes. This coverage article provides a comprehensive review of CYP genotyping evidence. Each section identifies cited literature to support coverage and the reason MolDX supports the citation or the reason MolDX did not find the evidence compelling.

**Effective Date: October 15, 2015**

Read this 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 MolDX Covered Tests webpage to:

- View complete list of Noridian MolDX coverage articles
- View complete list of Noridian MolDX Local Coverage Determinations (LCDs)

**EDUCATIONAL**

**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.

| DME      | https://med.noridianmedicare.com/web/jddme/education/act |

Comprehensive Model CJR Provider Education

MLN Matters® Number: MM9533
Related Change Request (CR) #: CR 9533
Related CR Release Date: February 19, 2016
Effective Date: April 1, 2016
Implementation Date: April 4, 2016
Related CR Transmittal #: R140DEMO

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

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

Background
Section 1115A of the Social Security Act (the Act) authorizes the Centers for Medicare & Medicaid Services (CMS) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children’s Health Insurance Program beneficiaries. Under this authority, CMS published a rule to implement a new five year payment model called the Comprehensive Care for Joint Replacement (CJR) model on April 1, 2016.

Under the CJR model, acute care hospitals in certain selected geographic areas will take on quality and payment accountability for retrospectively calculated bundled payments for LEJR episodes. Episodes will begin with admission to an acute care hospital for an LEJR procedure that is paid under the Inpatient Prospective Payment System (IPPS) through Medical Severity Diagnosis-Related Group (MS-DRG) 469 (Major joint replacement or reattachment of lower extremity with MCC) or 470 (Major joint replacement or reattachment of lower extremity without MCC) and end 90 days after the date of discharge from the hospital.
Key Points of CR9533

**CJR Episodes of Care**

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

**CJR Participant Hospitals**

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

**CJR Model Beneficiary Inclusion Criteria**

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

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

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

**CJR Performance Years**

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

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

**CJR Episode Reconciliation Activities**

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

**Identifying CJR Claims**

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

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

**Waivers and Amendments of Medicare Program Rules**

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

**Post-Discharge Home Visits**

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

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

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

- Licensed clinical staff will provide the service under the general supervision of a physician or NPP.
  These staff can come from a private physician office or may be either an employee or a contractor of
  the participant hospital.
- Services will be billed under the MPFS by the supervising physician or NPP or by the hospital or other
  party to which the supervising physician has reassigned his or her billing rights.
- Up to 9 post discharge home visits can be billed and paid per beneficiary during each CJR episode,
  defined as the 90-day period following the anchor hospitalization.
- The service cannot be furnished to a CJR beneficiary who has qualified, or would qualify, for home
  health services when the visit was furnished.
- All other Medicare rules for coverage and payment of services incident to a physician’s service continue
to apply.
As described in the “Medicare Claims Processing Manual”, Chapter 12, Sections 40-40.4, Medicare policy generally does not allow for separate billing and payment for a postoperative visit furnished during the global period of a surgery when it is related to recovery from the surgery. However, for CJR, CMS will allow the surgeon or other practitioners to bill and be paid separately for a post-discharge home visit that was furnished in accordance with these conditions. All other Medicare rules for global surgery billing during the 90 day post-operative period continue to apply.

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

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

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

Billing and Payment for Telehealth Services

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

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

- Telehealth services cannot substitute for in-person home health visits for patients under a home health episode of care.
- Telehealth services performed by social workers for patients under a home health episode of care will not be covered under the CJR model.
- The telehealth geographic area waiver and the allowance of home as an originating site under the CJR model does not apply for instances where a physician or allowed NPP is performing a face-to-face encounter for the purposes of certifying patient eligibility for the Medicare home health benefit.
- The principal diagnosis code reported on the telehealth claim cannot be one that is specifically excluded from the CJR episode definition.
- If the beneficiary is at home, the physician cannot furnish any telehealth service with a descriptor that precludes delivering the service in the home (for example, a hospital visit code).
- If the physician is furnishing an evaluation and management visit via telehealth to a beneficiary at home, the visit must be billed by one of nine unique HCPCS G-codes developed for the CJR model that reflect the home setting.
• For CJR telehealth home visits billed with HCPCS codes G9484, G9485, G9488, and G9489, the physician must document in the medical record that auxiliary licensed clinical staff were available on site in the patient’s home during the visit or document the reason that such a high-level visit would not require such personnel.

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

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

The telehealth home visits will be billed under the MPFS with one of nine HCPCS G-code specific to the CJR telehealth home visits. Those codes are G9481, G9482, G9483, G9484, G9485, G9586, G9487, G9488, and G9499. Attachment A of CR9533 provides the long descriptors of these codes. The telehealth home visit HCPCS codes will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for telehealth home visits for the CJR model will be accepted only when the claim contains one of nine of the CJR specific HCPCS G-Code.

Although CMS is associating the Demonstration Code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-Code. Additional information on billing and payment for the telehealth home visit HCPCS G-Codes will be available in the April 2016 release of the MPFS Recurring Update. Future updates to the RVUs and payment for these HCPCS codes will be included in the MPFS final rules and recurring updates each year.

Additional Information

EDUCATIONAL

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.
   • 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

Provider Enrollment Revalidation – Cycle 2
MLN Matters® Number: SE1605

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

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

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

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

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

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

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

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

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

• Due dates are established based on your last successful revalidation or initial enrollment (approximately 3 years for DME suppliers and 5 years for all other providers/suppliers).
In addition, the MAC will send a revalidation notice within 2-3 months prior to your revalidation due date either by email (to email addresses reported on your prior applications) or regular mail (at least two of your reported addresses: correspondence, special payments and/or your primary practice address) indicating the provider/supplier’s due date.

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

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

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

**Large Group Coordination**

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

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

**Unsolicited Revalidation Submissions**

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

- What is an unsolicited revalidation?
  - If you are not due for revalidation in the current 6 month period, your due date will be listed as “TBD” (To Be Determined). This means that you do not yet have a due date for revalidation. **Please do not submit a revalidation application if there is NOT a listed due date.**
  - Any off-cycle or ad hoc revalidations specifically requested by CMS or the MAC are not considered unsolicited revalidations.
  - If your intention is to submit a change to your provider enrollment record, you must submit a ‘change of information’ application using the appropriate CMS-855 form.

**Submitting Your Revalidation Application**

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

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

If you are an individual who reassigns benefits to more than one group or entity, you must include all organizations to which you reassign your benefits on one revalidation application. If you have someone else completing your revalidation application for you, encourage coordination with all entities to which you reassign benefits to ensure your reassignments remain intact.
The fastest and most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to https://pecos.cms.hhs.gov/pecos/login.do.

PECOS allows you to review information currently on file and update and submit your revalidation via the Internet. Once completed, YOU MUST electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper certification statement along with all required supporting documentation to your appropriate MAC IMMEDIATELY.

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

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

Getting Access to PECOS:

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

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

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

Deactivations Due to Non-Response to Revalidation or Development Requests

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

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

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

Revalidation Timeline and Example

Providers/suppliers may use the following table/chart as a guide for the sequence of events through the revalidation progression.
<table>
<thead>
<tr>
<th>Action</th>
<th>Timeframe</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revalidation list posted</td>
<td>Approximately 6 months prior to due date</td>
<td>March 30, 2016</td>
</tr>
<tr>
<td>Issue large group notifications</td>
<td>Approximately 6 months prior to due date</td>
<td>March 30, 2016</td>
</tr>
<tr>
<td>MAC sends email/letter notification</td>
<td>75 – 90 days prior to due date</td>
<td>July 2 - 17, 2016</td>
</tr>
<tr>
<td>MAC sends letter for undeliverable emails</td>
<td>75 – 90 days prior to due date</td>
<td>July 2 - 17, 2016</td>
</tr>
<tr>
<td>Revalidation due date</td>
<td></td>
<td>September 30, 2016</td>
</tr>
<tr>
<td>Apply payment hold/issue reminder letter (group members)</td>
<td>Within 25 days after due date</td>
<td>October 25, 2016</td>
</tr>
<tr>
<td>Deactivate</td>
<td>60 – 75 days after due date</td>
<td>November 29 – December 14, 2016</td>
</tr>
</tbody>
</table>

**Application Fees**

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

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

**SUMMARY:**

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

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

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

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

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

- If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.
Additional Information
To find out whether a provider/supplier has been mailed a revalidation notice go to http://go.cms.gov/MedicareRevalidation on the CMS website.


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

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

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

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

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

Implementation of Fingerprint-Based Background Checks - Revised
MLN Matters® Number: SE1417 Revised
This article was revised on January 27, 2016, to update language in the article and to emphasize affected providers and suppliers in the Caution Section.

Provider Types Affected
This MLN Matters® Special Edition article is intended for all providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
This Special Edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to announce the implementation of fingerprint-based background checks as part of enhanced enrollment screening provisions contained in Section 6401 of the Affordable Care Act.

Fingerprint-based background checks are generally completed on individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the high risk category. A 5 percent or greater owner includes any individual that has any partnership (general or limited) in a high risk provider or supplier. Note that the high level of risk category applies to providers and suppliers who are newly enrolling Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers or Home Health Agencies (HHA). It also applies to providers and suppliers who have been elevated to the high risk category. CMS may adjust a particular provider or supplier’s screening level from “limited” to “high” or “moderate” to “high” if any of the following occur:

- CMS has imposed a payment suspension within the last 10 years;
- Has been excluded from Medicare by the OIG;
- Has had billing privileges revoked by CMS within the previous 10 years;
- Has been excluded from any Federal Health Care program;
ENROLLMENT

- Has been subject to any final adverse action, in the previous 10 years;
- Has been terminated or is otherwise precluded from billing Medicaid; or
- CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

See the Background and Additional Information Sections of this article for further details.

Background

As part of the enhanced enrollment screening provisions contained in the Affordable Care Act (see http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf), the Centers for Medicare & Medicaid Services (CMS) implemented fingerprint-based background checks. The fingerprint-based background checks will be used to detect bad actors who are attempting to enroll in the Medicare program and to remove those currently enrolled. Once fully implemented, the fingerprint-based background check will be completed on all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the high risk category. A 5 percent or greater owner includes any individual that has any partnership (general or limited) in a provider or supplier. Fingerprint-based background checks are also required for any provider or supplier who has been elevated to the high risk category for any of the following reasons:

- CMS has imposed a payment suspension within the last 10 years;
- Has been excluded from Medicare by the OIG;
- Has had billing privileges revoked by CMS within the previous 10 years;
- Has been excluded from any Federal Health Care program;
- Has been subject to any final adverse action, in the previous 10 years;
- Has been terminated or is otherwise precluded from billing Medicaid; or
- CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.


The fingerprint-based background checks will be applied to providers and suppliers in the high level of risk category, which includes newly enrolling Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, Home Health Agencies (HHA) and providers and suppliers who have been elevated to the high risk category in accordance with enrollment screening regulations.

The fingerprint-based background check implementation has been phased in beginning in 2014.

Affected providers and suppliers will receive notification of the fingerprint requirements from their MAC. The MAC will send a notification letter to the affected providers or suppliers listing all 5 percent or greater owners who are required to be fingerprinted. The notification letter will be mailed to the provider or supplier’s correspondence address and the special payments address on file with Medicare. Generally, an individual will be required to be fingerprinted only once, but CMS reserves the right to request additional fingerprints if needed.

The relevant individuals will have 30 days from the date of the notification letter to be fingerprinted. If the provider or supplier finds a discrepancy in the ownership listing, the provider or supplier should contact their MAC immediately to communicate the discrepancy and take the appropriate action to update the enrollment record to correctly reflect the ownership information.
ENROLLMENT

The notification letter will identify contact information for the Fingerprint-Based Background Check Contractor (FBBC). The relevant individual(s) are required to contact the FBBC prior to being fingerprinted to ensure the fingerprints are accurately submitted to the Federal Bureau of Investigation (FBI) and results are properly returned to CMS. Providers/suppliers may contact the FBBC by telephone or by accessing the FBBC’s website. Contact information for the FBBC will be provided in the notification letter received from the MAC. Once contacted, the FBBC will provide at least three fingerprint locations convenient to the relevant individual’s location. One of these locations will be a local, state, or federal law enforcement facility.

The relevant individuals who are required to undergo the fingerprint-based background check will incur the cost of having their fingerprints taken, and the cost may vary depending on location. **Once an individual has submitted his/her fingerprints, if that individual is subsequently required to undergo a fingerprint-based background check in accordance with 42 CFR 424.518(c), CMS will, to the extent possible, rerun the fingerprint-based background check rather than requiring resubmission of fingerprints.** You can review 42 CFR 424.518(c) at http://www.ecfr.gov/cgi-bin/text-idx?SID=f14b263d1175a355d736e9f38f3a6baf&node=42:3.0.1.11.12.5.11&rgn=div8 on the Internet.

Fingerprinting can be completed on the FD-258 form or electronically at certain locations. CMS strongly encourages all required applicants to provide electronic fingerprints, but CMS will accept the FD-258 card instead. If the FD-258 form is submitted, the FBBC will convert the paper form to electronic submission to the FBI. You can review the FD-258 form at https://www.fbi.gov/about-us/cjis/identity-history-summary-checks/fd-258-1 on the Internet.

Once the fingerprint process is complete, the fingerprints will be forwarded to the FBI for processing. Within 24 hours of receipt, the FBI will compile the background history based on the fingerprints and will share the results with the FBBC. CMS, through the FBBC, will assess the law enforcement data provided for the fingerprinted individuals. The FBBC will review each record and provide a fitness recommendation to CMS. CMS will assess the recommendation and make a final determination.

All fingerprint data will be stored according to:

- Federal requirements;
- FBI Security and Management Control Outsourcing Standards for Channelers and Non-Channelers; and
- The FBI Criminal Justice Information Services (CJIS) Security Policy.

The FBBC will maintain Federal Information Systems Management Act (FISMA) certification and comply with the FBI (CJIS) Security Policy. All data will be secured in accordance with the Privacy Act of 1974 and the FBI CJIS Security Policy.

