KENTUCKY & OHIO PART A

# Medicare Bulletin

## Jurisdiction 15

*Reaching Out to the Medicare Community*

CGS®
A CELERIAN GROUP COMPANY

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

# Medicare Bulletin

## Jurisdiction 15

KENTUCKY & OHIO PART A

## ADMINISTRATION




## CLAIMS



## COVERAGE



## FEE SCHEDULE



## FQHC/RHC



## HOSPITAL



## ICD-10

*Administration*

## 2014 Provider Contact Center (PCC) Training

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our customer service representatives (CSRs). The CGS Part A PCC (1.866.590.703) will be closed for CSR training and staff development as indicated below. The Interactive Voice Response (IVR) unit will be available during these scheduled training sessions for automated customer service transactions.

Listed below are the training closure dates and time for July.

| Date | PCC/Office Closed |
|---|---|
| Friday, July 4, 2014 | Holiday – CGS office closed |
| Thursday, July 10, 2014 | PCC Closed 9:00 a.m. – 11:00 a.m. ET |
| Thursday, July 24, 2014 | PCC Closed 9:00 a.m. – 11:00 a.m. ET |

For your reference, access the **"Kentucky/Ohio Part A 2014 Holiday/Training Closure Schedule"** at http://www.cgsmedicare.com/parta/cs/holiday_schedule.pdf for a complete list of PCC closures.

*Administration*

## Contact Information for CGS Medicare Part A

To contact a CGS Customer Service Representative, call the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1. For additional contact information, please access the Kentucky & Ohio Part A "Contact Information" Web page at http://www.cgsmedicare.com/parta/cs/index.html for information about the myCGS Web portal, the Interactive Voice Response (IVR) system, as well as telephone numbers, fax numbers, and mailing addresses for other CGS departments.

*Administration*

## eOffset Using myCGS: Clarification of Valid Requests

In May, CGS announced a new feature in the myCGS Web Portal - eOffset. This feature allows registered users to submit electronic authorizations to offset from pending overpayments that are owed to CGS. This option allows providers to request an immediate offset each time a demanded overpayment is received, or authorize a permanent request for all future demanded overpayments.

To use the eOffset function for an immediate offset, the provider must have received an overpayment demand letter from CGS. The letter will include a number in the upper-right corner of the letter. An eOffset may be requested by using this number or the account receivable (AR) number located on the attachment to the demand letter.




RETURN TO TABLE OF CONTENTS

CGS is aware that some providers are attempting to use the eOffset feature to submit a voluntary refund. However, the eOffset function does not support voluntary refunds. To make a voluntary refund, follow the instructions provided on the Overpayment webpage, and use the appropriate Voluntary Refund form, available on the CGS website:

- Part A, http://www.cgsmedicare.com/parta/overpay/index.html
- Part B - Ohio, http://www.cgsmedicare.com/ohb/forms/overpayment.html
- Part B – Kentucky, http://www.cgsmedicare.com/kyb/forms/overpayment.html
- Home Health & Hospice, http://www.cgsmedicare.com/hhh/financial/Overpay.html

**Note:** Part A providers, including home health and hospices, are strongly encouraged to electronically adjust claims to correct overpayments, rather than submit a refund via the Voluntary Refund Request form.

If you have additional questions about using the eOffset feature, please contact the CGS EDI Department using the appropriate number below:

- Part A, **1.866.590.6703** (Option 2)
- Part B – Kentucky and Ohio, 1.866.276.9558 (Option 2)
- Home Health & Hospice: 1.877.299.4500 (Option 2)

You may also refer to the eOffset Job Aid located at http://www.cgsmedicare.com/pdf/eOffsetsJobAid.pdf.

***Administration***

## Medicare Learning Network®: A Valuable Educational Resource!

The Medicare Learning Network® (MLN), offered by the Centers for Medicare & Medicaid Services (CMS), includes a variety of educational resources for health care providers. Access Web-based training courses, national provider conference calls, materials from past conference calls, MLN articles, and much more. To stay informed about all of the CMS MLN products, refer to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MailingLists_FactSheet.pdf and subscribe to the CMS electronic mailing lists. Learn more about what the CMS MLN offers at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html on the CMS website.

***Administration***

## MLN Connects™ Provider e-News

The MLN Connects™ Provider e-News contains a weeks worth of Medicare-related messages issued by the Centers of Medicare & Medicaid Services (CMS). These messages ensure planned, coordinated messages are delivered timely about Medicare-related topics. The following provides access to the weekly messages. Please share with appropriate staff. If you wish to receive the listserv directly from CMS, please contact CMS at LearnResource-L@cms.hhs.gov.

- May 22, 2014 - http://go.cms.gov/1jVHzTn
- May 29, 2014 - http://go.usa.gov/8PgC
- June 5, 2014 - http://go.cms.gov/S8OnGR
- June 12, 2014 - http://go.usa.gov/8ugz



RETURN TO TABLE OF CONTENTS

*Administration*

## MM8456 (Rescinded): Modifying the Daily Common Working File (CWF) to Medicare Beneficiary Database (MBD) File to Include Diagnosis Codes on the Health Insurance Portability and Accountability Act Eligibility Transaction System (HETS) 270/271 Transactions

The Centers for Medicare & Medicaid Services (CMS) has rescinded the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

**MLN Matters® Number:** MM8456 *Rescinded*
**Related CR Release Date:** May 16, 2014
**Related CR Transmittal #:** R1386OTN
**Related Change Request (CR) #:** CR 8456
**Effective Date:** October 1, 2014
**Implementation Date:** October 6, 2014

**Note:** This article was rescinded on May 20, 2014, as a result of a revision to CR 8456, issued on May 16. The CR revision eliminated the need for provider education. As a result, this article is rescinded.

*Administration*

## MM8684: Claim Status Category and Claim Status Codes Update

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

**MLN Matters® Number:** MM8684
**Related CR Release Date:** May 23, 2014
**Related CR Transmittal #:** R2967CP
**Related Change Request (CR) #:** CR 8684
**Effective Date:** October 1, 2014
**Implementation Date:** October 6, 2014

### 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 Medicare administrative contractors (DME MACs) and home health & hospice MACs (HH&H MACs), for services to Medicare beneficiaries.

### Provider Action Needed

This article is based on CR 8684 which informs the MACs of the changes to Claim Status Category Codes and Claim Status Codes. Make sure that your billing personnel are aware of these changes.

### Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use



RETURN TO TABLE OF CONTENTS

(e.g. previous HIPAA named versions included 004010X093A1, more recent HIPAA named versions). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/ on the Internet.

All code changes approved during the June 2014 committee meeting will be posted on these sites on or about July 1, 2014. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

These code changes will be used in the editing of all X12 276 transactions processed on or after the date of implementation and are to be reflected in X12 277 transactions issued on and after the date of implementation of CR 8684.

### Additional Information

The official instruction, CR 8684 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2967CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

*Administration*

## MM8764: July 2014 Integrated Outpatient Code Editor (I/OCE) Specifications Version 15.2

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

**MLN Matters® Number:** MM8764
**Related CR Release Date:** May 16, 2014
**Related CR Transmittal #:** R2957CP
**Related Change Request (CR) #:** CR 8764
**Effective Date:** July 1, 2014
**Implementation Date:** July 7, 2014

### Provider Types Affected

This MLN Matters® article is intended for physicians, other providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including the home health and hospice MACs, for outpatient services provided to Medicare beneficiaries and paid under the Outpatient Prospective Payment System (OPPS) and for outpatient claims from any non-OPPS provider not paid under the OPPS, and for claims for limited services when provided in a home health agency (HHA) not under the Home Health Prospective Payment System (HH PPS) or claims for services to a hospice patient for the treatment of a non-terminal illness.

### Provider Action Needed

This article is based on CR 8764 which informs MACs about the changes to the I/OCE instructions and specifications for the I/OCE that is used under the OPPS and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a HHA not under the HH PPS



RETURN TO TABLE OF CONTENTS

or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staffs are aware of these changes.

### Background

This instruction informs the MACs that the I/OCE is being updated for July 1, 2014. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, which eliminates the need to update, install, and maintain two separate OCE software packages on a quarterly basis. The full list of I/OCE specifications is available at http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html on the CMS website. The summary of key changes for providers is in the following table:

| Effective Date | Modification |
|---|---|
| 10/1/2014 | Modify the effective begin date for edit 86 from 10/1/2013 to 10/1/2014, to be applied for claims with hospice bill types, 81X and 82X. |
| 1/1/2014 | Modify the logic for packaged laboratory services. If packaged laboratory services are submitted on a 13X bill type with modifier L1, change the Status Indicator (SI) from N to A. |
| 7/1/2014 | Make Healthcare Common Procedure Coding System (HCPCS)/Ambulatory Payment Classification (APC)/SI changes as specified by CMS (data change files). |
| 7/1/2014 | Implement version 20.2 of the NCCI (as modified for applicable institutional providers). |
| 1/1/2014 | Add new modifier L1 (Separately payable lab test) to the valid modifier list. |
| 7/1/2014 | Add new modifier SZ (Habilitative services) to the valid modifier list. |
| 1/1/2014 | Updated documentation in Appendix F(a) and Appendix L to include bill type 13x for laboratory services reported with modifier L1. |
| 7/1/2014 | Documentation change only: modified Appendix N, List B (PHP Services) to note the add-on codes in a separate list as part of "PHP List C", referred to in Appendix C-a (Partial Hospitalization Logic effective v10.0). |

### Additional Information

The official instruction, CR 8764 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2957CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