CMS will rely on existing authority to deny enrollment applications and revoke existing Medicare billing privileges per 42 CFR §424.530(a) and §424.535(a) (http://www.ecfr.gov/cgi-bin/text-idx?SID=f14b263d1175a355d736e9f38f3a6baf&node=42:3.0.1.11.12.5.15&rgn=div8) if an individual who maintains a 5 percent or greater direct or indirect ownership interest in a provider or supplier has submitted an enrollment application that contains false or misleading information. Providers or suppliers will be notified by CMS if the assessment of the fingerprint based background check results in the denial of its enrollment application or revocation of its existing Medicare billing privileges.

**Additional Information**

If you have any questions, please contact your MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.
ESRD PPS LVPA – Eligibility Changes for 2016 – Revised

MLN Matters® Number: MM9478 Revised
Related Change Request (CR) #: CR 9478
Related CR Release Date: January 13, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R219BP
Implementation Date: January 22, 2016

This article was revised on January 13, 2016, to reflect a revised Change Request (CR) that updated the attestation due date from January 22, 2016, to December 31, 2015 (page 2 below). 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 End Stage Renal Disease (ESRD) Facilities that submit claims to Medicare Administrative Contractors (MACs) for ESRD services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on CR 9478 which provides guidance to Medicare Administrative Contractors (MACs) on the changes made to the ESRD Prospective Payment System (PPS) Low Volume Payment Adjustment (LVPA) eligibility criteria effective January 1, 2016. Make sure that your billing staff are aware of these changes.

Background
For an End Stage Renal Disease (ESRD) facility to qualify for the ESRD Prospective Payment System (PPS) Low Volume Payment Adjustment (LVPA), certain criteria must be attested to by the ESRD facility and validated by the Medicare Administrative Contractor (MAC). These qualifying criteria include:

- The ESRD facility furnished less than 4,000 dialysis treatments in each of the 3 cost reporting years preceding its payment year;
- The ESRD facility must not have opened, closed, or received a new provider number due to change in ownership in the 3 years preceding the payment year; and
- Prior to January 1, 2016, the ESRD facility must not be located within 25 road miles of another ESRD facility under common ownership.

In addition, prior to January 1, 2016, the geographic proximity criterion is only applicable to ESRD facilities that are Medicare certified on or after January 1, 2011, to furnish outpatient maintenance dialysis treatments.

CR9478 instructs that effective January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) is implementing changes to the eligibility criteria for the LVPA. CMS has:

1. Removed the grandfathering of ESRD facilities that were Medicare certified prior to January 1, 2011, and
2. Changed the geographic proximity criterion.

Specifically (for the purposes of determining the number of treatments under the definition of a low-volume facility) beginning CY 2016, the number of treatments considered furnished by any ESRD facility (regardless of when it came into existence and was Medicare certified) will be equal to

- The aggregate number of treatments actually furnished by the ESRD facility, and
- The number of treatments furnished by other ESRD facilities that are both:
  - Under common ownership with the ESRD facility in question, and
  - 5 road miles or less from the ESRD facility in question.
In order to accommodate the timing of the policy changes, CMS extended the attestation deadline for the Calendar Year (CY) 2016 LVPA attestations until December 31, 2015, to allow ESRD facilities time to:

- Assess their eligibility based on the policy changes to the LVPA for CY 2016, and if appropriate, and
- Submit an attestation. MACs will review the attestations and determine eligibility.

CR 9478 specifically updates the “Medicare Benefit Policy Manual” (Chapter 11 (End Stage Renal Disease (ESRD)), Section 60.B.1) which is included as an attachment to CR9478. As noted in the manual updates, beginning January 1, 2016, the LVPA is 23.9 percent.

**ESRD PPS 2016 Payment Adjustments for Bacterial Pneumonia and Monoclonal Gammopathy**

End Stage Renal Disease (ESRD) PPS provides an adjustment to claims that include one or more co-morbid conditions. Effective January 1, 2016, two ICD-10-CM diagnosis codes do not qualify as a co-morbidity payment adjustment.

- Bacterial Pneumonia
- Monoclonal Gammopathy


**Reorganization of Chapter 9, Medicare Claims Processing Manual**

MLN Matters® Number: MM9397
Related Change Request (CR) #: CR 9397
Related CR Release Date: December 31, 2015
Effective Date: March 31, 2016
Related CR Transmittal #: R3434CP
Implementation Date: March 31, 2016

Provider Types Affected
This MLN Matters® Article is intended for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 9397 advises you that the “Medicare Claims Processing Manual,” Chapter 9 – Rural Health Clinics/Federally Qualified Health Centers has been reorganized and updated. The revised chapter is attached to CR9397.
Background
Chapter 9 of the “Medicare Claims Processing Manual,” RHCs and FQHCs, is revised to include more comprehensive billing information. There are no new policies contained in the updated manual chapter, which covers the following information:

• Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) General Information;
• RHC and FQHC All-Inclusive Rate (AIR) Payment System;
• FQHC Prospective Payment System (PPS) Payment System;
• Deductible and Coinsurance;
• Billing and Payment for General RHC and FQHC Services;
• Data Required on the Institutional Claim Sent to Your MAC;
• General Billing and Payment Requirements for RHCs and FQHCs;
• General Billing Requirements for Preventive Services;
• Services Non-covered on RHC and FQHC Claims; and
• Frequency of Billing and Same Day Billing.

Additional Information

RHC and FQHC Update – Chapter 13 – Medicare Benefit Policy Manual – Revised
MLN Matters® Number: MM9442 Revised
Related Change Request (CR) #: CR 9442
Related CR Release Date: January 15, 2016
Effective Date: February 1, 2016
Related CR Transmittal #: R220BP
Implementation Date: February 1, 2016
This article was revised on January 18, 2016, due to an updated Change Request (CR). The CR deleted Sections 180.5 and 210.2.1 from the chapter as the information has been reorganized to Sections 190.5 and 220.3 respectively. The CR release date, transmittal number and link to the transmittal were also changed. All other information remains the same.

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

What You Need to Know
CR 9442 informs MACs that Chapter 13 of the “Medicare Benefit Policy Manual” is updated to include new information, clarification of existing policies, and editorial changes.

Background
New Information Includes:
• Section 30.1 states that a RHC can count the time of a nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM) when furnishing direct patient care in a patient’s home or another location towards the requirement that an NP, PA, or CNM be available to furnish care at least 50 percent of the time the RHC is open to provide patient care.
• Section 110.5 states that payment for chronic care management (CCM) services is authorized for RHCs and FQHCs beginning on January 1, 2016, and provides an overview of the requirements.

• Sections 220.1 and 220.3 state that lung cancer screening using low-dose computed tomography is a covered preventive service and can be billed as a stand-alone visit if it is the only service furnished on that day with a RHC or FQHC practitioner, and applicable coinsurance and deductibles are waived.

Clarifying Information Includes:

• Use of Modifier 59 (Section 40.3)
• Payment for procedures (Section 40.4)
• Description of ambulance services that are non-covered (Section 60.1)
• Description of group services that are non-covered (Section 60.1)
• Information on payment codes for FQHCs (Section 70.4)
• Cost reporting requirements (Section 80.1 and 80.2)
• Billable visits by dentists, podiatrist, optometrists, and chiropractors (Section 110.1)
• Description of mental health visits, billing for mental health visits, and payment for medication management (Section 170)
• Hepatitis C screening in RHCs and FQHCs (Sections 220.1 and 220.2).

Additional Information

Guidance on the PQRS 2014 Reporting Year and 2016 Payment Adjustment for RHCs, FQHCs, and CAHs

MLN Matters® Number: SE1606

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

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

Frequently Asked Questions - RHCs and FQHCs

Question:
If I furnish professional Medicare Part B services only at an RHC or an FQHC, are the services eligible for Physician Quality Reporting System (PQRS)?

Answer:
If you bill professional services paid under or based on the Part B Medicare Physician Fee Schedule (PFS) submitted via CMS-1500 or CMS-1450 claim form or the electronic equivalents 837P and 837I, you are considered a PQRS Eligible Professional (EP) and you are subject to PQRS analysis. Technical services, which are covered under Part B Medicare PFS, are not eligible for PQRS.

Additionally, services rendered under billing methodologies other than Part B Medicare PFS will not be included in PQRS analysis (that is, an EP who bills under an organization that is registered as a Federally Qualified Health Center [FQHC], yet he or she renders services that are not covered by the FQHC methodology).
The “2015 Physician Quality Reporting System List of Eligible Professionals” is available on the CMS website.

**Question:**

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

**Answer:**

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

**Question:**

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

**Answer:**

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

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

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

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

For additional questions, contact the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) or via [qnetsupport@hcqis.org](mailto:). The Help Desk is available from 7:00 a.m. to 7:00 p.m. Central Time, Monday through Friday.

**Frequently Asked Questions - CAHs**

**Question:**

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

**Answer:**

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

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

If you need assistance determining whether or not your provided services are included in PQRS measures, please contact the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) or via [qnetsupport@hcqis.org](mailto:). The QualityNet Help Desk is available from 7:00 a.m. to 7:00 p.m. Central Time, Monday through Friday.
Question:
I’m a CAH provider paid under Method II. Am I required to report line-item rendering NPI information?

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

Additional Information
For additional information about PQRS, visit Physician Quality Reporting System on the CMS website.


Off-Cycle Update to the IPPS – 2016 Pricer
MLN Matters® Number: MM9523
Related Change Request (CR) #: CR 9523
Related CR Release Date: February 4, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R3449CP
Implementation Date: April 4, 2016

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

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

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

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

At this time, there are no changes to the IPPS payment calculation for capital-related costs of inpatient hospital services of Puerto Rico hospitals, and the capital IPPS payment for Puerto Rico hospitals for all discharges occurring during FY 2016 continue to be based on a blend of 25 percent of the capital IPPS Puerto Rico rate and 75 percent of the capital IPPS Federal rate.
The IPPS FY 2016 Pricer will include conforming changes to certain FY 2016 IPPS operating rates and factors that result from the application of the new Puerto Rico hospital operating IPPS payment calculation requirement. These changes are applicable to all IPPS hospital discharges on or after January 1, 2016. MACs will reprocess all IPPS claims with a discharge date on or after 01/01/16 through the implementation of the revised Pricer by May 31, 2016.

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

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

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

Additional Information

Off-Cycle Update to the LTCH PPS – 2016 Pricer

MLN Matters® Number: MM9527
Related Change Request (CR) #: CR 9527
Related CR Release Date: January 29, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R3445CP
Implementation Date: April 4, 2016

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

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

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

CR9527:

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

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

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

Additional Information

Payments to Long-Term Care Hospitals That Do Not Submit Required Quality Data – This CR Rescinds and Fully Replaces CR9105

MLN Matters® Number: MM9544
Related Change Request (CR) #: CR 9544
Related CR Release Date: March 4, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R55QRI
Implementation Date: April 1, 2016

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

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

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

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

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

There is a 30-day period from the date of the notification letter for the LTCH to submit a letter requesting reconsideration and documentation to support a finding of compliance.

CMS will then review all reconsiderations received and provide a determination to the MAC typically within a period of 2 to 3 months. In its review of the LTCH documentation, CMS will determine whether evidence to support a finding of compliance has been provided by the LTCH. The determination will be made based solely on the documentation provided. If clear evidence to support a finding of compliance is not present, the 2 percentage point reduction will be upheld. If clear evidence of compliance is present, the reduction will be reversed.

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

Additional Information

I/OCE Specifications Version 17.1 – April 2016 – Revised
MLN Matters® Number: MM9553 Revised
Related Change Request (CR) #: CR 9553
Related CR Release Date: March 22, 2016
Effective Date: April 1, 2016
Related CR Transmittal #: R3483CP
Implementation Date: April 4, 2016

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

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

What You Need to Know
Change Request (CR) 9553 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications that will be used under the Outpatient Prospective Payment System (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers,
and for limited services when provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes. The I/OCE specifications will be posted at [http://www.cms.gov/OutpatientCodeEdit/](http://www.cms.gov/OutpatientCodeEdit/) on the Centers for Medicare & Medicaid Services (CMS) website. These specifications contain the appendices mentioned in the table below.