***Administration***

## News Flash Messages from the Centers for Medicare & Medicaid Services (CMS)

- Products from the Medicare Learning Network® (MLN)
  - REVISED "Telehealth Services", Fact sheet (ICN 901705) available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf
  - REVISED "Advance Payment Accountable Care Organization" Fact Sheet, ICN 907403, downloadable at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Advance_Payment_Factsheet_ICN907403.pdf
  - NEW "Information on the National Physician Payment Transparency Program: Open Payments," Podcast, ICN 908961, downloadable only at http://www.cms.gov/



RETURN TO TABLE OF CONTENTS

Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/ICN908961-Podcast.html

- REVISED "Improving Quality of Care for Medicare Patients: Accountable Care Organizations", Fact Sheet, ICN 907407, downloadable at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Quality_Factsheet_ICN907407.pdf
- REVISED "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse", Booklet (ICN 907798) EPUB, QR at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Reduce-Alcohol-Misuse-ICN907798.pdf
- NEW "Medicare Enrollment Guidelines for Ordering/Referring Providers", Fact Sheet, ICN 906223, Downloadable, EPUB, QR at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf

- MLN Matters® Articles Index: Have you ever tried to search MLN Matters® articles for information regarding a certain issue, but you did not know what year it was published? To assist you next time in your search, try the CMS article indexes that are published at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/MLNMattersArticles/ on the CMS website. These indexes resemble the index in the back of a book and contain keywords found in the articles, including HCPCS codes and modifiers. These are published every month. Just search on a keyword(s) and you will find articles that contained those word(s). Then just click on one of the related article numbers and it will open that document. Give it a try.
- 2015 GEMs, Reimbursement Mappings, and ICD-10 Files Now Available -The 2015 General Equivalence Mappings (GEMs), Reimbursement Mappings, ICD-10-CM files, and ICD-10-PCS files are now available on the 2015 ICD-10-CM and GEMs Web page at http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html and 2015 ICD-10-PCS and GEMs Web page at http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-PCS-and-GEMs.html. The mappings can be used to convert policies from ICD-9-CM to ICD-10 codes. The GEMs provide both forward (ICD-9-CM to ICD-10) and backward (ICD-10 to ICD-9-CM) mappings. There are no new, revised, or deleted ICD-10-CM or ICD-10-PCS codes.

***Administration***

## Provider Contact Center Reminders

Your questions are important to us, and CGS's Provider Contact Centers (PCCs) strive to provide the most accurate and consistent information to our provider community. There may be times when we receive a question that requires additional research before an accurate response can be provided by the Customer Service Representative.

Please be advised that every effort is taken to research your questions and to return your call as soon as possible. However, the Centers for Medicare & Medicaid Services (CMS) does allow PCCs up to 10 business days to research and return your call. This information can be found in the CMS Medicare Contractor Beneficiary and Provider Communications Manual (Pub. 100-09) Chapter 6, Section 60.2.5 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/com109c06.pdf).

As a reminder, CGS offers the Interactive Voice Response (IVR) Unit and the myCGS Web portal for eligibility/claim status information.



RETURN TO TABLE OF CONTENTS

- IVR User Guide - http://www.cgsmedicare.com/parta/cs/cgs_j15_parta_ivr_user_guide.pdf
- myCGS - http://www.cgsmedicare.com/parta/myCGS/index.html

***Administration***

## Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all nonregulatory changes to Medicare including transmittals, 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*.

To receive notification when regulations and program instructions are added throughout the quarter, go to https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/CMS-Quarterly-Provider-Updates-Email-Updates.html to sign up for the Quarterly Provider Update (electronic mailing list).

We encourage you to bookmark the Quarterly Provider Update website at https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html and visit it often for this valuable information.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

***Administration***

## Stay Informed and Join the CGS ListServ Notification Service

The CGS ListServ Notification Service is the primary means used by CGS to communicate with Kentucky and Ohio Medicare Part A providers. This is a free email notification service that provides you with prompt notification of Medicare news including policy, benefits, claims submission, claims processing and educational events. Subscribing for this service means that you will receive information as soon as it is available, and plays a critical role in ensuring you are up-do-date on all Medicare information.

Consider the following benefits to joining the CGS ListServ Notification Service:

- It's free! There is no cost to subscribe or to receive information.
- You only need a valid e-mail address to subscribe.



RETURN TO TABLE OF CONTENTS

- Multiple people/e-mail addresses from your facility can subscribe. We recommend that all staff (clinical, billing, and administrative) who interacts with Medicare topics register individually. This will help to facilitate the internal distribution of critical information and eliminates delay in getting the necessary information to the proper staff members.

To subscribe to the CGS ListServ Notification Service, go to http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp and complete the required information.

***Administration***

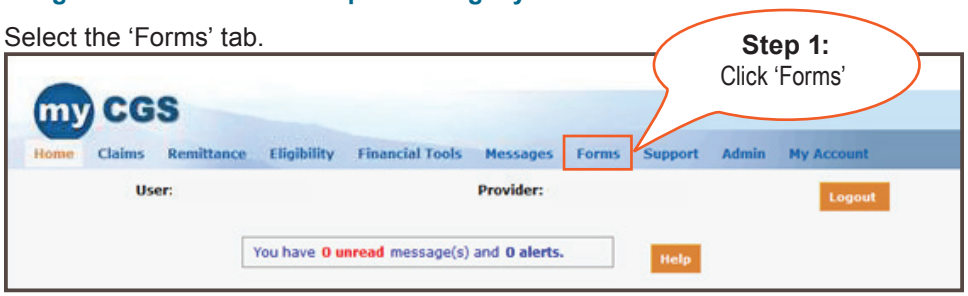
## Submit Your Redetermination Requests through the myCGS Web Portal!

It's fast, easy and cost effective! Redeterminations, the first level of appeal, and supporting medical records can be submitted through the myCGS Web portal. This allows providers to save the cost of printing and mailing paper documents. Once submitted, providers have the ability to monitor the status of these redeterminations within myCGS.

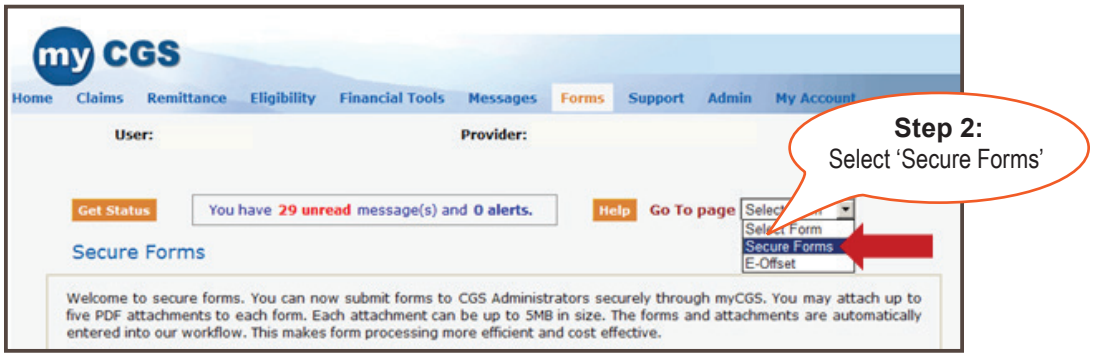
Redetermination requests are submitted through the 'Forms' tab. If you do not have access to the 'Forms' tab, but believe you should, talk with your myCGS Provider Administrator for your agency/organization, and they can update your security. If your agency/organization has not yet registered for myCGS, visit the myCGS registration Web page at http://cgsmedicare.com/mycgs/index.html today!

### Submitting a Redetermination Request using myCGS

1. Select the 'Forms' tab.




2. From the "Go To page" field drop-down box, select 'Secure Forms.' The 'Secure Forms' page will display.

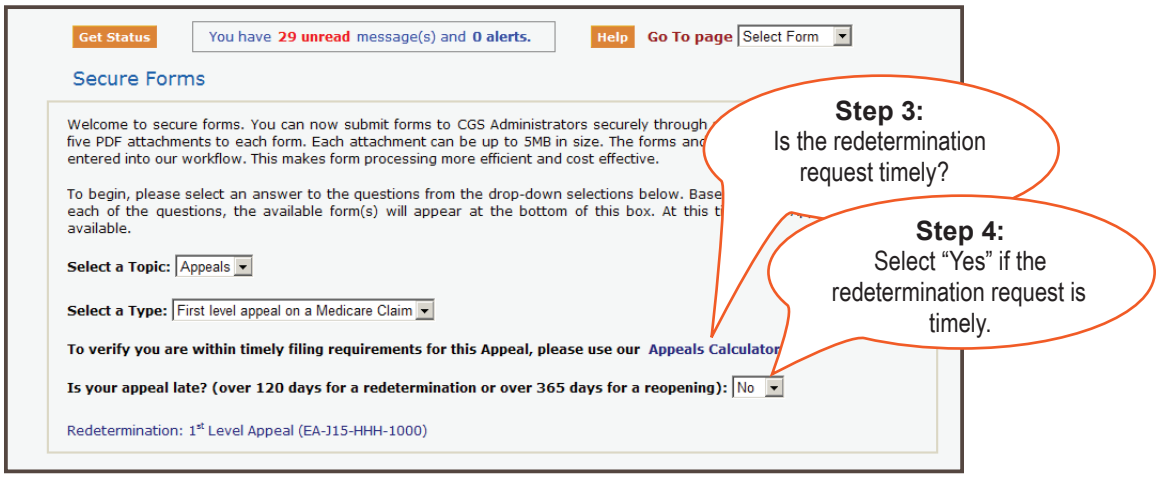



**NOTE:** The **Select a Topic** field on the 'Secure Forms' page defaults to "Appeals." The Select a Type field defaults to "First level appeal on a Medicare Claim."