**Key Changes for April 2016 I/OCE**

The modifications of the IOCE for the April 2016 v17.1 release are summarized in the following table. Note that some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the ‘Effective Date’ column.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
</table>
| 10/1/2015      | 2, 3, 86       | Update diagnosis editing for ICD-10 diagnosis codes (see quarterly data files, Dx10Map):  
• Removes age restrictions for specific newborn and pediatric diagnosis codes that are to be used throughout the patient’s lifetime;  
• Additions and removal of age edits for specific maternity diagnosis codes;  
• Removes sex restriction for specific diagnosis codes currently restricted for female patients; and  
• Additional codes added to the list of manifestation diagnosis codes. |
<p>| 1/1/2016       |                | Implement new logic to identify pass-through drugs and biologicals present for payment offset; output each offset amount condition present with Payer Value codes QR, QS, QT and identify the pass-through drug or biological procedures for payment offset with new payment adjustment flag values (see OPPS special processing logic, Table 5, Table 7 and Appendix G) |
| 1/1/2016       |                | Implement new logic to identify terminated device intensive procedures reported with modifier 73; output the device portion amount with Payer Value code QQ and identify the device intensive procedure reported with modifier 73 with a payment adjustment flag (see OPPS special processing logic, Table 5, Table 7 and Appendix G). |
| 1/1/2016       |                | Implement new logic to identify device credit conditions for device intensive Ambulatory Payment Classifications (APCs) when Condition Code 49, 50 or 53 is present; output the device credit amount with Payer Value code QQ and identify the device intensive procedure with a payment adjustment flag (see OPPS special processing logic, Table 5, Table 7 and Appendix G). |
| 4/1/2016       | 6, 91          | Implement edit 91 for Rural Health Clinic (RHC) claims with bill type 71x to be returned if non-covered services are reported (see special processing logic for FQHC PPS claims, Appendix F (a) and Appendix M); update the description for edit 91 to include RHC. Implement edit 6 for RHC (see Appendix F (a)). |
| 1/1/2016       |                | Update the program logic for CT scan payment reduction when not meeting National Electrical Manufacturers Association (NEMA) standards to assign payment adjustment flag 14 to the multiple imaging composite APC line if CT modifier is not present but there are composite constituent codes present that do report modifier CT (see OPPS special processing logic and Appendix K). |
| 1/1/2016       | 45             | Update the logic for edit 45 to include criteria for inpatient separate procedures reported on the same claim as a comprehensive APC procedure with a Status Indicator (SI) = J1. |
| 1/1/2016       |                | Update Appendix L to include procedure codes with SI = C in the list of non-allowed procedures by SI for OPPS claims. |</p>
<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the program logic for pass-through device payment offset to not provide the offset if the primary comprehensive APC procedure (SI = J1) is not paired with a pass-through device code present on the claim (see OPPS special processing logic and Appendix L).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update Appendix E with a note for setting the Payment Method Flag to 2 for laboratory codes with SI = Q4 that result in final assignment of SI = A.</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the program logic for comprehensive APC 5881 (inpatient procedure where patient expired) to correctly exclude services designated as comprehensive APC exclusions when reported on the same day when APC 5881 is assigned.</td>
</tr>
<tr>
<td>1/1/2015</td>
<td></td>
<td>Update program logic for comprehensive APC processing to recognize modifier 50 for comprehensive APC procedures that may be eligible for complexity adjustment (see Appendix L).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the program logic for Grandfathered Tribal Federally Qualified Health Center (FQHC) claims to identify the single payable visit (payment indicator 14) for each day if the claim contains multiple days (see Appendix M).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the program logic for Grandfathered Tribal FQHC claims to assign the composite adjustment flag only for the single payable visit for the day (see Appendix M).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Modify the output of the Payer Value Code and Amount field to pass blanks for the Value Code label (QN-QW) and zero-fill the Amount portion of the field if conditions for payment offset are not present on the claim (see Table 5 of the I/OCE specifications). Note: If conditions for edit 24 (Date out of OCE range) are present, Payer Value Code and Amount is blank (no zero-fill).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Add the following new Payer Value Codes to the field output (see Table 5): • QP: Placeholder reserved for future use • QQ: Terminated procedure with pass-through device OR condition for device credit present • QR: First APC pass-through drug or biological offset • QS: Second APC pass-through drug or biological offset • QT: Third APC pass-through drug or biological offset Revise the following Payer Value Code descriptions: • QN: First APC device offset • QO: Second APC device offset</td>
</tr>
<tr>
<td>Effective Date</td>
<td>Edits Affected</td>
<td>Modification</td>
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</table>
| 1/1/2016      | Add the following new Payment Adjustment Flag values (see Table 7 and Appendix G):  
• 15: Placeholder reserved for future use  
• 16: Terminated procedure with pass-through device  
• 17: Condition for device credit present  
• 18: Offset for first pass-through drug or biological  
• 19: Offset for second pass-through drug or biological  
• 20: Offset for third pass-through drug or biological  
Revise the following Payment Adjustment Flag descriptions:  
• 12: Offset for first device pass-through  
• 13: Offset for second device pass-through |
| 1/1/2016      | Correction of the issue with the interactive PC IOCE product that caused claims to not complete processing to the output report when the pass-through device offset amount was greater than $999.99. |
| 1/1/2016      | The following clarifying information is added (no change to software program logic):  
• Direct Referral logic to include J1 procedures (page 46) with the SI = T criteria  
• Critical Care packaged ancillary codes (page 11): update SI values for codes subject to modifier 59 exception.  
• Conditionally packaged laboratory codes (page 12): laboratory codes that are always packaged with SI = N, and removal of SI J1 and J2 (comprehensive APCs) from list of OPPS services by SI under which laboratory codes with SI = Q4 are changed to SI = A for claims with bill type 13x. |
| 11/24/2015    | 67  
Add mid-quarter editing for Food and Drug Administration (FDA) approval of code 90653 (SI changed to L). |
| 4/13/2015     | 68  
Add mid-quarter editing for NCD effective date for code G0475. |
| 4/1/2016      | Update the following procedure lists for the release (see quarterly data files):  
Procedures not recognized under OPPS (SI=B)  
Conditionally packaged laboratory services (SI=Q4)  
FQHC non-covered services  
Device offset pairs  
Device list (edit 92)  
Comprehensive APC exclusions  
New pass-through drug and biological/APC offset  
New device intensive procedures for terminated procedure and device credit (Value Code QQ) |
| 4/1/2016      | Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files). |
| 04/01/2016    | 20, 40  
Implement version 22.1 of the NCCI (as modified for applicable outpatient institutional providers). |

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

IPPS and LTCH PPS Changes for 2016 - Revised
MLN Matters® Number: MM9253
Related CR Release Date: December 29, 2015
Related Transmittal #: R3431CP
Change Request (CR) #: CR 9253
Implementation Date: October 1, 2015
Effective Date: October 5, 2015

This article was revised on December 30, 2015, to reflect a revised Change Request (CR). That CR added CardioMEMSTM HF Monitoring System to the list of items approved for a New Technology Add-On Payment (page 5 below) and to renumber the list. In the article the transmittal number, CR release date and link to the transmittal was also changed. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for hospitals that submit claims to Medicare Administrative Contractors (MACs) for acute care and long-term care hospital services provided to Medicare beneficiaries.

Provider Action Needed
Policy changes for FY 2016 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS will cover services effective for hospital discharges occurring on or after October 1, 2015, through September 30, 2016, unless otherwise noted. Not adhering to these new policies could affect payment of Medicare claims.

New IPPS and LTCH PPS Pricer software packages will be released prior to October 1, 2015, that will include updated rates that are effective for claims with discharges occurring on or after October 1, 2015, through September 30, 2016. The new revised Pricer program will be installed in a timely manner to ensure accurate payments for IPPS and LTCH PPS claims. Make sure that your billing staffs are aware of these IPPS and LTCH PPS changes for FY 2016.

Background
The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a PPS for Medicare payment of inpatient hospital services. In addition, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002. The Centers for Medicare & Medicaid Services (CMS) is required to make updates to these prospective payment systems annually. Change Request (CR) 9253 outlines those changes for FY 2016.

The following policy changes for FY 2016 were displayed in the Federal Register on July 31, 2015, with a publication date of August 17, 2015. CR9253 is effective for hospital discharges occurring on or after October 1, 2015, through September 30, 2016, unless otherwise noted.
**IPPS FY 2016 Update**

**A. FY 2016 IPPS Rates and Factors**

The FY2016 IPPS rates and factors and operating rates are in the following tables:

**Table – FY 2016 IPPS Rates and Factors**

| Standardized Amount Applicable Percentage Increase | • 1.017 if Quality = ‘1’ and EHR = ‘blank’ in PSF; or  
| • 1.011 if Quality = ‘0’ and EHR = ‘blank’ in PSF; or  
| • 1.005 if Quality = ‘1’ and EHR = ‘Y’ in PSF; or  
| • 0.999 if Quality = ‘0’ and EHR = ‘Y’ in PSF |
| Common Fixed Loss Cost Outlier Threshold | $22,539 |
| Federal Capital Rate | $438.75 |
| Puerto Rico Capital Rate | $212.55 |

**Operating Rates for Wage Index > 1**

**Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.7 Percent)**

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<thead>
<tr>
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<tr>
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**Hospital did NOT submit Quality Data and is a Meaningful EHR User (Update = 1.1 Percent)**

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**Hospital Submitted Quality Data and is NOT Meaningful EHR User (Update = 0.5 Percent)**

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**Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.1 Percent)**

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**Operating Rates for Wage Index < 1**

**Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.7 Percent)**

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### Hospital did NOT submit Quality Data and is a Meaningful EHR User (Update = 1.1 Percent)

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### Hospital Submitted Quality Data and is NOT Meaningful EHR User (Update = 0.5 Percent)

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### Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.1 Percent)

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<td>$992.09</td>
</tr>
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</table>

### B. PRICER Logic Changes

Pricer now applies the rural floor wage index policy to the Puerto Rico specific wage index for Puerto Rico providers. It compares each Puerto Rico provider’s Puerto Rico specific Core Based Statistical Area (CBSA) wage index to the rural Puerto Rico CBSA (“4*”) wage index. If the rural Puerto Rico specific wage index is higher than the provider’s Puerto Rico specific CBSA wage index, Pricer uses the rural Puerto Rico specific wage index for the provider.

### C. MS-DRG Grouper and Medicare Code Editor (MCE) Changes

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed the new ICD-10 MS-DRG Grouper, Version 33.0, software package effective for discharges on or after October 1, 2015. The GROUPEP assigns each case into a MS-DRG on the basis of the reported diagnosis and procedure codes and demographic information (that is, age, sex, and discharge status). The ICD-10 MCE Version 33.0, which is also developed by 3M-HIS, uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after October 1, 2015.

For discharges occurring on or after October 1, 2015, the Fiscal Intermediary Standard System (FISS) calls the appropriate GROUPEP based on discharge date. For discharges occurring on or after October 1, 2015, the MCE selects the proper internal code edit tables based on discharge date.

CMS created the following new MS-DRGs:
- MS-DRG 268 (Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC)
- MS-DRG 269 (Aortic and Heart Assist Procedures Except Pulsation Balloon without MCC)
- MS-DRG 270 (Other Major Cardiovascular Procedures with MCC)
- MS-DRG 271 (Other Major Cardiovascular Procedures with CC)
- MS-DRG 272 (Other Major Cardiovascular Procedures without CC/MCC)
- MS-DRG 273 (Percutaneous Intracardiac Procedures with MCC) and
- MS-DRG 274 (Percutaneous Intracardiac Procedures without MCC).

CMS deleted the following MS-DRGs:
- MS-DRG 237 (Major Cardiovascular Procedures with MCC) and
- MS-DRG 238 (Major Cardiovascular Procedures without MCC).
D. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2016 have been evaluated against the general post-acute care transfer policy criteria using the FY 2014 MedPAR data according to the regulations under Section 412.4 (c). As a result of this review the following MS-DRGs will be added to the list of MS-DRGs subject to the post-acute care transfer policy and special payment policy:

- 273 and 274 (Percutaneous Intracardiac Procedures with and without MCC, respectively)

See corrected Table 5 of the [FY 2016 IPPS/LTCH PPS Final Rule](#) and subsequent correction notice for a listing of all Post-acute and Special Post-acute MS-DRGs. Then click on the link on the left side of the screen titled, “FY 2016 IPPS Final Rule Home Page” or “Acute Inpatient Files for Download”.

E. New Technology Add-On

The following items will continue to be eligible for new-technology add-on payments in FY 2016:

1. Name of Approved New Technology: Argus
   - Maximum Add on Payment: $72,028.75;
   - MACs will identify and make new technology add-on payments with ICD-10-PCS procedure code 08H005Z or 08H105Z.

2. Name of Approved New Technology: Kcentra
   - Maximum Add on Payment: $1,587.50;
   - MACs will identify and make new technology add-on payments with ICD-10-PCS procedure code 30283B1;
   - MACs will not make this payment if one of the following diagnosis codes are on the bill: D66, D67, D68.1, D68.2, D68.0, D68.311, D68.312, D68.318, D68.32, and D68.4.

3. Name of Approved New Technology: CardioMEMS™ HF Monitoring System
   - Maximum Add on Payment: $8,875
   - Identify and make new technology add-on payments with ICD-10-PCS procedure code 02HQ30Z or 02HR30Z

4. Name of Approved New Technology: MitraClip® System
   - Maximum Add on Payment: $15,000;
   - MACs will identify and make new technology add-on payments with ICD-10-PCS procedure code 02UG3JZ.

5. Name of Approved New Technology: RNS® System
   - Maximum Add on Payment: $18,475;
   - MACs will identify and make new technology add-on payments with ICD-10-PCS procedure code 0NH00NZ in combination with 00H00MZ

Following are the items that are eligible for new-technology add-on payments in FY 2016:

1. Name of Approved New Technology: Blinatumomab (BLINCYTO™)
   - Maximum Add on Payment: $27,017.85;
   - MACs will identify and make new technology add-on payments with ICD 10 PCS procedure code XW03351 or XW04351.

2. Name of Approved New Technology: LUTONIX® Drug Coated Balloon (DCB) Percutaneous Transluminal Angioplasty (PTA) and IN.PACT™Admiral™ Paclixel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter
   - Maximum Add on Payment: $1,035.72;
   - MACs will identify and make new technology add-on payments with any of the following ICD-10-PCS procedure codes: 047K041, 047K0D1, 047K0Z1, 047K341, 047K3D1, 047K3Z1, 047K441,
F. Cost of Living Adjustment (COLA) Update for IPPS PPS

The IPPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2016, and are the same COLAs established for FY 2014. For reference, a table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2014, can be found in the FY 2016 IPPS/LTCH PPS final rule and is also displayed in Table 2 in Attachment 1 of CR9253.

G. FY 2016 Wage Index Changes and Issues

1. New Wage Index Labor Market Areas and Transitional Wage Indexes

Effective October 1, 2014, CMS revised the labor market areas used for the wage index based on the most recent labor market area delineations issued by the Office of Management and Budget (OMB) using 2010 Census data.

In order to mitigate potential negative payment impacts due to the adoption of the new OMB delineations, CMS adopted a one-year transition for FY 2015 for hospitals that are experiencing a decrease in their wage index exclusively due to the implementation of the new OMB delineations. This transition adjustment expired effective October 1, 2015, and is not applicable in FY 2016.

In addition, for the few hospitals that were located in an urban county prior to October 1, 2014, that became rural effective October 1, 2014, under the new OMB delineations, CMS is assigning a hold-harmless urban wage index value of the labor market area in which they are physically located for FY 2014 for 3 years beginning in FY 2015. That is, for FYs 2015, 2016, and 2017, assuming no other form of wage index reclassification or redesignation is granted, these hospitals are assigned the area wage index value of the urban CBSA in which they were geographically located in FY 2014. Note that for hospitals that are receiving the 3-year hold-harmless wage index, the transition is only for the purpose of the wage index and does not affect the hospital’s urban or rural status for any other payment purposes.

2. Treatment of Certain Providers Redesignated under Section 1886(d)(8)(B) of the Social Security Act (or The Act)

42 CFR 412.64(b)(3)(ii) implements Section 1886(d)(8)(B) of the Act, which redesignates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as “Lugar counties.”) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they are redesignated. A hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status, and is considered rural for all IPPS purposes.

3. Section 505 Hospital (Out-Commuting Adjustment)

Section 505 of the Medicare Modernization Act of 2003 (MMA), also known as the “outmigration adjustment,” is an adjustment that is based primarily on commuting patterns and is available to hospitals that are not reclassified by the Medicare Geographic Classification Review Board (MGCRB).

H. Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals under Section 412.103

An urban hospital that reclassifies as a rural hospital under Section 412.103 is considered rural for all IPPS purposes. Note, hospitals reclassified as rural under Section 412.103 are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see Section 412.320(a)(1)).

I. Multicampus Hospitals with Inpatient Campuses in Different CBSAs

Beginning with the FY 2008 wage index, CMS instituted a policy that allocates the wages and hours to the CBSA in which a hospital campus is located when a multicampus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility
at which the discharge occurred. Also note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA. In general, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers.

**J. Updating the Provider Specific File (PSF) for Wage Index, Reclassifications, and Redesignations**

CR9253 provides MACs with instructions for updating their PSF with appropriate wage index based on policies mentioned above.

**K. Medicare-Dependent, Small Rural Hospital (MDH) Program**

The MDH program provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. The MDH program is currently effective through September 30, 2017, as provided by Section 205 of the Medicare Access and CHIP Reauthorization Act of 2015. Provider Types 14 and 15 continue to be valid through September 30, 2017.

**L. Hospital Specific (HSP) Rate Factors for Sole Community Hospitals (SCHs) and MDHs**

For FY 2016, the HSP amount in the PSF for SCHs and MDHs will continue to be entered in FY 2012 dollars. PRICER will apply the cumulative documentation and coding adjustment factor for FYs 2011 through 2014 of 0.9480 and apply all of the updates and DRG budget neutrality factors to the HSP amount for FY 2013 and beyond.

**M. Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2016**

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Section 204 of the Medicare Access and CHIP Reauthorization Act of 2015 extended the temporary changes to the low-volume hospital payment adjustment through September 30, 2017.

In order to qualify as a low-volume hospital in FY 2016, a hospital must be located more than 15 road miles from another “subsection (d) hospital” and have less than 1,600 Medicare discharges (which includes Medicare Part C discharges and is based on the latest available MedPAR data). The applicable low-volume percentage increase is determined using a continuous linear sliding scale equation that results in a low-volume hospital payment adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more Medicare discharges. For FY 2016, qualifying low-volume hospitals and their payment adjustment are determined using Medicare discharge data from the March 2015 update of the FY 2014 MedPAR file. Attachment 9 of CR9253 is the corrected Table 14 of the FY 2016 IPPS/LTCH PPS final rule and subsequent correction notice, which will be available and lists the “subsection (d)” hospitals with fewer than 1,600 Medicare discharges based on the March 2015 update of the FY 2014 MedPAR file and their low-volume hospital payment adjustment for FY 2016 (if eligible). CMS notes that the list of hospitals with fewer than 1,600 Medicare discharges in Table 14 does not reflect whether or not the hospital meets the mileage criterion (that is, the hospital is located more than 15 road miles from any other subsection (d) hospital, which, in general, is an IPPS hospital).

A hospital must notify and provide documentation to its MAC that it meets the mileage criterion. The use of a web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion for low-volume hospitals, is acceptable. The MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance (in road miles) from the hospital requesting low-volume hospital status, is sufficient to document that it meets the mileage criterion. If not, the MAC will follow up with the hospital to obtain additional necessary information to determine whether or not the hospital meets the low-volume hospital mileage criterion.

To receive a low-volume hospital payment adjustment under Section 412.101 for FY 2016, a hospital must have made a written request for low-volume hospital status that is received by its MAC no later than September 1, 2015, in order for the applicable low-volume hospital payment adjustment to be applied to payments for discharges occurring on or after October 1, 2015. Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment in FY 2015 may continue to receive a low-volume hospital payment adjustment for FY 2016 without reapplying if it continues to meet the Medicare discharge criterion established for FY 2016 (as shown in corrected Table 14 of the FY 2016 IPPS/LTCH PPS Final Rule and subsequent correction notice) and the mileage criterion. However, the hospital must have sent a written verification that was received by its MAC no later than September 1, 2015, stating that it...
continues to be more than 15 miles from any other “subsection (d)” hospital. This written verification could be a brief letter to the MAC stating that the hospital continues to meet the low-volume hospital distance criterion as documented in a prior low-volume hospital status request. If a hospital’s written request for low-volume hospital status for FY 2016 was received after September 1, 2015, and if the MAC determines that the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital’s FY 2016 discharges, effective prospectively within 30 days of the date of its low-volume hospital status determination.

The MAC will determine, based on the most recent data available, if the hospital qualifies as a low-volume hospital, so that the hospital will know in advance whether or not it will receive a payment adjustment for the FY. The MAC and CMS may review available data, in addition to the data the hospital submits with its request for low-volume hospital status, in order to determine whether or not the hospital meets the qualifying criteria.

N. Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at www.qualitynet.org on the Internet. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website, and MACs will update their file as needed. A list of hospitals that will receive the statutory reduction to the annual payment update for FY 2016 under the Hospital Inpatient Quality Reporting (IQR) Program was provided to the MACs.

O. Hospital Acquired Condition Reduction Program (HAC)

Section 3008 of the Affordable Care Act establishes a program, beginning in FY 2015, for IPPS hospitals to improve patient safety, by imposing financial penalties on hospitals that perform poorly with regard to certain Hospital Acquired Conditions (HACs). HACs are conditions that patients did not have when they were admitted to the hospital, but which developed during the hospital stay. Under the HAC Reduction Program, a 1-percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of HACs acquired during the applicable period, and applies to all of the hospital’s discharges for the specified fiscal year.

The HAC Reduction Program adjustment amount (that is, the 1-percent payment reduction) is calculated after all other IPPS per discharge payments, which includes adjustments for DSH (including the uncompensated care payment), IME, outliers, new technology, readmissions, VBP, low-volume hospital payments, and capital payments. This amount will be displayed in the HAC PAYMENT AMT field in the IPPS PRICER output record. For SCHs and MDHs, the HAC Reduction Program adjustment amount applies to either the Federal rate payment amount or the hospital-specific rate payment amount, whichever results in a greater operating IPPS payment.

A list of providers subject to the HAC Reduction Program for FY 2016 was not publicly available in the final rule because the review and correction process was not yet completed. CMS provided the MACs with a preliminary list of hospitals subject to the HAC Reduction Program. Updated hospital level data for the HAC Reduction Program will be made publicly available following the review and corrections process.

P. Hospital Value Based Purchasing

Section 3001 of the Affordable Care Act added Section 1886(o) to the Social Security Act, establishing the Hospital Value-Based Purchasing (VBP) Program. This program began adjusting base operating DRG payment amounts for discharges from subsection (d) hospitals, beginning in FY 2013. Under its current agreement with CMS, Maryland hospitals are not subject to the Hospital VBP Program for the FY 2016 program year. The regulations that implement this provision are in Subpart I of 42 CFR Part 412 (Section 412.160 through Section 412.162).

Under the Hospital VBP Program, CMS reduces base operating DRG payment amounts for subsection (d) hospitals by the applicable percent defined in statute. The applicable percent for payment reductions for FY 2016 is 1.75 percent. This percent is gradually increasing each fiscal year from 1.0 in FY 2013 to 2.0 percent in FY 2017. These payment reductions fund value-based incentive payment to hospitals that meet or exceed performance standards on the measures selected for the program. By law, CMS must base value-based incentive payments on hospitals’ performance under the Hospital VBP Program, and the total amount available for value-based incentive payments must be equal to the amount of payment reductions, as estimated by the Secretary of Health and Human Services. CMS calculates a Total Performance Score (TPS) for each hospital eligible for the Hospital VBP Program. CMS then uses a linear exchange function to
convert each hospital’s TPS into a value-based incentive payment. Based on that linear exchange function’s slope, as well as an individual hospital’s TPS, the hospitals’ own annual base operating DRG payment amount, and the applicable percent reduction to base operating DRG payment amounts, CMS calculates a value-based incentive payment adjustment factor that will be applied to each discharge at a hospital, for a given fiscal year.

For FY 2016, CMS will implement the base operating DRG payment amount reduction and the value-based incentive payment adjustments, as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2016. CMS expects to post the value-based incentive payment adjustment factors for FY 2016 in the near future in Table 16B of the FY 2016 IPPS/LTCH PPS final rule, which will be available on the CMS website. (MACs received subsequent communication of the value-based incentive payment adjustment factors for FY 2016 in Table 16B.)

Q. Hospital Readmissions Reduction Program

For FY 2016, the readmissions adjustment factor is the higher of a ratio or 0.97 (-3 percent). The readmissions adjustment factor is applied to a hospital’s “base operating DRG payment amount” that is, the wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable), to determine the reduction amount under the Hospital Readmissions Reduction Program. Add-on payments for IME, DSH (including the uncompensated care payment), outliers, and low-volume hospitals are not adjusted by the readmissions adjustment factor. In addition, for SCHs, the difference between the SCH’s operating IPPS payment under the hospital-specific rate and the Federal rate is not adjusted by the readmissions adjustment factor. For FY 2016, the portion of a MDH’s payment reduction due to excess readmissions that is based on 75 percent difference between payment under the hospital-specific rate and payment under the Federal rate will be determined at cost report settlement. Consequently, in determining the claim payment, the PRICER will continue to only apply the readmissions adjustment factor to a MDH’s wage-adjusted DRG payment amount (adjusted under the transfer policy, if applicable) plus new technology add-on payment (if applicable) to determine the payment reduction due to excess readmissions.

The readmissions payment adjustment factors for FY 2016 are in Table 15 of the FY 2016 IPPS/LTCH PPS final rule, which will be available on the CMS website. Hospitals that are not subject to a reduction under the Hospital Readmissions Reduction Program in FY 2016 (such as Maryland hospitals) have a readmission adjustment factor of 1.0000. For FY 2016, hospitals should only have a readmission adjustment factor between 1.0000 and 0.9700.

Hospitals located in Maryland (for FY 2016) and in Puerto Rico are not subject to the Hospital Readmissions Reduction Program, and therefore, are not listed in Table 15.

R. Medicare Disproportionate Share Hospitals (DSH) Program

Section 3133 of the Affordable Care Act modified the Medicare DSH program beginning in FY 2014. Starting in FY 2014, hospitals received 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive a portion of this uncompensated care pool based on its share of total uncompensated care reported by Medicare DSH hospitals. A Medicare DSH hospital’s share of uncompensated care is based on its share of insured low income days, defined as the sum of Medicare SSI days and Medicaid days, relative to all Medicare DSH hospitals’ insured low income days.

The Medicare DSH payment will be reduced to 25 percent of the amount they previously would have received under the current statutory formula in PRICER. The calculation of the Medicare DSH payment adjustment will remain unchanged and the 75 percent reduction to the DSH payment will be applied in PRICER.

The total uncompensated care payment amount to be paid to the Medicare DSH hospitals was finalized in the FY 2016 IPPS Final Rule. The uncompensated care payment will be paid on the claim as an estimated per discharge amount to the hospitals that have been projected to receive Medicare DSH for FY 2016. The estimated per claim amount is determined by dividing the total uncompensated care payment by the average number of claims from the most recent three years of claims data (FY2012-2014). CMS is issued a Correction Notice to the FY 2016 IPPS final rule, which changed each provider’s uncompensated care payment per claim amounts. Attachment 3 of CR9253 includes the updated estimated per discharge
uncompensated care payment amounts per claim to be used for updating the PSF, which will be displayed in the corrected Medicare DSH Supplemental Data File for the Corrected Notice to the FY 2016 IPPS Final rule on the CMS website. The estimated per discharge uncompensated care payment amount will be included in the outlier payment determinations. In addition the estimated per discharge uncompensated care payment amount will be included as a Federal payment for SCHs to determine if a claim is paid under the hospital-specific rate or Federal rate and for Medicare Dependent Hospitals to determine if the claim is paid 75 percent of the difference between payment under the hospital-specific rate and payment under the Federal rate. The total uncompensated care payment amount finalized in the Correction Notice to the FY 2016 IPPS Final Rule will be reconciled at cost report settlement with the interim estimated uncompensated care payments that are paid on a per discharge basis.

The hospitals that were located in urban counties that are becoming rural under our adoption of the new OMB delineations, are subject to a transition for their Medicare DSH payment. For a hospital with more than 99 beds and less than 500 beds that was redesignated from urban to rural, it would be subject to a DSH payment adjustment cap of 12 percent. Under the transition, per the regulations at Section 412.102, for the second year after a hospital loses urban status, the hospital will receive an additional payment that equals one-third of the difference between DSH payment before its redesignation from urban to rural and the DSH payment otherwise applicable to the hospital subsequent to its redesignation from urban to rural. In the second year after a hospital loses urban status, the hospital will receive an additional payment that equals one third of the difference between the DSH payments applicable to the hospital before its redesignation from urban to rural and the DSH payments otherwise applicable to the hospital subsequent to its redesignation from urban to rural. This adjustment will be determined at cost report settlement. In determining the claim payment, the PRICER will only apply the DSH payment adjustment based on its urban/rural status according to the redesignation.