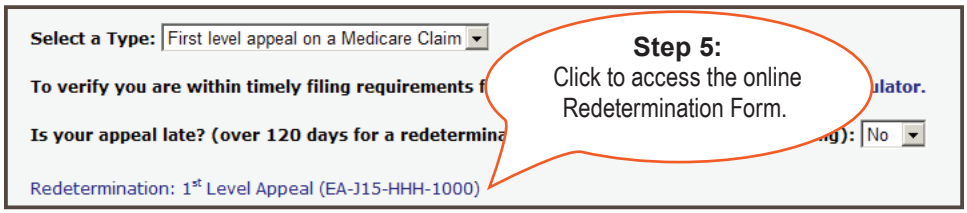


RETURN TO TABLE OF CONTENTS

3. Redetermination requests must be submitted within 120 days of the initial determination (i.e., date on the Medicare remittance advice). If you need to verify that the redetermination request is timely, click on the 'Appeals Calculator' link.




4. Once you have determined that your request is timely, select "Yes" from the drop-down menu. If your appeal is untimely, you cannot submit your redetermination request via the myCGS portal.
5. Click on the "Redetermination: 1st Level Appeal" link to access the online Redetermination Form.

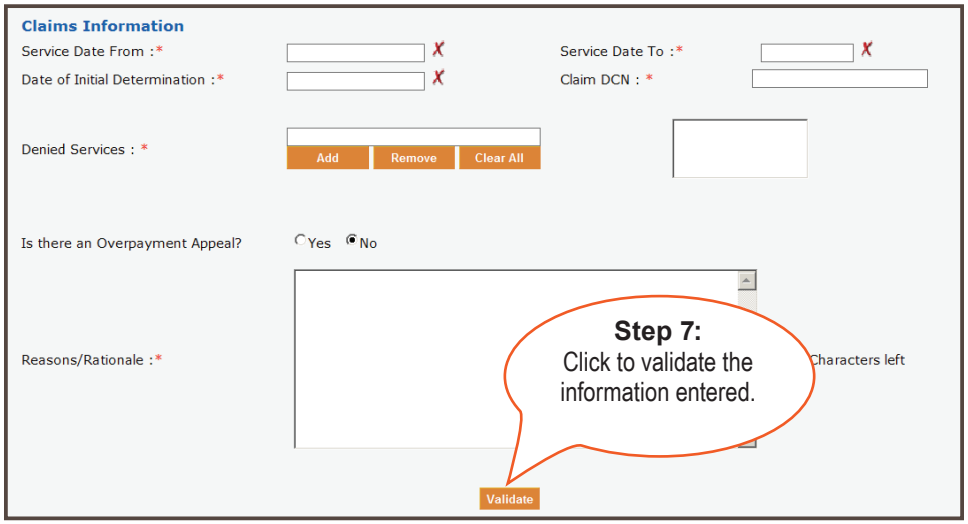



6. The myCGS 'Redetermination 1st Level Appeal' form will appear. There are four sections; 1) Beneficiary Information; 2) Provider Information; 3) Claims Information; and 4) Attachments. Complete the required fields, which are marked with a red asterisk (*).

   Refer to the 'Forms' Tab instructions found on the *myCGS User Manual* Web page at http://www.cgsmedicare.com/mycgs/manual.html for additional information.
7. Once all the information is entered, click 'Validate.' myCGS will validate the information entered. If information is missing or invalid, a message will display indicating the information that must be corrected. If information entered is complete and correct, the message "Your entries have been validated. Please attached the required documents, input your name, and click Submit" will display.

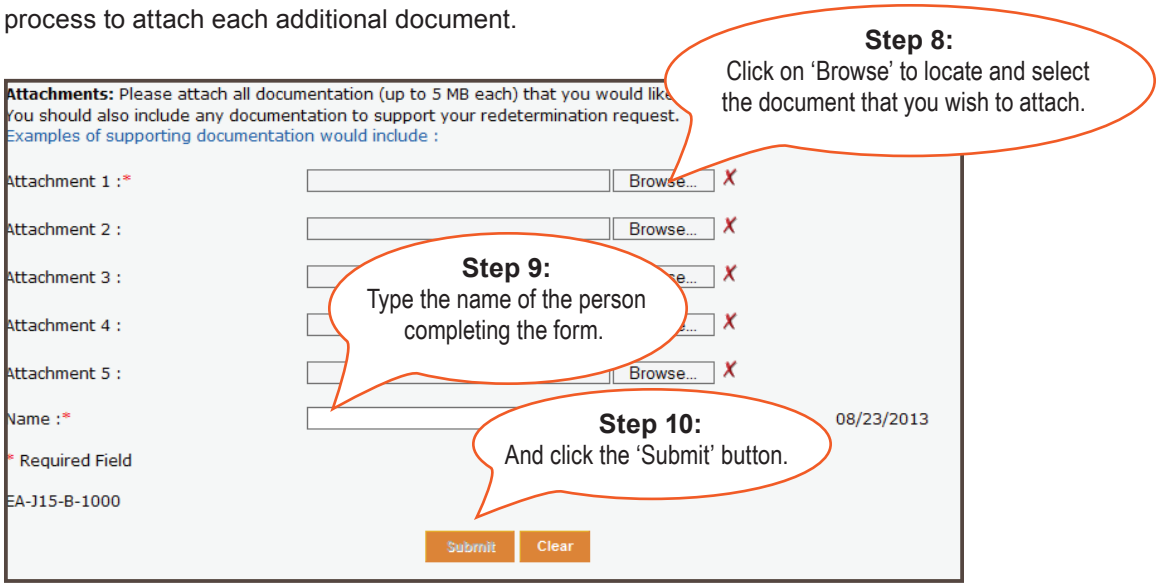


RETURN TO TABLE OF CONTENTS




**NOTE:** The 'Attachments' section of the Redetermination form allows you to attach documentation (e.g., medical records, notes, orders, etc.) you would like CGS to consider when processing your redetermination request. You can attach up to 5 documents (up to 5 MB each). At least one document is required. The documents must be in a PDF format.

8. To add an attachment, select the "Browse" button, and a window will open allowing you to locate the document on your computer that you wish to attach. Repeat this process to attach each additional document.



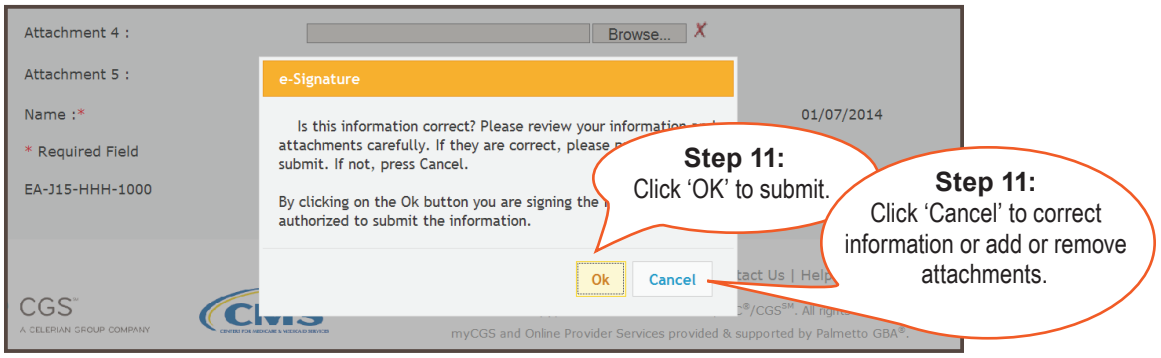

9. Below the attachments section, complete the 'Name' field by typing the name of the person who completed the form.
10. Click the "Submit" button to submit your redetermination requests to CGS. You will receive a message in your myCGS inbox. You can access the message by either clicking on the Messages tab, or clicking the link displayed in the Message bar.
11. An 'e-signature' box will appear, asking you to verify that the information entered and attachments are correct. This ensures the signature requirement for all redetermination requests has been met.

    If the information was entered correctly, and all desired attachments were included, click 'OK' to submit the Redetermination form and all attachments.



RETURN TO TABLE OF CONTENTS

If any information needs to be corrected, or if any attachments need to be added or deleted, click 'Cancel' to return to the form.




12. Once submitted, a message will display in your myCGS inbox with the Subject indicating "Secure Form Received."

Refer to the 'Messages' Tab instructions found on the *myCGS User Manual* Web page at http://www.cgsmedicare.com/mycgs/manual.html for additional information about the messages received in myCGS.

***Claims***

## MM8401 (Revised): Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims

The Centers for Medicare & Medicaid Services (CMS) revised the following ***Medicare Learning Network® (MLN) Matters*** article on May 15, 2014. The article was revised again on June 9, 2014. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

**MLN Matters® Number:** MM8401 *Revised*
**Related CR Release Date:** May 13, 2014
**Related CR Transmittal #:** R2955CP
**Related Change Request (CR) #:** CR 8401
**Effective Date:** January 1, 2014
**Implementation Date:** January 6, 2014

**Note:** This article was revised on May 15, 2014, to reflect the revised CR 8401 issued on May 13. The article has been revised to delete information regarding entry of the clinical trial number on institutional paper or Direct Data Entry (DDE) claim UB-04. Also, the transmittal number, the CR release date, and the Web address for accessing the CR are revised. All other information remains the same.

**Note:** This article was revised on June 9, 2104, to emphasize that coding "CT" in front of the clinical trial number applies ONLY to paper claims. The "CT" is not to be coded on electronic claims. All other information remains the same.

### Provider Types Affected

This MLN Matters® article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, durable medical equipment (DME) Medicare administrative contractors (MACs) and A/B MACs) for items and services provided in clinical trials to Medicare beneficiaries.

### Provider Action Needed

This article is based on CR 8401, which informs you that, effective January 1, 2014, it will be mandatory to report a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the "Medicare National



RETURN TO TABLE OF CONTENTS

Coverage Determination (NCD) Manual," Section 310.1.

The clinical trial number to be reported is the same number that has been reported voluntarily since the implementation of CR 5790, dated January 18, 2008. That is the number assigned by the National Library of Medicine (NLM) http://clinicaltrials.gov/ website when a new study appears in the NLM Clinical Trials data base.

Make sure that your billing staffs are aware of this requirement.

### Background

CR 5790, Transmittal 310, dated January 18, 2008, titled "Requirements for Including an 8-Digit Clinical Trial Number on Claims" is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R310OTN.pdf on the CMS website. The MLN Matters® Article for CR 5790 is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5790.pdf on the CMS website.

This number is listed prominently on each specific study's page and is always preceded by the letters 'NCT.'

CMS uses this number to identify all items and services provided to beneficiaries during their participation in a clinical trial, clinical study, or registry. Furthermore, this identifier permits CMS to better track Medicare payments, ensure that the information gained from the research is used to inform coverage decisions, and make certain that the research focuses on issues of importance to the Medicare population.

Suppliers may verify the validity of a trial/study/registry by consulting CMS's clinical trials/registry website at http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html on the CMS website.

For institutional claims that are submitted on the electronic claim 837I, the 8-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:

- Condition code 30;
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

For professional claims, the 8-digit clinical trial number preceded by the 2 alpha characters of CT (use CT only on paper claims) must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REF01=P4) (**do not use CT on the electronic claim, e.g., 12345678**) when a clinical trial claim includes:

- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

Medicare Part B clinical trial/registry/study claims with dates of service on and after January 1, 2014, not containing an 8-digit clinical trial number will be returned as unprocessable to the provider for inclusion of the trial number using the messages listed below.

- Claim Adjustment Reason Code (CARC) 16: "Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either National Council for Prescription Drug Programs (NCPDP) Reject Reason Code, or Remittance Advice Remark Code (RARC) that is not an ALERT.)"
- RARC MA50: "Missing/incomplete/invalid Investigational Device Exemption number



RETURN TO TABLE OF CONTENTS

for FDA-approved clinical trial services."

- RARC MA130: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."
- Group Code-Contractual Obligation (CO).

**Note:** This is a reminder/clarification that clinical trials that are also investigational device exemption (IDE) trials must continue to report the associated IDE number on the claim form as well.

### Additional Information

The official instruction, CR 8401, issued to your Medicare contractor regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2955CP.pdf on the CMS website.

See MLN Matters® Article SE1344 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1344.pdf) for information on an interim alternative method of satisfying the requirement in CR 8401 for providers who do not have the ability to submit the clinical trial number for trial related claims.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

*Coverage*

## MM8739 (Revised): Fluorodeoxyglucose (FDG) Positron Emission Tomography (PET) for Solid Tumors (This Change Request (CR) rescinds and fully replaces MM 8468, dated February 6, 2014.)

The Centers for Medicare & Medicaid Services (CMS) has revised the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

**MLN Matters® Number:** MM8739 *Revised*
**Related CR Release Date:** May 28, 2014
**Related CR Transmittal #:** R2932CP, R168NCD
**Related Change Request (CR) #:** CR 8739
**Effective Date:** June 11, 2013

**Implementation Date:** May 19, 2014 - MAC Non-Shared System Edits; July 7, 2014 - CWF development/testing, FISS requirement development; October 6, 2014 - CWF, FISS, MCS Shared System Edits

**Note:** This article was revised on May 30, 2014, to reflect the revised CR8739 issued on May 28. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

### Provider Types Affected

This MLN Matters® article is intended for physicians, providers and suppliers submitting claims to Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

### Provider Action Needed

This article is based on CR 8739, which advises MACs, effective for dates of service on



RETURN TO TABLE OF CONTENTS

or after June 11, 2013, to cover three FDG PET scans when used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same cancer diagnosis. Coverage of any additional FDG PET scans (that is, beyond three) used to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for the same diagnosis will be determined by your MAC. Make sure your billing staffs are aware of these changes.

### Background

CMS has reconsidered Section 220.6, of the "National Coverage Determinations (NCD) Manual" to end the prospective data collection requirements across all oncologic indications of FDG PET in the context of CR8739. The term FDG PET includes PET/computed tomography (CT) and PET/magnetic resonance (MRI).

CMS is revising the "NCD Manual", Section 220.6, to reflect that CMS has ended the coverage with evidence development (CED) requirement for (2-[F18] fluoro-2-deoxy-D-glucose) FDG PET, PET/CT, and PET/MRI for all oncologic indications contained in Section 220.6.17 of the "NCD Manual." This removes the current requirement for prospective data collection by the National Oncologic PET Registry (NOPR) for oncologic indications for FDG (Healthcare Common Procedure Coding System (HCPCS) Code A9552) only.

**Note:** For clarification purposes, as an example, each different cancer diagnosis is allowed one (1) initial treatment strategy (-PI modifier) FDG PET Scan and three (3) subsequent treatment strategy (-PS modifier) FDG PET Scans without the -KX modifier. The fourth FDG PET Scan and beyond for subsequent treatment strategy for the same cancer diagnosis will always require the -KX modifier. If a different cancer diagnosis is reported, whether reported with a -PI modifier or a -PS modifier, that cancer diagnosis will begin a new count for subsequent treatment strategy for that beneficiary. A beneficiary's file may or may not contain a claim for initial treatment strategy with a -PI modifier. The existence or non-existence of an initial treatment strategy claim has no bearing on the frequency count of the subsequent treatment strategy (-PS) claims.

Providers may refer to Attachment 1 of CR 8739 for a list of appropriate diagnosis codes.

Effective for claims with dates of service on or after June 11, 2013, Medicare will accept and pay for FDG PET oncologic claims billed to inform initial treatment strategy or subsequent treatment strategy for suspected or biopsy proven solid tumors for all oncologic conditions without requiring the following:

- Q0 modifier: Investigational clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);
- Q1 modifier: routine clinical service provided in a clinical research study that is in an approved clinical research study (institutional claims only);
- V70.7: Examination of participant in clinical research; or
- Condition code 30 (institutional claims only).

Effective for dates of service on or after June 11, 2013, MACs will use the following messages when denying claims in excess of three for PET FDG scans for subsequent treatment strategy when the –KX modifier is not included, identified by CPT codes 78608, 78811, 78812, 78813, 78814, 78815, or 78816, modifier –PS, HCPCS A9552, and the same cancer diagnosis code:

- Claim Adjustment Reason Code (CARC) 96: "Non-Covered Charge(s). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."
- Remittance Advice Remarks Code (RARC) N435: "Exceeds number/frequency approved/allowed within time period without support documentation."



RETURN TO TABLE OF CONTENTS

- Group Code PR assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.
- 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.

MACs will not search their files to adjust claims processed prior to implementation of CR 8739. However, if you have such claims and bring them to the attention of your MAC, the MAC will adjust such claims if appropriate.

### Synopsis of Coverage of FDG PET for Oncologic Conditions

Effective for claims with dates of service on and after June 11, 2013, the chart below summarizes national FDG PET coverage for oncologic conditions:

| **FDG PET for Cancers Tumor Type** | **Initial Treatment Strategy** (formerly "diagnosis" & "staging") | **Subsequent Treatment Strategy** (formerly "restaging" & "monitoring response to treatment") |
|---|---|---|
| Colorectal | Cover | Cover |
| Esophagus | Cover | Cover |
| Head and Neck (not thyroid, CNS) | Cover | Cover |
| Lymphoma | Cover | Cover |
| Non-small cell lung | Cover | Cover |
| Ovary | Cover | Cover |
| Brain | Cover | Cover |
| Cervix | Cover with exceptions * | Cover |
| Small cell lung | Cover | Cover |
| Soft tissue sarcoma | Cover | Cover |
| Pancreas | Cover | Cover |
| Testes | Cover | Cover |
| Prostate | **Non-cover** | Cover |
| Thyroid | Cover | Cover |
| Breast (male and female) | Cover with exceptions * | Cover |
| Melanoma | Cover with exceptions * | Cover |
| All other solid tumors | Cover | Cover |
| Myeloma | Cover | Cover |
| All other cancers not listed | Cover | Cover |

* Cervix: Nationally non-covered for the initial diagnosis of cervical cancer related to initial anti-tumor treatment strategy. All other indications for initial anti-tumor treatment strategy for cervical cancer are nationally covered.

* Breast: Nationally non-covered for initial diagnosis and/or staging of axillary lymph nodes. Nationally covered for initial staging of metastatic disease. All other indications for initial anti-tumor treatment strategy for breast cancer are nationally covered.

* Melanoma: Nationally non-covered for initial staging of regional lymph nodes. All other indications for initial anti-tumor treatment strategy for melanoma are nationally covered.

### Additional Information

The official instruction, CR 8739, issued to your MAC regarding this change, is available at in two transmittals at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2932CP.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R168NCD.pdf on the CMS website.