S. Recalled Devices

A hospital’s IPPS payment is reduced, for specified MS-DRGs, when the implantation of a device is replaced without cost or with a credit equal to 50 percent or more of the cost of the replacement device. New MS-DRGs are added to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they are formed from procedures previously assigned to MS-DRGs that were already on the list. MS-DRGs 266 and 267 (Endovascular Cardiac Valve Replacement with MCC and Endovascular Cardiac Valve Replacement without MCC, respectively) were inadvertently omitted from the list of MS-DRGs subject to the policy for FY 2015; therefore they are being added to the list with an effective date retroactive to October 1, 2014.

For FY 2016, MS-DRGs 237 and 238 (Major Cardiovascular Procedures with MCC and without MCC, respectively) will be deleted. The following MS-DRGs will be added:

- MS-DRG 268 (Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC)
- MS-DRG 269 (Aortic and Heart Assist Procedures Except Pulsation Balloon without MCC)
- MS-DRG 270 (Other Major Cardiovascular Procedures with MCC)
- MS-DRG 271 (Other Major Cardiovascular Procedures with CC)
- MS-DRG 272 (Other Major Cardiovascular Procedures without CC/MCC)
- MS-DRG 273 (Percutaneous Intracardiac Procedures with MCC)
- MS-DRG 274 (Percutaneous Intracardiac Procedures without MCC)

The complete list of MS-DRGs subject to the IPPS policy for replaced devices offered without cost or with a credit and their effective and termination dates is displayed in CR9121.
LTCH PPS FY 2016 Update

A. FY 2016 LTCH PPS Rates and Factors

FY 2016 LTCH PPS Rates and Factors are in the following table:

Table – FY 2016 LTCH PPS Rates and Factors

<table>
<thead>
<tr>
<th>LTCH PPS Standard Federal Rates</th>
<th>Rates based on successful reporting of quality data. Full update (quality indicator on PSF = 1): $41,762.85 Reduced update (quality indicator on PSF = 0 or blank): $40,941.55</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor Share</td>
<td>62.0 percent</td>
</tr>
<tr>
<td>Non-Labor Share</td>
<td>38.0 percent</td>
</tr>
<tr>
<td>High-Cost Outlier Fixed-Loss Amount for Standard Federal Rate Discharges</td>
<td>$16,423</td>
</tr>
<tr>
<td>High-Cost Outlier Fixed-Loss Amount for Site-Neutral Rate Discharges</td>
<td>$22,539</td>
</tr>
</tbody>
</table>

The LTCH PPS Pricer has been updated with the Version 33.0 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2015, and on or before September 30, 2016.

1. Application of the Site Neutral Payment Rate

Section 1206(a) of Public Law 113–67 amended Section 1886(m) of the Act to establish patient-level criteria for payments under the LTCH PPS for implementation for cost reporting periods beginning on or after October 1, 2015. This revision to payments under the LTCH PPS established a dual-rate payment structure, under which discharges are paid based on either of the following:

- The LTCH PPS standard Federal payment rate (that is, generally consistent with the payment amount determined under the LTCH PPS prior to the amendments made by Public Law 113–67) for LTCH cases meeting the specified patient criteria upon discharge; or
- The site neutral payment rate (that is, the lesser of an “IPPS-comparable” payment amount determined under Section 412.529(d)(4), including a high cost outlier payment under Section 412.525(a) as applicable, or 100 percent of the estimated cost of the case as determined under Section 412.529(d)(2)) for those cases not meeting specified patient criteria upon discharge.

In order to be paid at the LTCH PPS standard Federal rate amount, the following criteria must be met:

- The discharge must not have a principal diagnosis in the LTCH of a psychiatric diagnosis or rehabilitation as indicated by the grouping of the discharge into one of 15 “psychiatric and rehabilitation” MS-LTC-DRGs (that is, MS-LTC-DRGs 876, 880, 881, 882, 883, 884, 885, 886, 887, 894, 895, 896, 897, 945, and 946).
- The discharge must have been immediately preceded by an IPPS hospital discharge (“immediately preceded” is defined as the LTCH admission occurring within one day of the IPPS hospital discharge based on the admission date on the LTCH discharge claim and the discharge date on the IPPS hospital claim).
- The patient discharged from the LTCH must have spent 3 days in the ICU during the immediately preceding IPPS hospital stay (discharges meeting this criteria will be identified by the use of revenue center codes 020x and 021x on the IPPS hospital discharge claim) or have received at least 96 hours of respiratory ventilation services during the LTCH stay (which will generally be identified by the use of ICD-10-PCS procedure code 5A1955Z on the LTCH claim).

The site neutral payment rate amount will be paid for patients discharged from the LTCH that do not meet the above criteria. The application of the site neutral payment rate is codified in the regulations at Section 412.522. Additional information on the final policies implementing the application of the
site neutral payment rate are in the FY 2016 Final Rule (80 FR 49601-49623). Information on the requirements implementing the application of the site neutral payment rate are in CR9015. A related MLN Matters® article, MM9015, is available on the CMS website.

Existing LTCH PPS policies, such as the short-stay outlier (SSO) policy (for discharges paid the LTCH PPS standard Federal rate) and the Interrupted Stay policy, will continue to apply in determining the applicable payment amount (that is, site neutral payment rate or standard Federal payment rate) under the LTCH PPS.

2. Transition Blended Payment Rate for FYs 2016 and 2017

Public Law 113-67 establishes a transitional payment method site neutral payment rate for LTCH discharges occurring in cost reporting periods beginning during FY 2016 or FY 2017. The blended payment rate is comprised of 50 percent of the site neutral payment rate for the discharge and 50 percent of the LTCH PPS standard Federal payment rate that would have applied to the discharge if the provisions of Public Law 113-67 had not been enacted. Under new Section 412.522(c)(1), the site neutral payment rate is the lower of the IPPS comparable per diem amount determined under Section 412.529(d)(4), including any applicable outlier payments under Section 412.525(a), or 100 percent of the estimated cost of the case determined under Section 412.529(d)(2). For purposes of the blended payment rate, the payment rate that would otherwise be applicable had the provisions of Public Law 113-67 not been enacted, is the LTCH PPS standard Federal payment determined under Section 412.523 (that is, the LTCH PPS standard Federal payment rate that is applicable to discharges that meet the criteria for exclusion from the site neutral payment rate under new Section 412.522(a)(2)).

Under the blended payment rate at Section 412.522(c)(3), for LTCH discharges occurring in cost reporting periods beginning on or after October 1, 2015, and on or before September 30, 2017 (that is, discharges occurring in cost reporting periods beginning during FYs 2016 and 2017), the portions of the payment amounts determined under Section 412.522(c)(1) (the site neutral payment rate) and under Section 412.523 (the LTCH PPS standard Federal rate) include any applicable adjustments, such as HCO payments, as applicable, consistent with the requirements under Section 412.523(d). For example, the portion of the blended payment for the discharge that is based on the site neutral payment rate includes 50 percent of any applicable site neutral payment rate HCO payment under our revised HCO payment policy under Section 412.525(a). Similarly, the portion of the blended payment for the discharge that is based on the LTCH PPS standard Federal payment rate includes any applicable HCO payment under existing Section 412.525(a).

3. Subclause (II) LTCHs

In the FY 2015 IPPS Final Rule, CMS established a payment adjustment under the LTCH PPS at Section 412.526 for hospitals “classified under subclause (II) of subsection (d)(1)(B)(iv)” of the Act (referred to as “subclause (II) LTCHs), effective for cost reporting periods beginning on or after October 1, 2014 (that is, Federal FY 2015 and beyond). Under this payment adjustment, payments to subclause (II) LTCHs are adjusted so that their LTCH PPS payments are generally equivalent to an amount determined under the reasonable cost-based reimbursement rules for both operating and capital-related costs. Consequently, the application of the site neutral payment rate at Section 412.522 is not applicable to subclause (II) LTCHs. Currently there is only one hospital meeting the statutory definition of a subclause (II) LTCH, which is located in New York. The FY 2016 LTCH PPS Pricer includes logic to determine the claim payment amount for discharges from the subclause (II) LTCH that does not include the application of the site neutral payment rate in accordance with these policies.

B. Average Length Of Stay Calculation

Consistent with the amendments made by Public Law 113–67, beginning with cost reporting periods starting on or after October 1, 2015, for LTCHs which were classified as such by December 10, 2013, Medicare Advantage (MA) discharges and discharges paid the site neutral payment rate will not be included in the calculation of an LTCH’s Average Length of Stay (ALOS) for the purposes of a hospital’s payment classification as an LTCH under Section 412.23(e). All other requirements for calculating an LTCH’s ALOS remain unchanged.

C. Discharge Payment Percentage

For all LTCHs’ FY 2016 or later cost reporting periods, the statute requires LTCHs to be notified of their “discharge payment percentage” (DPP). The DPP is the ratio (expressed as a percentage) of the LTCHs’
FFS discharges which received LTCH PPS standard Federal rate payment to the LTCHs’ total number of LTCH PPS discharges. The LTCH’s total number of LTCH PPS discharges for a cost reporting period and discharges which were paid at the LTCH PPS standard Federal payment rate are to be determined at cost report settlement using data from the define?(PS&R). (Additional information regarding the identification of the discharge counts used in this calculation is forthcoming.) To calculate the DPP, divide the number of discharges paid at the LTCH PPS standard Federal payment rate by total LTCH PPS discharges. The percent equivalent of that result is the DPP. MACs will provide notification to the LTCH of its DPP upon final settlement of the cost report, beginning with cost reporting periods beginning on or after October 1, 2015. MACs may use the form letter in Attachment 2 of CR9253 to notify LTCHs of their DPP.

**D. LTCH Quality Reporting (LTCHQR) Program**

Section 3004(a) of the Affordable Care Act requires the establishment of the LTCH Quality Reporting (LTCHQR) Program. For FY 2016, the annual update to a standard Federal rate will continue to be reduced by 2.0 percentage points if a LTCH does not submit quality reporting data in accordance with the LTCHQR Program for that year.

**E. Provider Specific File (PSF)**

CR9253 provides instructions for MACs to use in updating relevant fields in their PSF.

**F. Cost of Living Adjustment (COLA) under the LTCH PPS**

The LTCH PPS incorporates a COLA for hospitals located in Alaska and Hawaii. There are no changes to the COLAs for FY 2016, and are the same COLAs established in the FY 2014 IPPS/LTCH PPS final rule. For reference, a table showing the applicable COLAs that will continue to be effective for discharges occurring on or after October 1, 2015, is in the FY 2016 IPPS/LTCH PPS final rule and is also shown in Table 2 in Attachment 1 of CR9253.

Additional Information

The official instruction, CR9253 (R3373CP) issued to your MAC regarding this change is available on the CMS website.

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**IRF**

**Payments to IRFs That Do Not Submit Required Quality Data – This CR Rescinds and Fully Replaces CR9106**

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

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

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

Additional Information

MEDICAL POLICIES

2016 CPT/HCPCS LCDs and Articles Revision – Effective January 1, 2016

The following Local Coverage Determinations (LCDs) have 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).

<table>
<thead>
<tr>
<th>Medicare Coverage Database Number/Contractor Determination Number</th>
<th>Policy Name</th>
<th>Effective Date</th>
<th>Summary of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A53959</td>
<td>High Resolution Anoscopy</td>
<td>01/01/2016</td>
<td>Added: 46601 and 46607</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Deleted: G6027, G6028</td>
</tr>
<tr>
<td>A53010</td>
<td>Intraocular Bevacizumab Coding Billing Guidelines</td>
<td>01/01/2016</td>
<td>Added: J7999</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Deleted: Q9977</td>
</tr>
<tr>
<td>L35458</td>
<td>Nerve Blockade for the Treatment of Chronic Pain and Neuropathy</td>
<td>01/01/2016</td>
<td>Added: 64461 – 64463</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Deleted: 64412. Per the 2016 CPT book, the replacement code was 64999 which will not be added to the LCD.</td>
</tr>
<tr>
<td>Medicare Coverage Database Number/Contractor Determination Number</td>
<td>Policy Name</td>
<td>Effective Date</td>
<td>Summary of Changes</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>----------------</td>
<td>------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| L34886                                                          | Non Covered Services         | 01/01/2016     | **Added:**<br>• 43210, 0396T, 0397T, 0398T, 0400T, 0401T, 0402T, 0406T, 0407T, 0408T, 0409T, 0410T, 0411T, 0412T, 0413T, 0414T, 0415T, 0416T, 0417T, 0418T, 0419T, 0420T, 0421T, 0422T, 0423T, 0424T, 0425T, 0426T, 0427T, 0428T, 0429T, 0430T, 0431T, 0432T, 0433T, 0434T, 0435T, and 0436T to group 1.<br>• 93050, 0399T to group 2.<br>• 93050 added in group 2 to replace 0311T deleted 1/1/2016.<br>• 0403T, 0405T to group 3.<br><br>**Deleted:**<br>• 0103T, 0123T, 0223T, 0224T, 0225T, 0233T, 0240T, 0241T, 0243T, 0244T and 0311T.<br>A new code for the procedure Transoral Incisionless Fundoplication is 43210 and is added to group 1.<br><br>To access the Noridian Active LCDs from our website, follow the instructions below.<br>• Go to [https://med.noridianmedicare.com/web/jfa/policies/lcd/active](https://med.noridianmedicare.com/web/jfa/policies/lcd/active)<br>• The End User Agreement for Providers will appear if you have not recently visited the website. Select “Accept” (if necessary).<br>• On the “Active LCDs” page, locate the above listed CMS MCD number or LCD title and select the coordinating state abbreviation.<br>• This link will redirect you to the state specific Active Effective LCD on the CMS website.
### MolDx: Molecular Diagnostic Tests (MDT) LCD – 2016 CPT/HCPCS Coverage Article Revisions

The following local coverage articles have 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).