RETURN TO TABLE OF CONTENTS

*Coverage*

# MM8757: Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

**MLN Matters® Number:** MM8757
**Related CR Release Date:** May 16, 2014
**Related CR Transmittal #:** R167NCD and R2959CP
**Related Change Request (CR) #:** CR 8757
**Effective Date:** January 9, 2014
**Implementation Date:** October 6, 2014

## Provider Types Affected

This MLN Matters® article is intended for providers submitting claims to Medicare administrative contractors (MACs) for services furnished to Medicare beneficiaries.

## Provider Action Needed

Effective for claims with dates of service on and after January 9, 2014, Medicare will only allow coverage with evidence development (CED) for percutaneous image-guided lumbar decompression (PILD) for lumbar spinal stenosis (LSS) for beneficiaries enrolled in an approved clinical trial.

## Background

PILD is a procedure that was proposed as a treatment for symptomatic LSS unresponsive to conservative therapy. PILD is a posterior decompression of the lumbar spine performed under indirect image guidance without any direct visualization of the surgical area. It is generally described as a non-invasive procedure using specially designed instruments to percutaneously remove a portion of the lamina and debulk the ligamentum flavum. The procedure is performed under x-ray guidance (e.g., fluoroscopic, CT) with the assistance of contrast media to identify and monitor the compressed area via epiduragram.

CMS currently does not cover PILD; and moreover, after careful consideration, determines that PILD for lumbar spinal stenosis LSS is not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act (the Act).

However, CMS has determined that effective for claims with dates of service on or after January 9, 2014, Medicare will cover PILD only when it is provided in a clinical study under section 1862(a)(1)(E) of the Act, through CED, for beneficiaries with LSS who are enrolled in an approved clinical study that meets the criteria described in the National Coverage Determinations (NCD) Manual at NCD150.13.

## Specific Payment Actions

- On or after January 9, 2014, effective for hospital outpatient procedures on type of bill (TOB) 13X or 85X, and for professional claims billed with a place of service (POS) 22 (outpatient) or 24 (ambulatory surgical center), Medicare will allow CED for PILD (procedure code 0275T) for LSS, ICD-9 diagnosis range 724.01-724.03, or ICD-10 diagnosis range M48.05-M48.07, only when billed with:
  - **a.** Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) and condition code 30 either in the primary or secondary positions; and
  - **b.** Modifier Q0; and



RETURN TO TABLE OF CONTENTS

   c. An 8-digit clinical trial number listed at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/PILD.html on the CMS CED website.

- On or after January 9, 2014, effective for hospital outpatient procedures on type of bill (TOB) 13X or 85X, your MAC will reject claims for PILD, procedure code 0275T for LSS, ICD-9 diagnosis range 724.01-724.03, or ICD-10 diagnosis range M48.05-M48.07, when billed without:

   a. Diagnosis code ICD-9 V70.7 (ICD-10 Z00.6) in either the primary/secondary positions;

   b. Modifier Q0, condition code 30 (institutional claims only); and,

   c. An 8-digit clinical trial number listed on the CMS website.

When rejecting these claims, they will use:

   a. Claims Adjustment Reason Code (CARC): 50 -These are non-covered services because this is not deemed a "medical necessity" by the payer;

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

   c. Group Code – Contractual Obligation (CO).

- MACs will return the professional PILD claim as unprocessable when billed with a diagnosis code other than 724.01-724.03 (ICD-9) or M48.05-M48.07 (ICD-10), using:

   a. CARC B22: "This payment is adjusted based on the diagnosis;"

   b. RARC N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.;" and

   c. Group Code-Contractual Obligation (CO).

- MACs will return the professional PILD claim as unprocessable when billed in a place of service other than 22 (outpatient) or 24 (ambulatory surgical center), using:

   a. CARC 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service;"

   b. RARC N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.;" and

   c. Group Code-Contractual Obligation (CO).

- MACs will return the professional PILD claim as unprocessable if it does not contain the required clinical trial diagnosis code V70.7 (ICD-9) or Z00.6 (ICD-10) in either the primary/secondary positions, using:

   a. CARC B22: "This payment is adjusted based on the diagnosis;"

   b. RARC M76: "Missing/incomplete/invalid diagnosis or condition;"

   c. RARC N704: "Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.;" and

   d. Group Code-Contractual Obligation (CO).

- MACs will return the professional PILD claim as unprocessable when billed without Modifier Q0, using:

   a. CARC 4: "The procedure code is inconsistent with the modifier used or a required modifier is missing;"

   b. RARC N657: "This should be billed with the appropriate code for these services.;"



RETURN TO TABLE OF CONTENTS

c. RARC N704: "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information;" and

d. Group Code-Contractual Obligation (CO).

- MACs will accept the numeric, 8-digit clinical trial identifier number preceded by the two alpha characters of "CT" when placed in Field 19 of paper Form CMS-1500, or when entered WITHOUT the "CT" prefix in the electronic 837P in Loop 2300 REF02 (REF01=P4). **NOTE: The "CT" prefix is required on a paper claim, but it is not required on an electronic claim.**
- For PILD claims submitted without a clinical trial identifier number, they will follow the requirements outlined in CR8401, Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims, released on October 30, 2013. You can find the associated MLN Matters® article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf on the CMS website.

MACs will not search their files to adjust claims already processed, but will adjust claims that you bring to their attention.

Finally, you should note that endoscopically assisted laminotomy/laminectomy, which requires open and direct visualization, as well as other open lumbar decompression procedures for LSS, are not within the scope of this NCD.

### Additional Information

The official instruction, CR 8757, issued to your MAC, consists of two transmittals. The first updates the "Medicare National Coverage Determinations Manual" and it is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R167NCD.pdf on the CMS website. The second transmittal updates the "Medicare Claims Processing Manual" and it is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2959CP.pdf on the same site.

*Fee Schedule*

## MM8664 (Revised): April Update to the Calendar Year (CY) 2014 Medicare Physician Fee Schedule Database (MPFSDB)

The Centers for Medicare & Medicaid Services (CMS) has revised the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

**MLN Matters® Number:** MM8664 *Revised*
**Related CR Release Date:** April 4, 2014
**Related CR Transmittal #:** R2923CP
**Related Change Request (CR) #:** CR 8664
**Effective Date:** January 1, 2014
**Implementation Date:** April 7, 2014

**Note:** This article was revised on April 8, 2014, to reflect the revised CR 8664 issued on April 4. The CR was revised to reflect the President signing into law the "Protecting Access to Medicare Act of 2014" on April 1, 2014, thus averting the expiration of the 0.5% update to the physician fee schedule conversion factor and the 1.0 work floor GPCI, which will now remain in effect until December 31, 2014. Similar changes were made to this article. The CR release date and the Web address for accessing the CR are revised. All other information remains the same.



RETURN TO TABLE OF CONTENTS

### Provider Types Affected

This MLN Matters® article is intended for physicians, other providers, and suppliers who submit claims to Medicare claims administration contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (MACs), home health and hospices (HH&Hs) MACs, and/or regional HH intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

### Provider Action Needed

This article is based on CR 8664 which amends the payment files that were issued to Medicare contractors based upon the CY 2014 MPFS, Final Rule and passage of the "Protecting Access to Medicare Act of 2014," which the President signed on April 1, 2014. Make sure that your billing staffs are aware of these changes.

### Background

The Social Security Act (Section 1848(c)(4); see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm on the Internet) authorizes CMS to establish ancillary policies necessary to implement relative values for physicians' services.

In order to reflect appropriate payment policy as included in the CY 2014 MPFS Final Rule, the MPFSDB has been updated with April changes, and those necessitated by "Protecting Access to Medicare Act of 2014," which the President signed on April 1, 2014. This law extends the 0.5% update through December 31, 2014. Since the Act extends the MPFSDB policies to all of CY 2014, the April update payment files that were previously created to be effective from January 1, 2014, to March 31, 2014, can now be used by MACs to be effective from January 1, 2014, to December 31, 2014.

**Note:** Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims brought to their attention.

### CR 8664 Summary of Changes

The summary of changes for the April 2014 update consists of the following:

1. **Short Description Corrections for HCPCS codes G0416 - G0419**

| HCPCS Code | Old Short Description | Revised 2014 Short Description |
|---|---|---|
| **G0416** | Sat biopsy prostate 1-20 spc | Biopsy prostate 10-20 spc |
| **G0417** | Sat biopsy prostate 21-40 | Biopsy prostate 21-40 |
| **G0418** | Sat biopsy prostate 41-60 | Biopsy prostate 41-60 |
| **G0419** | Sat biopsy prostate: >60 | Biopsy prostate: >60 |

2. **Adjust the Facility and Non-Facility PE RVUs for HCPCS code 77293-Global and 77293-TC via CMS update files.**

| HCPCS | Mod | Status | Description | Non- Facility PE RVUs | Facility PE RVUs | Global | |
|---|---|---|---|---|---|---|---|
| 77293 | | A | Respirator motion mgmt simul | 9.96 | NA | ZZZ | Jan 1 to March 31, 2014 |
| 77293 | TC | A | Respirator motion mgmt simul | 9.16 | NA | ZZZ | Jan 1 to March 31, 2014 |
| 77293 | | A | Respirator motion mgmt simul | 10.72 | NA | ZZZ | Correction April 1, 2014, RVU change effective January 1 to December 31, 2014 |
| 77293 | TC | A | Respirator motion mgmt simul | 9.92 | NA | ZZZ | Correction April 1, 2014, RVU change effective January 1 to December 31, 2014 |