<table>
<thead>
<tr>
<th>Medicare Coverage Database Number/Contractor Determination Number</th>
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<th>Summary of Changes</th>
</tr>
</thead>
</table>
| A54357                                                        | MolDX: Afirma™ Assay by Veracyte Billing and Coding Guidelines | 01/01/2016 | Added: • 81545  
Deleted: • 81479 |
| A54365                                                        | MolDX: AlloMap Billing and Coding Guidelines | 01/01/2016 | Added: • 81595  
Deleted: • Z94.1  
**Deleted:** • 81479  
• Z48.280, Z94.3 |
| A54387                                                        | MolDX: bioTheranostics Cancer TYPE ID® Billing and Coding Guidelines | 01/01/2016 | Added: • 81540  
Deleted: • 81479 |
| A54430                                                        | MolDX: Corus® CAD Test Billing and Coding Guidelines | 01/01/2016 | Added: • 81493  
Deleted: • 81479 |
| A54501                                                        | MolDX: FDA-Approved KRAS Tests (formerly “MolDX: therascreen® KRAS PCR Kit Billing/ Coding Guidelines”) | 01/01/2016 | Title is changed as noted.  
**Deleted:** • C78.00, C78.30, C79.00, C79.10, C79.40, C79.60, C79.70 and C79.9 |
| A54481                                                        | MolDX: Oncotype DX® Breast Cancer Assay Billing and Coding Guidelines | 01/01/2016 | Added: • D05.00, D05.10, D05.80 and D05.90 |
| A54485                                                        | MolDX: Oncotype DX® Colon Cancer Coding and Billing Guidelines | 01/01/2016 | Added: • 81525  
Deleted: • 81479 |

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

- Go to [https://med.noridianmedicare.com/web/jfa/policies/moldx/covered-tests](https://med.noridianmedicare.com/web/jfa/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 “MolDX Covered Tests” page, locate the above-listed LCD or article title.
MolDX: BRCA 1 and BRCA 2 Genetic Testing Final LCD – Effective April 15, 2016

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

**Medicare Coverage Database Number/Contractor Determination Number:** L36163

**LCD Title:** MolDX: BRCA 1 and BRCA 2 Genetic Testing

**Effective Date:** April 15, 2016

**Summary of LCD:** This policy covers testing for the BRCA 1 and BRCA 2 genes for patients suspected of hereditary breast and/or ovarian cancer syndromes when certain specified criteria are met.

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, locate the above listed CMS Medicare Coverage Database (MCD) number or LCD title and select the coordinating state abbreviation.
  - This link will redirect you to the state specific Future Effective LCD on the CMS website.

CPT Category III Non Covered and Covered Codes Coverage Article Retired – Effective March 1, 2016

The following JF local 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 Number:** A52797

**Article Title:** CPT Category III Non Covered and Covered Codes

**Effective Date:** March 1, 2016

The article is retired as all Non-Coverage of CPT Category III Codes are listed in the Non Covered Services LCD (L34886). CPT Category III codes not listed in the Non-Covered Services LCD are payable when all CMS and Noridian requirements are met, including the medical necessity documented in the medical record.

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

- Go to [https://med.noridianmedicare.com/web/jfa/policies/coverage-articles](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, select the state of interest in the table under “Retired Articles.”
  - This link will redirect you to the CMS website.
- Locate the above listed CMS Medicare Coverage Database (MCD) number and article title and select the title of interest.
Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs)  
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), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database Number: DL33979

Comment period: February 4 – April 10, 2016

Providers can submit comments via email or mail and must reference the specific policy to which they are related.

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.

Total Hip Arthroplasty 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), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database Number: DL36573

Comment period: February 4 – April 10, 2016

Providers can submit comments via email or mail and must reference the specific policy to which they are related.

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.

Total Knee Arthroplasty 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), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database Number: DL36577

Comment period: February 4 – April 10, 2016

Providers can submit comments via email or mail and must reference the specific policy to which they are related.

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.

Intensity Modulated Radiation Therapy (IMRT) 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), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database Number: DL34080

Comment period: February 4 – April 10, 2016

Providers can submit comments via email or mail and must reference the specific policy to which they are related.

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.
MGMT Promoter Methylation Analysis Final LCD – Effective April 15, 2016

The following Local Coverage Determination (LCD) has completed the Open Public and Carrier Advisory Committee 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 Number/Contractor Determination Number: L36192

LCD Title: MGMT Promoter Methylation Analysis

Effective Date: April 15, 2016

Summary of LCD: This policy provides limited coverage for MGMT methylation analysis testing for adult patients when certain criteria are met.

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, locate the above listed CMS Medicare Coverage Database (MCD) number or LCD title and select the coordinating state abbreviation.
  - This link will redirect you to the state specific Future Effective LCD on the CMS website.

Mohs Micrographic Surgery 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: L35703

LCD Title: Mohs Micrographic Surgery

Effective Date: October 1, 2015

Summary of Changes:

- Added ICD-10-CM code D03.21 - Melanoma in situ of right ear and external auricular canal
- Added ICD-10-CM code D03.22 - Melanoma in situ of left ear and external auricular canal

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 redirect you to the state specific Active LCD on the CMS website.

MolDX: HLA-B 15:02 Genetic Testing Final LCD – Effective April 1, 2016

The following Local Coverage Determination (LCD) has completed the Open Public and Carrier Advisory Committee 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 Number/Contractor Determination Number: L36149

LCD Title: MolDX: HLA-B*15:02 Genetic Testing

Effective Date: April 1, 2016
Summary of LCD: This policy provides limited coverage for HLA-B*15:02 genotype testing for patients of Asian and Oceanian ancestry and when initial treatment with carbamazepine, phenytoin or fosphenytoin is planned.

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, locate the above listed CMS Medicare Coverage Database (MCD) number or LCD title and select the coordinating state abbreviation.
  - This link will redirect you to the state specific Future Effective LCD on the CMS website.


The following Local Coverage Determination (LCD) has completed the Open Public and Carrier Advisory Committee comment period and is now finalized under contractor number 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/Contractor Determination Number: L36386

LCD Title: MolDX: Breast Cancer Assay: Prosigna

Effective Date: May 3, 2016

Summary of LCD: This LCD provides limited coverage of the Prosigna breast cancer gene signature assay to patients that meet criteria consistent with FDA indications.

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

MolDX-Chromosome 1p-19q Deletion Analysis 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), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database Number: DL36542

Comment period: February 4 – April 10, 2016

Providers can submit comments via email or mail and must reference the specific policy to which they are related.

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.
MolDX: Genetic Testing for BCR-ABL Negative Myeloproliferative Disease Final LCD – Effective April 19, 2016

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

Medicare Coverage Database Number/Contractor Determination Number: L36186

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

Effective Date: April 19, 2016

Summary of LCD: This LCD provides limited coverage for genetic testing for myeloproliferative disorders, including polycythemia vera (PV), essential thrombocytopenia (ET), and primary myelofibrosis (PMF).

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

• Go to https://med.noridianmedicare.com/web/fra/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, locate the above listed CMS Medicare Coverage Database (MCD) number or LCD title and select the coordinating state abbreviation.
    • This link will redirect you to the state specific Future Effective LCD on the CMS website.

MolDX – HLA-DQB1-06-02 Testing for Narcolepsy 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), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

Medicare Coverage Database Number: DL36544

Comment period: February 4 – April 10, 2016

Providers can submit comments via email or mail and must reference the specific policy to which they are related.

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.

Molecular RBC Phenotyping Final LCD – Effective April 1, 2016

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

Medicare Coverage Database Number/Contractor Determination Number: L36171

LCD Title: MolDX: Molecular RBC Phenotyping

Effective Date: April 1, 2016

Summary of LCD: This policy provides limited-coverage for molecular phenotyping of erythrocyte antigens performed on the HEA BeadChip™ (Immucor, Warren, NJ). This molecular assay may be used to characterize human red blood cell (RBC) antigens only for the specific situations denoted in the policy when alloantibodies or antigens identification is medically necessary to prevent transfusion reactions.
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, locate the above listed CMS Medicare Coverage Database (MCD) number or LCD title and select the coordinating state abbreviation.
  - This link will redirect you to the state specific Future Effective LCD on the CMS website.

**Chest X-Ray 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/Contractor Determination Number:**  L34097

**LCD Title:** Chest X-Ray

**Effective Date:** October 1, 2015

**Summary of Change:** The LCD is revised to add the following ICD-10 codes; E87.70, I48.91, I60.9, I61.9, I62.00, I62.9, I63.9, J93.9, K92.2, M79.601-603, R10.1, R10.819, R41.4, R41.82, S29.9XXA, S29.9XXD and S29.9XXS.

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 CMS MCD number or LCD title and select the coordinating state abbreviation.
  - This link will redirect you to the state specific Active Effective LCD on the CMS website.

**Chest X-Ray LCD – R5**

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 Number:** L34097

**LCD Title:** Chest X-Ray

**Effective Date:** October 1, 2015

**Summary of Change:** Added ICD-10-CM codes C34.91, C34.92 and Z79.899 in Group 1.

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 CMS MCD number or LCD title and select the coordinating state abbreviation.
  - This link will redirect you to the state specific Active Effective LCD on the CMS website.
Treatment of Ulcers and Symptomatic Hyperkeratoses 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) and 03601 (WY).

Medicare Coverage Database (MCD) Number/Contractor Determination Number: L36107

LCD Title: Treatment of Ulcers and Symptomatic Hyperkeratoses

Effective Date: 10/1/2015

Summary of Changes:

• Added ICD-10-CM codes to “ICD-10 Codes that Support the Medical Necessity” section.
  • Group 1: E10.65, S01.01XA, S01.01XD and S01.01XS
  • Group 2: E75.21, G60.0, G60.1, G60.2, G60.3, G60.8, L85.8 and L86
• Added ICD-10-CM codes to “Medical Necessity ICD-10 Codes Asterisk Explanation” section
  • Group 1: E10.65
  • Group 2: E75.21, G60.0, G60.1, G60.2, G60.3, G60.8, L85.8 and L86
• Added the number 17 in the Group 2 Medical Necessity ICD-10 Codes Asterisk Explanation.
• Replaced “nine” with “17” in “Group 3 Paragraph” and “Group 3 Medical Necessity ICD-10 Codes Asterisk Explanation.
• Revised Noridian claims processing edit for this LCD to ensure that routine foot care claims meeting the Medicare criteria pay correctly.

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 CMS MCD number or LCD title and select the coordinating state abbreviation.
  • This link will redirect you to the state specific Active LCD on the CMS website.

Treatment of Ulcers and Symptomatic Hyperkeratoses LCD – R4

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: L36107

LCD Title: Treatment of Ulcers and Symptomatic Hyperkeratoses

Effective Date: October 1, 2015

Summary of Changes: Added ICD-10-CM codes to the Group 1 “ICD-10 Codes that Support the Medical Necessity” section.

• S81.031X-Puncture wound without foreign body, right knee
• S81.032X-Puncture wound without foreign body, left knee
• S81.041X-Puncture wound with foreign body, right knee
• S81.042X-Puncture wound with foreign body, left knee
• S81.801X-Unspecified open wound, right lower leg
• S81.802X-Unspecified open wound, left lower leg
• S81.811X-Laceration without foreign body, right lower leg
• S81.812X-Laceration without foreign body, left lower leg
• S81.821X-Laceration with foreign body, right lower leg
• S81.822X-Laceration with foreign body, left lower leg
• S81.831X-Puncture wound without foreign body, right lower leg
• S81.832X-Puncture wound without foreign body, left lower leg
• S81.841X-Puncture wound with foreign body, right lower leg
• S81.842X-Puncture wound with foreign body, left lower leg
• S81.851X-Open bite, right lower leg
• S81.852X-Open bite, left lower leg
• Added the following 7th character to above listed ICD-10-CM codes:
  • A – Initial encounter;
  • D – Subsequent encounter; and
  • S – Sequela

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 redirect you to the state specific Active LCD on the CMS website.

**Treatment of Males with Low Testosterone Levels 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), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), 03601 (WY).

**Medicare Coverage Database Number:** DL36569

**Comment period:** February 4 – April 10, 2016

Providers can submit comments via email or mail and must reference the specific policy to which they are related.

See the Noridian Draft LCDs webpage to access the draft LCDs and address details for comment submission.

The following Local Coverage Determination (LCD) has completed the Open Public and Carrier Advisory Committee 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 Number/Contractor Determination Number: L36198

LCD Title: MolDX-CDD: NSCLC, Comprehensive Genomic Profile Testing

Effective Date: April 15, 2016

Summary of LCD: This policy provides limited coverage for comprehensive somatic genomic profiling on tumor tissue for patients with metastatic non-small cell lung cancer who meet certain criteria.

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, locate the above listed CMS Medicare Coverage Database (MCD) number or LCD title and select the coordinating state abbreviation.
  - This link will redirect you to the state specific Future Effective LCD on the CMS website.

Percutaneous Endovascular Cardiac Assist Procedures and Devices – R2 and R3

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: 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:

- In the article text, added “cardiogenic shock or severe decompensated heart failure with threatening multi-organ failure” after the word sufficient and replaced the words “adhered to” with “followed”.
- Changed ICD-10-PCS code from 5A0221D to 02HL3DZ in Group 1 Paragraph for Part A Providers.

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.
Positron Emission Tomography Scans Coverage – R3 and R4

The following Noridian coverage requirements for the Positron Emission Tomography Scans 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:** Positron Emission Tomography Scans Coverage 220

<table>
<thead>
<tr>
<th>Revision Number</th>
<th>Summary of Changes</th>
<th>Effective Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>R4</td>
<td>Diagnosis R91.8 was deleted in error and is added back to the article. This change is viewable on the Noridian website and will be viewable in the MCD March 10, 2016.</td>
<td>October 1, 2015</td>
</tr>
<tr>
<td>R3</td>
<td>Article is revised to clarify that modifiers PI and PS are required when billing scans with tracer HCPCS code A9580 for oncologic indications. Multiple diagnosis additions were added to Lists I, II and III to be consistent with CMS published diagnoses for the NCD. The following diagnoses are deleted effective April 15, 2016: R91.8 from List I and D3A.010-D3A.029 from List II.</td>
<td>October 1, 2015 and April 15, 2016</td>
</tr>
</tbody>
</table>

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 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.

Serum Magnesium LCD – 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:** L34059

**LCD Title:** Serum Magnesium

**Effective Date:** October 1, 2015

**Summary of Changes:** Added ICD-10-CM code R41.0 - Disorientation, unspecified.

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 redirect you to the state specific Active LCD on the CMS website.
Nerve Blockade for Treatment of Chronic Pain and Neuropathy – R5

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 Number: L35458

LCD Title: Nerve Blockade for Treatment of Chronic Pain and Neuropathy

Effective Date: January 1, 2016

Summary of Changes: Clarified when duplicated ICD-10-CM codes G58.7, G58.8, G58.9 G59, M54.10 and M79.2 are allowed and denied with CPT code 64450. These ICD-10-CM codes are allowed when 64450 is billed without CPT codes 76881, 76882, 76942, 76999, 97032, 97139, G0282 and G0283 on the same date of service.

All ICD-10-CM codes listed in Group 1 of the “ICD-10 that DO NOT Support the Medical Necessity” section will be denied when CPT code 64450 is billed with CPT codes 76881, 76882, 76942, 76999, 97032, 97139, G0282 or G0283 on the same date of service.

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 CMS MCD number or LCD title and select the coordinating state abbreviation.
  • This link will redirect you to the state specific Active LCD on the CMS website

Nerve Blockade for Treatment of Chronic Pain and Neuropathy LCD– R6

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 Number: L35458

LCD Title: Nerve Blockade for Treatment of Chronic Pain and Neuropathy

Effective Date: January 1, 2016

Summary of Changes: LCD revised to add:

• ICD-10-CM codes R10.11-R10.13, R10.31-R10.33 & asterisks to ICD-10-CM codes G57.91-G57.92 in the Group 1 ICD-10 codes that Support Medical Necessity.

• ICD-10-CM codes G57.91-G57.92 codes to the Group 1: Medical Necessity ICD-10 codes Asterisk Explanation.

• ICD-10-CM codes G57.91-G57.92 to the Group 1 Paragraph & list of Codes in the ICD-10-CM Codes that DO NOT Support Medical Necessity section.

• Added the following statements:
  • CPT codes 64450 or 64640 may not be billed with diagnosis G57.61 and G57.62. The correct CPT procedure codes are 64455 or 64632 when billing for the diagnosis of Morton’s Neuroma to Group 1 Paragraph in the CPT/HCPCS Code Section; and
  • G57.61, G57.62 - The correct CPT procedure codes are 64455 or 64632 when billing for the diagnosis of Morton’s Neuroma. CPT codes 64450 or 64640 may not be billed with diagnosis G57.61, G57.62 to the Group 1: Medical Necessity ICD-10 Codes Asterisk Explanation.
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 redirect you to the state specific Active LCD on the CMS website

### Non-Covered Services LCD – R10

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:** L34886  
**LCD Title:** Non-Covered Services  
**Effective Date:** February 8, 2016  
**Summary of Changes:** Removed CPT code 0281T from Group 1.

To access the Noridian Active LCD 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 LCD” page, locate the above listed LCD title.
  - This link will redirect you to the state specific Active LCD on the CMS website.

### Non-Covered Services LCD - R11

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:** L34886  
**LCD Title:** Non-Covered Services  
**Effective Date:** April 1, 2016  
**Summary of Changes:** Removed CPT codes 90867, 90868, 90869 from group 1.

To access the Noridian Future LCD 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” LCD” page, locate the above listed LCD title.
  - This link will redirect you to the state specific Future LCD on the CMS website.
Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Billing and Coding

The following Noridian coverage requirements for the Single Chamber and Dual Chamber Permanent Cardiac Pacemakers 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:** Cardiac Pacemakers: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers (20.8.3)

**Article Summary:** View coverage, coding and billing information for Single Chamber and Dual Chamber Permanent Pacemakers defined by the SSA, NCD and CMS manuals, including contractor determined coding criteria.

**Effective Date:** April 15, 2016

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.

**Single Chamber and Dual Chamber Permanent Cardiac Pacemakers – Billing and Coding – R1**

The following Noridian coverage requirements for the Single Chamber and Dual Chamber Permanent Cardiac Pacemakers National Coverage Determination (NCD) have been published 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:** Single Chamber and Dual Chamber Permanent Cardiac Pacemakers NCD 20.8.3

**Effective Date:** May 1, 2016

**Article Summary:** View the following updated information:

- The provisions in this article will be applied to dates of service on or after May 1, 2016.
- ICD-10-CM code was revised from I44.2 to I44.1 in the following indication in the “Diagnosis Codes (ICD-9-CM /ICD-10-CM) (Attest with Modifier - KX)” section:
  - ICD-9-CM code 427.2 was added to the following condition/indication in the “Contractor (Additional) Diagnosis Codes (ICD-9-CM /ICD-10-CM) Allowed by the NCD – Group II (Attest with Modifier - KX)” section:
    - Paroxysmal supraventricular tachycardia/supraventricular tachycardia (SVT that is reproducibly terminated by pacing when catheter ablation and/or drugs fail to control the arrhythmia or produce intolerable side effects) (427.0/427.2/ I47.1/I47.9).
ICD-10-CM code I48.91 was removed from the condition/indication (atrial flutter) in the “Contractor (Additional) Diagnosis Codes (ICD-9-CM /ICD-10-CM) Allowed by the NCD – Group II (Attest with Modifier - KX)” section as it is specific to atrial fibrillation and is already referenced in that condition/indication:

- Atrial flutter/atrial flutter, typical/atypical/unspecified (427.32 / I48.3/I48.4/I48.92) with symptomatic bradycardia due to necessary medical therapy.

“Medically necessary” was added to the following requirement for modifier - SC:

- For medically necessary pacemaker insertion in conditions not addressed by the NCD or this article, Group III, use modifier - SC (Medically necessary service or supply).

The following modifier requirement was added regarding the use of modifiers GA and GZ:

- Modifiers –GA and –GZ:
  - Modifier –GA (Waiver of liability statement issued as required by payer policy, individual case) should be used when the provider wants to indicate that he/she anticipates that Medicare will deny a specific service as not reasonable and necessary and an Advanced Beneficiary Notice (ABN) Form CMS-R-131 has been signed by the beneficiary and is on file. Modifier –GA may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed.
  - For claims submitted to the Part A MAC, occurrence code 32 and the date of the ABN are required.
  - Modifier – GZ should be used when the provider wants to indicate that it is expected that Medicare will deny the specific services as not reasonable and necessary and the beneficiary was not asked to sign an ABN.

Claims for pacemaker claims that do not meet the criteria for modifier –KX or –SC should have modifier –GA or –GZ appended depending on the ABN status and will be denied.

ICD-10-CM code I48.1 and I48.92 was added to Group 2 in the “Covered ICD-10-CM Codes” section.

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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) and 03601 (WY).

**Medicare Coverage Database (MCD) Number/Contractor Determination Number:** L34060

**LCD Title:** Urinalysis Policy

**Effective Date:** October 1, 2015

**Summary of Changes:** Diagnosis M54.9 is added.

To access the Noridian Active LCDs 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 “Active LCDs” page, locate the above-listed CMS MCD number or LCD title and select the coordinating state abbreviation.
  - This link will redirect you to the state specific Active LCD on the CMS website.
Urinalysis Policy LCD – 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: L34060
LCD Title: Urinalysis Policy
Effective Date: October 1, 2015
Summary of Changes: Added ICD-10 code R50.9 Fever, unspecified.
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 CMS MCD number or LCD title and select the coordinating state abbreviation.
  • This link will redirect you to the state specific Active LCD on the CMS website.

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

Medicare Coverage Database Number/Contractor Determination Number: L36599
LCD Title: Treatment of Varicose Veins of the Lower Extremity
Effective Date: March 13, 2016
Summary of LCD: This policy addresses indications for surgical treatment of varicose veins of the lower extremity. It also addresses the use and limitations of endoluminal radiofrequency ablation (ERFA), Doppler ultrasound or duplex studies, and ultrasound guidance.
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, locate the above listed CMS Medicare Coverage Database (MCD) number or LCD title and select the coordinating state abbreviation.
  • This link will redirect you to the state specific Future Effective LCD on the CMS website.

Treatment of Varicose Veins of Lower Extremities LCD – 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: L36599
LCD Title: Treatment of Varicose Veins of the Lower Extremities
Effective Date: March 13, 2016
Summary of Changes: The LCD is revised editorially to be consistent for both Jurisdictions JE and JF AB MACs. There are no changes in coverage. The effective date remains the same.

To access the Noridian Active LCD 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 LCD” page, locate the above listed CMS MCD number or LCD title and select the coordinating state abbreviation.
  - This link will redirect you to the state specific Active LCD on the CMS website.

I/OCE Specifications Version 17.0 – January 2016

MLN Matters® Number: MM9459
Related Change Request (CR) #: CR 9459
Related CR Release Date: January 6, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R3437CP
Implementation Date: January 4, 2016

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

Provider Action Needed
CR 9459 provides the instructions and specifications for the Integrated Outpatient Code Editor (I/OCE) to 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 not under the Home Health Prospective Payment System (PPS) or to a hospice patient for the treatment of a non-terminal illness. This notification applies to Chapter 4, Section 40.1 of the “Medicare Claims Processing Manual”. Make sure that your billing staffs are aware of these changes.

Background
CR 9459 informs the MACs and the Fiscal Intermediary Shared System (FISS) maintainer that the I/OCE is being updated for January 1, 2016. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE. The I/OCE specifications are available at [http://www.cms.gov/OutpatientCodeEdit/](http://www.cms.gov/OutpatientCodeEdit/) on the Centers for Medicare & Medicaid Services (CMS) website. The modifications of the I/OCE for the January 2016 Version 17.0 release are summarized in the table below. Some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the ‘Effective Date’ column.

You should also read through the entire CR9459 document and note the highlighted sections, which also indicate changes from the prior release of the software. A full summary of data changes in I/OCE V17, including diagnosis, Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) codes, Status Indicators (SIs), and Ambulatory Payment Classification (APC) codes, is attached to CR9459.
### Effective Date | Edits Affected | Modification
--- | --- | ---
1/1/2016 | Move the former Appendix O (Summary of Modifications) to the beginning of the specification document and rename to “Summary of Quarterly Release Modifications”; rename Appendix P (Code Lists) to Appendix O. |
1/1/2016 | Implement new program logic for pass-through device offset amount passed to Pricer by way of Payer Value Code with Payer Value Code Amount field in the Claim Return Buffer (Table 5 of I/OCE specifications). Assign new payment adjustment flag values to identify pass-through devices (see OPPS special processing logic, Table 5, 7 and Appendix G). |
1/1/2016 | Update comprehensive APC program logic to add new Comprehensive Observation C-APC 8011, and SI = J2 (see OPPS special processing logic and Appendix L); add new flowchart for Comprehensive Observation APC logic. |
1/1/2016 | Update the program logic for processing inpatient procedures when the patient expires to be assigned under comprehensive APCs (see OPPS special processing logic and Appendix L). |
1/1/2016 | Add new program logic to exclude SRS (stereotactic radiosurgery) planning and preparation services from packaging under C-APCs if present on the same claim as the SRS C-APC (see OPPS special processing logic and Appendix L). |
1/1/2016 | Update the Critical care ancillary packaging to remove the exception when ancillary services are reported with modifier 59 as not applicable under C-APCs (see OPPS special processing logic). |
1/1/2016 | Add program logic for processing Advanced Care Planning services for payment by either the Medicare Physician Fee Schedule (SI = A) or by APC through conditional packaging (SI = Q1) (see OPPS special processing logic). |
1/1/2016 | Add program logic for conditionally packaged laboratory services with new SI = Q4 (see OPPS special processing logic). |
1/1/2016 | Add program logic for certain CT scan codes reported with modifier CT that do not meet National Electrical Manufacturers Association (NEMA) equipment standards; pass new payment adjustment flag 14 (see OPPS special processing logic, Appendix G and Appendix K). |
1/1/2016 | Update Appendix K to note the deactivation of composite APC 8009; add reference to Comprehensive Observation APC for direct referral logic. |
1/1/2016 | Implement new Status Indicators (see Table 7):  
• J2: Hospital Part B services that may be paid through a comprehensive APC  
• Q4: Conditionally packaged laboratory services |
1/1/2016 | Implement new Payment Adjustment Flag values (see Table 7 and Appendix G):  
• 12: Offset for device pass-through  
• 13: Offset for additional device pass-through  
• 14: Protecting Access to Medicare Act of 2014 (PAMA) Section 218 reduction on CT scan |
1/1/2016 | Implement new Payment Indicator values (see Table 7):  
• 14: Grandfathered tribal Federally Qualified Health Center (FQHC) encounter payment |
1/1/2016 | 93 | Implement new edit 93 (Corneal tissue processing reported without cornea transplant procedure) (see Table 4). Edit criteria: Corneal tissue processing HCPCS (V2785) is reported and there is no cornea transplant procedure present for the same service date (LIR). |
<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
</table>
| 1/1/2016       | 94            | Implement new edit 94 (Biosimilar HCPCS reported without biosimilar modifier) (see Table 4). Edit criteria:  
• A biosimilar HCPCS code is reported on the claim without its corresponding biosimilar manufacturing modifier (RTP). |
| 10/1/2015      | 2             | Remove the age edit restriction for ICD-10 diagnosis codes F930, F938, F939, F941-F949, F9821, F9829, F983, F988, and F989. |
| 1/1/2016       | 8             | Updates to the male and female sex restriction edit for new procedure codes. |
| 1/1/2016       | 22            | New modifiers:  
• CP: C-APC adjunctive service  
• CT: CT does not meet NEMA standards  
• ZA: Novartis/Sandoz |
| 1/1/2016       |               | Update program logic and documentation for any references to APC values that now reflect new APC values due to restructure of APC groups (for example, Partial Hospitalization Program (PHP) logic, Mental Health composite). |
| 1/1/2016       |               | Update FQHC program logic for Grandfathered Tribal FQHC encounters (see special processing conditions for FQHC claims and Appendix M). |
| 1/1/2016       |               | Update FQHC program logic for separate payment of Chronic Care Management services (see special processing conditions for FQHC claims and Appendix M). |
| 1/1/2016       |               | Update FQHC program logic for Advanced Care Planning services; treat as qualifying visit code or packaged preventive service (see special processing conditions for FQHC claims and Appendix M). |
| 1/1/2016       | 67            | Update mid-quarter FDA effective dates for the following codes:  
• 90621: 10/29/2014  
• 90620: 01/23/2015 |
| 6/2/2014       | 68            | Update the SI assignment for HCPCS G0472 to SI A, effective with the mid-quarter NCD edit already in place. |
| 1/1/2016       | 68            | Implement mid-quarter NCD effective dates for the following codes:  
• G0296: 02/05/2015  
• G0297: 02/05/2015  
• G0476: 07/09/2015  
• 90630: 08/01/2015 |
Effective Date | Edits Affected | Modification
--- | --- | ---
1/1/2016 | Update the following lists for the release (see quarterly data files):
- Comprehensive APCs (C-APC list, ranking, exclusions, complexity-adjusted code pairs)
- Skin substitute products (edit 87, Appendix O)
- Conditionally STV-packaged and T-packaged
- Deductible/Coinsurance N/A
- Inpatient Only procedures (edit 18)
- Device and Device-Procedures (edit 92)
- Lab Services (conditional packaging)
- FQHC (preventive services, flu/PPV vaccine, non-covered and qualifying visit pairs)
- Cornea transplant procedures (new edit 93)
- CT Scan not meeting NEMA standard (new, payment adjustment flag 14)
- Device Offset (new, payment adjustment flag 12, 13)
- SRS planning and preparation codes (new C-APC logic)
- ICD-10 diagnosis age edit restrictions (edit 2)
- Procedure and sex conflict edit restrictions (edit 8)
1/1/2016 | 57 | Update the edit description to remove the reference to ‘Composite’.
1/1/2016 | Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).
1/1/2016 | 20, 40 | Implement version 22.0 of the NCCI (as modified for applicable institutional providers).