RETURN TO TABLE OF CONTENTS

3. **HCPCS code G9361 will be added to your Medicare contractor's systems.**

| HCPCS Code | G9361 |
|---|---|
| Procedure Status | M |
| Short Descriptor | Doc comm risk calc |
| Effective Date | 01/01/2014 |
| Work RVU | 0 |
| Full Non-Facility PE RVU | 0 |
| Full Non-Facility NA Indicator | (blank) |
| Full Facility PE RVU | 0 |
| Full Facility NA Indicator | (blank) |
| Malpractice RVU | 0 |
| Multiple Procedure Indicator | 9 |
| Bilateral Surgery Indicator | 9 |
| Assistant Surgery Indicator | 9 |
| Co-Surgery Indicator | 9 |
| Team Surgery Indicator | 9 |
| PC/TC | 9 |
| Site of Service | 9 |
| Global Surgery | XXX |
| Pre | 0.00 |
| Intra | 0.00 |
| Post | 0.00 |
| Physician Supervision Diagnostic Indicator | 09 |
| Diagnostic Family Imaging Indicator | 99 |
| Non-Facility PE used for OPPS Payment Amount | 0.00 |
| Facility PE used for OPPS Payment Amount | 0.00 |
| MP Used for OPPS Payment Amount | 0.00 |
| Type of Service | 9 |
| Long Descriptor | Medical indication for induction [Documentation of reason(s) for elective delivery or early induction (e.g., hemorrhage and placental complications, hypertension, preeclampsia and eclampsia, rupture of membranes-premature, prolonged maternal conditions complicating pregnancy/delivery, fetal conditions complicating pregnancy/delivery, malposition and malpresentation of fetus, late pregnancy, prior uterine surgery, or participation in clinical trial)] |

4. **Correct the Physician Supervision of Diagnostic Procedures indicator for the TC's of the following codes, effective January 1, 2014.**

| HCPCS Code | | Physician Supervision of Diagnostic Procedures (Phys Diag Supv) | Effective Date |
|---|---|---|---|
| 70450-TC | Ct head/brain w/o dye - Phys Diag Supv Correction (TC) | 01 | 01/01/2014 |
| 70460-TC | Ct head/brain w/dye - Phys Diag Supv Correction (TC) | 02 | 01/01/2014 |
| 70551-TC | Mri brain stem w/o dye - Phys Diag Supv Correction (TC) | 01 | 01/01/2014 |



RETURN TO TABLE OF CONTENTS

| HCPCS Code | | Physician Supervision of Diagnostic Procedures (Phys Diag Supv) | Effective Date |
|---|---|---|---|
| 70552-TC | Mri brain stem w/dye - Phys Diag Supv Correction (TC) | 02 | 01/01/2014 |
| 70553-TC | Mri brain stem w/o & w/dye - Phys Diag Supv Correction (TC) | 02 | 01/01/2014 |
| 72141-TC | Mri neck spine w/o dye - Phys Diag Supv Correction (TC) | 01 | 01/01/2014 |
| 72142-TC | Mri neck spine w/dye - Phys Diag Supv Correction (TC) | 02 | 01/01/2014 |
| 72146-TC | Mri chest spine w/o dye - Phys Diag Supv Correction (TC) | 01 | 01/01/2014 |
| 72147-TC | Mri chest spine w/dye - Phys Diag Supv Correction (TC) | 02 | 01/01/2014 |
| 72148-TC | Mri lumbar spine w/o dye - Phys Diag Supv Correction (TC) | 01 | 01/01/2014 |
| 72149-TC | Mri lumbar spine w/dye - Phys Diag Supv Correction (TC) | 02 | 01/01/2014 |
| 72156-TC | Mri neck spine w/o & w/dye - Phys Diag Supv Correction (TC) | 02 | 01/01/2014 |
| 72157-TC | Mri chest spine w/o & w/dye - Phys Diag Supv Correction (TC) | 02 | 01/01/2014 |
| 72158-TC | Mri lumbar spine w/o & w/dye - Phys Diag Supv Correction (TC) | 02 | 01/01/2014 |
| 72191-TC | Ct angiograph pelv w/o&w/dye - Phys Diag Supv Correction (TC) | 02 | 01/01/2014 |
| 74174-TC | Ct angio abd&pelv w/o&w/dye - Phys Diag Supv Correction (TC) | 02 | 01/01/2014 |
| 74175-TC | Ct angio abdom w/o & w/dye - Phys Diag Supv Correction (TC) | 02 | 01/01/2014 |
| 93880-TC | Extracranial bilat study - Phys Diag Supv Correction (TC) | 01 | 01/01/2014 |
| 93882-TC | Extracranial uni/ltd study - Phys Diag Supv Correction (TC) | 01 | 01/01/2014 |
| 77001-TC | Fluoroguide for vein device - Phys Diag Supv Correction (TC) | 03 | 01/01/2014 |
| 77002-TC | Needle localization by xray - Phys Diag Supv Correction (TC) | 03 | 01/01/2014 |
| 77003-TC | Fluoroguide for spine inject - Phys Diag Supv Correction (TC) | 03 | 01/01/2014 |

### Additional Information

The official instruction, CR 8664, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2923CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.



RETURN TO TABLE OF CONTENTS

*Fee Schedule*

# MM8773: July Update to the Calendar Year (CY) 2014 Medicare Physician Fee Schedule Database (MPFSDB)

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

**MLN Matters® Number:** MM8773
**Related CR Release Date:** June 6, 2014
**Related CR Transmittal #:** R2974CP
**Related Change Request (CR) #:** CR 8773
**Effective Date:** July 1, 2014
**Implementation Date:** July 7, 2014

## Provider Types Affected

This MLN Matters® article is intended for physicians, other providers, and suppliers who submit claims to Medicare administrative contractors (MACs), including home health and hospice (HHH) MACs, for services provided to Medicare beneficiaries.

## Provider Action Needed

This article is based on CR 8773 which amends the payment files that were issued to MACs based upon the CY 2014 MPFS, Final Rule as modified by the "Pathway for SGR Reform Act of 2013" (Section 101) passed on December 18, 2013, and further modified by section 101 of the "Protecting Access to Medicare Act of 2014" on April 1, 2014. Make sure your billing staffs are aware of these changes.

## Background

The Social Security Act (Section 1848 (c)(4) (available at http://www.socialsecurity.gov/OP_Home/ssact/title18/1848.htm) authorizes CMS to establish ancillary policies necessary to implement relative values for physicians' services.

In order to reflect appropriate payment policy based on current law and the Calendar Year (CY) 2014 Medicare Physician Fee Schedule (MPFS) Final Rule, the MPFS Database (MPFSDB) has been updated using the 0.5 percent update conversion factor, effective January 1, 2014, to December 31, 2014.

Payment files were issued to MACs based upon the CY 2014 MPFS Final Rule, published in the Federal Register on December 10, 2013, which is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1600-FC.html, and as modified by section 101 of the "Pathway for SGR Reform Act of 2013" passed on December 18, 2013, and further modified by section 101 of the "Protecting Access to Medicare Act of 2014" on April 1, 2014, for MPFS rates to be effective January 1, 2014, to December 31, 2014.

The summary of Healthcare Common Procedure Coding System (HCPCS) Code additions for the July 2014 update are shown in the following table:

| HCPCS | Short Descriptor | Procedure Status |
|---|---|---|
| Q9970 | Inj Ferric Carboxymaltos 1mg | E |
| Q9974 | Morphine epidural/intratheca | E |
| S0144 | Inj, Propofol, 10mg | I |
| S1034 | Art pancreas system | I |
| S1035 | Art pancreas inv disp sensor | I |



RETURN TO TABLE OF CONTENTS

| HCPCS | Short Descriptor | Procedure Status |
|---|---|---|
| S1036 | Art pancreas ext transmitter | I |
| S1037 | Art pancreas ext receiver | I |
| 0347T | Ins bone device for rsa | C |
| 0348T | Rsa spine exam | C |
| 0349T | Rsa upper extr exam | C |
| 0350T | Rsa lower extr exam | C |
| 0351T | Intraop oct brst/node spec | C |
| 0352T | Oct brst/node i&r per spec | C |
| 0353T | Intraop oct breast cavity | C |
| 0354T | Oct breast surg cavity i&r | C |
| 0355T | Gi tract capsule endoscopy | C |
| 0356T | Insrt drug device for iop | C |
| 0358T | Bia whole body | C |
| 0359T | Behavioral id assessment | C |
| 0360T | Observ behav assessment | C |
| 0361T | Observ behav assess addl | C |
| 0362T | Expose behav assessment | C |
| 0363T | Expose behav assess addl | C |
| 0364T | Behavior treatment | C |
| 0365T | Behavior treatment addl | C |
| 0366T | Group behavior treatment | C |
| 0367T | Group behav treatment addl | C |
| 0368T | Behavior treatment modified | C |
| 0369T | Behav treatment modify addl | C |
| 0370T | Fam behav treatment guidance | C |
| 0371T | Mult fam behav treat guide | C |
| 0372T | Social skills training group | C |
| 0373T | Exposure behavior treatment | C |
| 0374T | Expose behav treatment addl | C |

All the additional codes listed in the above table are effective as of July 1, 2014. For full details on the above codes, including on descriptors, place of service codes, co-surgery indicators, etc. see the tables in CR 8773. The Web address for CR 8773 is in the "Additional Information" section below.

In addition to the codes that were added, codes J2271 (Morphine SO4 injection 100mg) and J2275 (Morphine sulfate injection) have a change in their procedure status code from E to I, effective July 1, 2014.