Additional Information
The official instruction, CR 9459, issued to your MAC regarding this change, is available on the CMS website.

Hospital OPPS – April 2016 Update
Related Change Request (CR) #: CR 9549
MLN Matters® Number: MM9549
Effective Date: April 1, 2016
Related CR Release Date: February 26, 2016
Related CR Transmittal #: R3471CP
Implementation Date: April 4, 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 paid under the Outpatient Prospective Payment System (OPPS).
Provider Action Needed
Change Request (CR) 9549 describes changes to and billing instructions for various payment policies implemented in the April 2016 OPPS update.

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

Key Points of CR9549
Key changes to and billing instructions for various payment policies implemented in the April 2016 OPPS updates are as follows:

**Neurostimulator HCPCS Codes C1822 and C1820**

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

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


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

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

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

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

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

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

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

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

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

Revised Status Indicator for HCPCS Codes

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

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

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

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

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

These codes and the effective dates for the status indicator changes are listed in Table 3.
Table 3 – Drugs and Biologicals with Revised Status Indicators

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

Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

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

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

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

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

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

Table 4 – Excluded Planning and Preparation CPT Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CY 2016 Short Descriptor</th>
<th>CY 2016 Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>70551</td>
<td>Mri brain stem w/o dye</td>
<td>Q3</td>
</tr>
<tr>
<td>70552</td>
<td>Mri brain stem w/dye</td>
<td>Q3</td>
</tr>
<tr>
<td>70553</td>
<td>Mri brain stem w/o &amp; w/dye</td>
<td>Q3</td>
</tr>
<tr>
<td>77011</td>
<td>Ct scan for localization</td>
<td>N</td>
</tr>
<tr>
<td>77014</td>
<td>Ct scan for therapy guide</td>
<td>N</td>
</tr>
<tr>
<td>77280</td>
<td>Set radiation therapy field</td>
<td>S</td>
</tr>
<tr>
<td>77285</td>
<td>Set radiation therapy field</td>
<td>S</td>
</tr>
</tbody>
</table>
Changes to OPPS Pricer Logic

Effective April 1, 2016, there will be four diagnostic radiopharmaceuticals (1 newly approved) and one contrast agent receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical or contrast agent payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical or contrast agent with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical or contrast agent expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals and contrast agents are the “policy-packaged” portions of the CY 2016 APC payments for nuclear medicine procedures and are available on the CMS website. MACs will adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of the April 2016 OPPS Pricer.

Coverage Determinations

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

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

Additional Information


Revision to FISS Lab Travel Allowance Editing to Include New Specimen Collection Code G0471

MLN Matters® Number: MM9471
Related Change Request (CR) #: CR 9471
Related CR Release Date: February 5, 2016
Effective Date: April 1, 2014
Related CR Transmittal #: R1619OTN
Implementation Date: For claims processed on or after July 5, 2016

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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CY 2016 Short Descriptor</th>
<th>CY 2016 Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>77290</td>
<td>Set radiation therapy field</td>
<td>S</td>
</tr>
<tr>
<td>77295</td>
<td>3-d radiotherapy plan</td>
<td>S</td>
</tr>
<tr>
<td>77336</td>
<td>Radiation physics consult</td>
<td>S</td>
</tr>
</tbody>
</table>
Provider Action Needed
Change Request (CR) 9471, from which this article was developed, updates Fiscal Intermediary Shared System (FISS) reason code 32436 to include HCPCS code G0471 in the list of specimen collection fee codes that will allow the travel allowance to be paid on outpatient claims. **Notify your MAC if your claims for lab travel allowance (HCPCS codes P9603 or P9604), for dates of service on or after April 1, 2014, were returned or rejected when billed with specimen collection fee HCPCS code G0471.**

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

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

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

Upon implementation of CR9471, your MAC will:

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

Additional Information

Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens
MLN Matters® Number: MM9485
Related Change Request (CR) #: CR 9485
Related CR Release Date: December 31, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3433CP
Implementation Date: February 1, 2016

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

Provider Action Needed
Change Request (CR) 9485 revises the payment of travel allowances when billed on a per mileage basis using Healthcare Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat-rate basis using HCPCS code P9604 for CY 2016.
Background

Medicare Part B allows payment for a specimen collection fee and travel allowance, when medically necessary, for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act. Payment for these services is made based on the clinical laboratory fee schedule.

The travel codes allow for payment either on a per mileage basis (P9603) or on a flat-rate per trip basis (P9604). Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen, including the laboratory technician’s salary and travel expenses.

Your MAC has the discretion to choose either a mileage basis or a flat rate, and how to set each type of allowance. Many MACs established local policy to pay based on a flat-rate basis only.

Under either method, when one trip is made for multiple specimen collections (for example, at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat-rate is set by the MAC.

Per Mile Travel Allowance (P9603): The minimum “per mile travel allowance” is $0.99, which is to be used in situations where the average trip to the patients’ homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip. This allowance per mile was computed using the Federal mileage rate of $0.54 per mile plus an additional $0.45 per mile to cover the technician’s time and travel costs. MACs have the option of establishing a higher per mile rate in excess of the minimum $0.99 per mile if local conditions warrant it. The minimum mileage rate will be reviewed and updated throughout the year, as well as in conjunction with the Clinical Laboratory Fee Schedule (CLFS), as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician. The Internal Revenue Service (IRS) determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating and automobile.

Per Flat-rate Trip Basis Travel Allowance (P9604): The per flat-rate trip basis travel allowance is $9.90.

MACs will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, MACs will adjust claims brought to their attention.

Additional Information


MPFSDB – 2016 Emergency Update

MLN Matters® Number: MM9495
Related Change Request (CR) #: CR 9495
Related CR Release Date: January 8, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R3438CP
Implementation Date: January 4, 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) 9495 amends payment files that were issued to contractors based on the CY 2016 Medicare Physician Fee Schedule (MPFS) Final Rule. The Centers for Medicare & Medicaid Services (CMS)
amended these payment files in order to correct technical errors to the MPFS update files, and to include corrections described in the CY 2016 MPFS Final Rule Correction Notice. Your MAC will disclose the revised MPFS fees on their website as soon as possible, if they have not done so already.

Background
Some Relative Value Units published in the CY 2016 MPFS Final Rule have been revised to align their values with the CY 2016 MPFS Final Rule policies. These changes are discussed in the CY 2016 MPFS Final Rule Correction Notice. In addition, there were corrections made to invalid or missing payment indicators for several procedure codes. The amended 2016 MPFS payment files reflect all these changes for services furnished on or after January 1, 2016.

Additional Information

MPFSDB – Quarterly Update April 2016
MLN Matters® Number: MM9531
Related Change Request (CR) #: CR 9531
Related CR Release Date: February 19, 2016
Effective Date: April 1, 2016
Related CR Transmittal #: R3469CP
Implementation Date: April 4, 2016

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

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

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

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

The key changes for the April update that are effective as of January 1, 2016 are as follows:
• CPT/HCPCS code G0464 is assigned a procedure status of I;
• Code 10030 is assigned Global period days of 000;
• Code 77014 is assigned a PC/TC Indicator of 1; and
• Code 80055 is assigned a procedure status of X.

Other changes that are effective for services performed on or after April 1, 2016 are as follows:
• Code G9678 is assigned a procedure status of X;
• G9481 (Remote E/M new pt 10mins) has a PE RVU = 0, all other MPFS indicators/values = code 99201;
• G9482 (Remote E/M new pt 20mins) has a PE RVU = 0, all other MPFS indicators/values = 99202;
• G9483 (Remote E/M new pt 30mins) has a PE RVU = 0, all other MPFS indicators/values = 99203;
• G9484 (Remote E/M new pt 45mins) has a PE RVU = 0, all other MPFS indicators/values = 99204;
• G9485 (Remote E/M new pt 60mins) has a PE RVU = 0, all other MPFS indicators/values = 99205;
• G9486 (Remote E/M est. pt 10mins) has a PE RVU = 0, all other MPFS indicators/values = 99212;
• G9487 (Remote E/M est. pt 15mins) has a PE RVU = 0, all other MPFS indicators/values = 99213;
• G9488 (Remote E/M est. pt 25mins) has a PE RVU = 0, all other MPFS indicators/values = 99214;
• G9489 (Remote E/M est. pt 40mins) has a PE RVU = 0, all other MPFS indicators/values = 99215; and
• G9490 (Joint replac mod home visit) with all MPFS indicators & RVUs = those of G9187.

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

Additional Information

ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files – April 2016

MLN Matters® Number: MM9536
Related Change Request (CR) #: CR 9536
Related CR Release Date: February 4, 2016
Effective Date: April 1, 2016
Related CR Transmittal #: R3450CP
Implementation Date: April 4, 2016

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

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

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

Background
The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in the “Medicare Claims Processing Manual,” Chapter 4, Section 50.

The following table shows how the files will be applied.
Files | Effective Date for Dates of Service
---|---
April 2016 ASP and ASP NOC | April 1, 2016, through June 30, 2016
January 2016 ASP and ASP NOC | January 1, 2016, through March 31, 2016
October 2015 ASP and ASP NOC | October 1, 2015, through December 31, 2015
July 2015 ASP and ASP NOC | July 1, 2015, through September 30, 2015
April 2015 ASP and ASP NOC | April 1, 2015, through June 30, 2015

Additional Information

DMEPOS Fee Schedule – April 2016 Quarterly Update
MLN Matters® Number: MM9554
Related Change Request (CR) #: CR 9554
Related CR Release Date: February 26, 2016
Effective Date: April 1, 2016
Related CR Transmittal #: R3472CP
Implementation Date: April 4, 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) 9554 provides the April quarterly update for the Medicare DMEPOS fee schedule. The instructions include information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. Because there are no updates from the previous quarter (January through March 2016), an April update to the 2016 DMEPOS and Parenteral and Enteral Nutrition (PEN) fee schedule files is not scheduled for release. However, an April 2016 DMEPOS Rural ZIP code file containing Quarter Two, 2016 rural ZIP Code changes is being provided to the MACs.

The [April 2016 DMEPOS Rural ZIP code Public Use File (PUF)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3450CP.pdf), containing the rural ZIP codes effective for Quarter 2, 2016, will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the above file.

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

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

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

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

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

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

Additional Information

UPDATE

Update to Pub. 100-08, Chapter 15
MLN Matters® Number: MM9390
Related Change Request (CR) #: CR 9390
Related CR Release Date: February 4, 2016
Effective Date: March 4, 2016
Related CR Transmittal #: R636PI
Implementation Date: March 4, 2016

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

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

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

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

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

1. If online verification of an IDTF technician’s credentials is not available or cannot be made, the MAC will request a copy of the technician’s certification card.
2. The MAC will not request a social security card to verify an individual’s identity or social security number.

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

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

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

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

Additional Information

Changes to the Laboratory NCD Edit Software – July 2016
MLN Matters® Number: MM9584
Related Change Request (CR) #: CR 9584
Related CR Release Date: March 25, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3485CP
Implementation Date: July 5, 2016

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.

What You Need to Know
Change Request (CR) 9584 informs MACs about changes that will be included in the July 2016 quarterly release of the edit module for clinical diagnostic laboratory services. Make sure that your billing staffs are aware of these changes.

For the July 2016 update, effective for services furnished on or after July 1, 2016, International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes E61.1, M79.641, M79.642, M79.644, and M79.645 are added to the list of ICD-10-CM codes that are covered by Medicare for the Serum Iron Studies (190.18) National Coverage Determination (NCD).

Additional Information

Prompt Payment Interest Rate – January 2016 Update
The Treasury Department notified Noridian that the new Prompt Payment Interest Rate is 2.5% effective January 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