Also, Section 651 of Medicare Modernization Act (MMA) required the Secretary of Health and Human Services to conduct a demonstration for up to 2 years to evaluate the feasibility and advisability of expanding coverage for chiropractic services under Medicare. The demonstration expanded Medicare coverage to include: "(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and (B) diagnostic and other services that a chiropractor is legally authorized to perform by the state or jurisdiction in which such treatment is provided." The demonstration, which ended on March 31, 2007, was required to be budget neutral as section 651(f)(1)(B) of MMA mandates the Secretary to ensure that "the aggregate payments made by the Secretary under the Medicare program do not exceed the amount which the Secretary would



RETURN TO TABLE OF CONTENTS

have paid under the Medicare program if the demonstration projects under this section were not implemented." The costs of this demonstration were higher than expected and CMS has been recovering costs by deducting 2 percent from payments for chiropractic services. Since CMS has determined that the costs are fully recovered, the July update eliminates the 2 percent reduction for CPT codes 98940, 98941, and 98942 that was utilized for the first half of CY 2014, effective July 1, 2014.

### Additional Information

The official instruction, CR 8773 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2974CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

*FQHC/RHC*

## MM8743: Implementation of a Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs)

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

**MLN Matters® Number:** MM8743
**Related CR Release Date:** May 9, 2014
**Related CR Transmittal #:** R1383OTN
**Related Change Request (CR) #:** CR 8743
**Effective Date:** October 1, 2014
**Implementation Date:** October 6, 2014

### Provider Types Affected

This MLN Matters® article is intended for federally qualified health centers (FQHCs) submitting claims to Part A Medicare administrative contractors (A MACs) for services furnished to Medicare beneficiaries.

### Provider Action Needed

**STOP – Impact to You**
CMS is establishing a Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) with specific payment codes that FQHCs must use in order to ensure payment.

**CAUTION – What You Need to Know**
CR 8743, from which this article is taken, implements the FQHC PPS, effective for cost reporting periods beginning on or after October 1, 2014. This article does not apply to any FQHC claims that are not subject to the PPS. FQHCs will remain under the all-inclusive rate (AIR) system until their first cost reporting period beginning on or after October 1, 2014.

**GO – What You Need to Do**
Make sure your billing staffs are aware of these new coding requirements.

### Background

Except for services that are paid at 100 percent of costs, Medicare currently pays FQHCs 80 percent of their AIR. MACs reconcile costs and visits at year-end through cost report settlement.



RETURN TO TABLE OF CONTENTS

In compliance with the statutory requirements of the Affordable Care Act, CMS established a national encounter-based prospective payment rate for all FQHCs, determined based on an average of the reasonable costs of all FQHCs.

FQHCs will transition to the FQHC PPS based on their cost reporting periods. For FQHCs with cost reporting periods beginning before October 1, 2014, MACs shall continue to pay the FQHCs using the current AIR system. For FQHCs with cost reporting periods beginning on or after October 1, 2014, MACs shall pay the FQHCs using the FQHC PPS.

Under the FQHC PPS, Medicare will pay FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically-necessary, face-to-face FQHC visit is furnished to a Medicare beneficiary. Medicare will allow for an additional payment when an illness or injury occurs subsequent to the initial visit, or when a mental health visit is furnished on the same day as a medical visit.

The PPS rate will be adjusted when a FQHC furnishes care to a patient who is new to the FQHC or to a beneficiary receiving an initial preventive physical examination (IPPE) or an annual wellness visit (AWV). CMS is establishing specific payment codes to be used under the FQHC PPS based on descriptions of services that will correspond to the appropriate PPS rates.

The PPS rates will also be adjusted to account for geographic differences in the cost of inputs by applying FQHC geographic adjustment factors (FQHC GAFs). In calculating the total payment amount, the FQHC GAF will be based on the locality of the site where the services are furnished. For FQHC organizations with multiple sites, the FQHC GAF may vary depending on the location of the FQHC delivery site.

From October 1, 2014, through December 31, 2015, the FQHC PPS base payment rate is $158.85. Updates to the FQHC PPS base payment rate and the FQHC GAF will be made available through program instruction.

The FQHC PPS rates will be calculated as follows:

**Base payment rate x FQHC GAF = PPS rate**

If the patient is new to the FQHC, or the FQHC is furnishing an IPPE, initial AWV, or subsequent AWV, the PPS rate will be adjusted by 1.3416. This is a composite adjustment factor and would only be applied once per day. The PPS rate in this case would be calculated as follows:

**Base payment rate x FQHC GAF x 1.3416 = PPS rate**

To qualify for an encounter-based payment, a FQHC visit must meet all applicable coverage requirements. Additional information on the coverage requirements for FQHC visits can be found in the “Medicare Benefit Policy Manual”, Pub 100-02, Chapter 13, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf on the CMS website.

### FQHC Specific Payment Codes

CMS is establishing five specific payment codes to be used by FQHCs submitting claims under the PPS:

1. **G0466 – FQHC visit, new patient**
   A medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.



RETURN TO TABLE OF CONTENTS

2. **G0467 – FQHC visit, established patient**
   A medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
3. **G0468 – FQHC visit, IPPE or AWV**
   A FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.
4. **G0469– FQHC visit, mental health, new patient**
   A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.
5. **G0470 – FQHC visit, mental health, established patient**
   A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

FQHCs shall use the specific payment code that corresponds to the type of visit that qualifies the encounter for Medicare payment, and these codes will correspond to the appropriate PPS rates. Each FQHC shall report a charge for the FQHC visit code that would reflect the sum of regular rates charged to both beneficiaries and other paying patients for a typical bundle of services that would be furnished per diem to a Medicare beneficiary.

### Basic Billing Requirements

When reporting an encounter/visit for payment, the claim (77X TOB) must contain a FQHC specific payment code (G0466, G0467, G0468, G0469 or G0470) that corresponds to the type of visit.

FQHC specific payment specific codes G0466, G0467 and G0468 must be reported under revenue code 052X or under revenue code 0519. NOTE: Revenue code 0519 is only used for Medicare Advantage (MA) Supplemental claims.

FQHC specific payment codes G0469 and G0470 must be reported under revenue code 0900 or 0519.

FQHCs must continue to report detailed HCPCS coding on the claim to describe all services that occurred during the encounter. All service lines must be reported with their associated charges.

Payment for a FQHC encounter requires a medically necessary face-to-face visit. Each FQHC specific payment code (G0466-G0470) must have a corresponding service line with a HCPCS code that describes the qualifying visit. See Attachment A of CR 8743 for a list of qualifying visits that correspond to the specific payment codes. (NOTE: A link to CR 8743 is available in the “Additional Information” section at the end of this article.)

When submitting a claim for a mental health visit furnished on the same day as a medical visit, FQHCs must report a specific payment code for a medical visit (G0466, G0467, or G0468) and a specific payment code for a mental health visit (G0470), and each specific payment code must be accompanied by a service line with a qualifying visit.



RETURN TO TABLE OF CONTENTS

When submitting a claim for a subsequent illness or injury, FQHCs must report the appropriate specific payment code (G0467 for a medical visit or G0470 for a mental health visit) with modifier 59. Modifier 59 is the FQHC's attestation that the patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day. Modifier 59 should only be used when reporting unrelated services that occurred at separate times during the day (e.g., the patient had left the FQHC and returned later in the day for an unscheduled visit for a condition that was not present during the first visit). NOTE: A qualifying visit is still required when reporting modifier 59 with G0467 or G0470.

FQHCs must report all services that occurred on the same day on one claim.

FQHC may submit claims that span multiple days of service. However, FQHCs transitioning to the PPS must submit separate claims for services subject to the PPS and services paid based on the AIR. MACs shall reject claims with multiple dates of service that include both PPS and non-PPS dates, as determined based on the individual FQHC's cost reporting period.

Durable Medical Equipment (DME), laboratory services (excluding 36415), ambulance services, hospital-based services, group services, and non-face-to-face services will be rejected.

Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) services are subject to the frequency edits described in Pub 100-04, Chapter 18, and should not be reported on the same day.

FQHCs must report HCPCS codes for influenza and pneumococcal vaccines and their administration on a FQHC claim, and these HCPCS codes will be considered informational only. MACs shall continue to pay for the influenza and pneumococcal vaccines through the cost report.

Please refer to the examples in Attachment B of CR8743 for additional billing guidance.

### Medicare Payment

The total payment amount for a FQHC visit shall be the lesser of the FQHC's reported charge for the FQHC payment code or the fully adjusted FQHC PPS rate for the specific payment code. Under the FQHC PPS, MACs shall generally pay 80 percent of the lesser of the FQHC's charge for the FQHC payment code or the corresponding FQHC PPS rate. Coinsurance will generally be 20 percent of the lesser of the actual charge or the FQHC PPS rate.

Medicare waives coinsurance for certain preventive services. For FQHC claims that consist solely of preventive services that are exempt from beneficiary coinsurance, MACs shall pay 100 percent of the lesser of the provider's charge for the FQHC payment code or the FQHC PPS rate, and no beneficiary coinsurance would be assessed.

For FQHC claims that include a mix of preventive and non-preventive services, MACs shall use the lesser of the provider's charge for the specific FQHC payment code or the corresponding FQHC PPS rate to determine the total payment amount. To determine the amount of Medicare payment and the amount of coinsurance that should be waived, MACs shall use the FQHC's reported line-item charges and subtract the dollar value of the FQHC's reported line-item charge for the preventive services from the full payment amount. (See the "Medicare Claims Processing Manual," Pub. 100-04, chapter 18, section 1.2, for a table of preventive services that are exempt from beneficiary coinsurance. That manual chapter is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf on the CMS website.)



RETURN TO TABLE OF CONTENTS

### Claims for Medicare Advantage (MA) Supplemental Payments

FQHCs that have a written contract with a MA organization that furnishes care to beneficiaries covered by the MA plan are paid by the MA organization at the rate that is specified in their contract. If the MA contract rate is less than the Medicare PPS rate, Medicare will pay the FQHC the difference, less any cost sharing amounts owed by the beneficiary. The supplemental payment is only paid if the contracted rate is less than the fully adjusted PPS rate. To facilitate accurate payment, claims for MA supplemental payments under the FQHC PPS must include the specific payment codes that correspond to the appropriate PPS rates and the detailed HCPCS coding required for all FQHC PPS claims.

### Additional Information

The official instruction, CR 8743, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1383OTN.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

*FQHC/RHC*

## SE1039 (Revised): Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing Guide

The Centers for Medicare & Medicaid Services (CMS) has revised the following ***Special Edition Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2010-MLN-Matters-Articles.html

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**Note:** At the time this article was first published in 2010, the information reflected Medicare policy correctly at that time. Since then, more current information is available and new articles have been released. This article was updated on June 5, 2014, to refer to some of the key new articles.

### Provider Types Affected

This article is for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) submitting claims to Medicare contractors (fiscal intermediaries (FIs) and/or A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries.

### What You Need to Know

This Special Edition article is based on CR 7038, CR 7208, and CR 8743; and it provides a billing guide for FQHCs and RHCs. It describes the information FQHCs are required to submit in order for CMS to develop and implement a Prospective Payment System (PPS) for Medicare FQHCs. It also explains how RHCs should bill for certain preventive services under the Affordable Care Act. Effective for dates of service on or after January 1, 2011, coinsurance and deductible are not applicable for the Initial Preventive Physical Examination (IPPE) provided by RHCs. However, to ensure coinsurance and deductible are not applied, detailed Healthcare Common Procedure Coding System (HCPCS)



RETURN TO TABLE OF CONTENTS

coding must be provided for preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. The Affordable Care Act also waives the deductible for planned colorectal cancer screening tests that become diagnostic.

### Background

Historically, RHCs and FQHCs billing instructions have been the same. However, effective January 1, 2011, the billing requirements will be different for each of these facilities' types.

As outlined in CR 7208, transmittal 2122, RHCs are only required to submit detailed HCPCS codes for preventive services with a United States Preventive Services Task Force (USPSTF) grade of A or B in order to waive coinsurance and deductible. As outlined in CR 7038 (see the related MLN Matters® article, MM7038 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7038.pdf on the CMS website), FQHCs are required to submit detailed HCPCS code(s) for all services rendered during the encounter. As outlined in CR 8743 (see the related MLN Matters® article, MM8743 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8743.pdf on the CMS website) and effective for cost reporting periods beginning on or after October 1, 2014, FQHCs are required to implement a prospective payment system (PPS). FQHCs will remain under the all-inclusive rate (AIR) system until their first cost reporting period beginning on or after October 1, 2014. Listed below is a summary of the billing requirements for each facility that you need to know when submitting claims for either RHCs or FQHCs.

### RHCs (71X Types of Bills (TOBs):

The professional components of preventive services are part of the overall encounter, and for TOB 71x, these services have always been billed on revenue lines with the appropriate site of service revenue code in the 052x series. In previous requirements, HCPCS codes have only been required to report certain preventive services subject to frequency limits.

Effective for dates of service on or after January 1, 2011, coinsurance and deductible are waived for the IPPE, the annual wellness visit, and other Medicare covered preventive services recommended by the USPSTF with a grade of A or B. Detailed HCPCS coding is required to ensure that coinsurance and deductible are not applied to these preventive services.

Payment for the professional component of allowable preventive services is made under the all-inclusive rate when all of the program requirements are met. Lab and technical components should continue to be billed as non RHC services.

### Basic RHC Billing for Preventive Services:

When one or more preventive service that meets the specified criteria is provided as part of an RHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary coinsurance and deductible. For example, if the total charge for the visit is $150, and $50 of that is for a qualified preventive service, the beneficiary coinsurance and deductible is based on $100 of the total charge.

To ensure coinsurance and deductible are waived for qualified preventive services, RHCs must report an additional revenue line with the appropriate site of service revenue code in the 052X series with the approved preventive service HCPCS code and the associated charges. For example, the service lines should be reported as follows:



RETURN TO TABLE OF CONTENTS

| Line | Revenue Code | HCPCS Code | Date of Service | Charges |
|---|---|---|---|---|
| 1 | 052X | | 01/01/2011 | 100.00 |
| 2 | 052X | Preventive Service Code | 01/01/2011 | 0.00 |

The services reported without the HCPCS code will receive an encounter/visit payment. Payment will be based on the all-inclusive rate, and the coinsurance and deductible will be applied. The qualified preventive service will not receive payment, as payment is made under the all-inclusive rate for the services reported on the first revenue line. Coinsurance and deductible are not applicable to the service line with the preventive service.

### Exceptions

If the only service provided is a preventive service (such as the IPPE or Annual Wellness Visit (AWV)), report only one line with the appropriate site of service revenue code (052X) and the preventive service HCPCS code. The services will be paid based on the all inclusive rate. Coinsurance and deductible are not applicable.

**NOTE:** An additional visit may be paid for IPPE when billed with another qualified encounter/visit, as outlined with CR 6445 (see the related MLN Matters® article, MM6445, at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6445.pdf on the CMS website).

RHCs are not required to report separate revenue lines for influenza virus or pneumococcal pneumonia vaccines on the 71x claims as the cost for these services are not included in the encounter. Costs for the influenza virus or pneumococcal pneumonia vaccines are included in the cost report and no line items are billed. Coinsurance and deductible do not apply to either of these vaccines.

The hepatitis B vaccine is included in the encounter rate. The charges of the vaccine and its administration shall be carved out of the office visit and reported on a separate line as outlined in the above example. An encounter cannot be billed if vaccine administration is the only service the RHC provides. For additional information on incident to services, please see the "Medicare Benefit Policy Manual" (Chapter 13, Section 60) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf on the CMS website.

RHCs do not receive any reimbursement on TOBs 71x for the technical component of services provided by clinics. This is because the technical component of services are not within the scope of Medicare-covered RHC services. The associated technical component of services furnished by the clinic/center are billed on other types of claims that are subject to strict editing to enforce statutory frequency limits.

### FQHCs (77X TOBs)

The Affordable Care Act (Section 10501(i)(3)(A) amended the Social Security Act (Section 1834; see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm) by adding a new subsection (o) titled "Development and Implementation of Prospective Payment System."

This subsection provides the statutory framework for development and implementation of a Prospective Payment System (PPS) for Medicare FQHCs. The Social Security Act (Section 1834(o)(1)(B)) as amended by the Affordable Care Act, addresses collection of data necessary to develop and implement the new Medicare FQHC PPS. Specifically, the Affordable Care Act grants the Secretary of Health and Human Services the authority to require FQHCs to submit such information as may be required in order to develop and implement the Medicare FQHC PPS, including the reporting of services using HCPCS



RETURN TO TABLE OF CONTENTS

codes. The Affordable Care Act requires that the Secretary impose this data collection submission requirement no later than January 1, 2011.

Beginning with dates of service on or after January 1, 2011, when billing Medicare, FQHCs must report all services provided during the encounter/visit by listing the appropriate HCPCS code. The additional revenue lines with detailed HCPCS code(s) are for information and data gathering purposes in order to develop the FQHC PPS set to be implemented in 2014. The additional data will not be utilized to determine current Medicare payment to FQHCs. The Medicare claims processing system will continue to make payments under the current FQHC interim per-visit payment rate methodology.

### Basic FQHC Billing Requirements:

For dates of service on or after January 1, 2011, all valid UB04 revenue codes except the following may be used to report the additional services that are needed for data collection and analysis purposes only:

- 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096x-310x.

Medicare will make one payment at the all-inclusive rate for each date of service that contains a valid HCPCS code for professional services when one of the following revenue codes is present:

| Revenue Code | Definition |
|---|---|
| **0521** | Clinic visit by member to RHC/FQHC |
| **0522** | Home visit by RHC/FQHC practitioner |
| **0524** | Visit by RHC/FQHC practitioner to a member in a covered Part A stay at a Skilled Nursing Facility (SNF) |
| **0525** | Visit by RHC/FQHC practitioner to a member in a SNF (not in a covered Part A stay) or NF or ICF MR or other residential facility |
| **0527** | RHC/FQHC Visiting Nurse Service(s) to a member's home when in a Home Health Shortage Area |
| **0528** | Visit by RHC/FQHC practitioner to other non RHC/FQHC site (e.g., scene of accident) |

### Payments for Encounter/Visits

Medicare will make an additional encounter payment at the all-inclusive rate on the same claim when:

- Effective January 1, 2011, two services lines are submitted with a 052X revenue code and one line contains modifier 59. Modifier 59 signifies that the conditions being treated are totally unrelated and services are provided at separate times of the day, e.g., treatment for an ear infection in the morning and treatment for injury to a limb in the afternoon;
- Services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900;
- Diabetes Self Management Training (DSMT) is billed under revenue code 052x and HCPCS code G0108 and Medical Nutrition Therapy (MNT) is billed under revenue code 052x and HCPCS code 97802, 97803, or G0270; and
- The Initial Preventive Physical Examination (IPPE) billed under revenue code 052X and HCPCS code G0402. This is a once in a lifetime benefit. HCPCS coding is required.

**Note:** Modifier 59 is **not required** for DSMT, MNT, or IPPE in order to receive an additional encounter payment.



RETURN TO TABLE OF CONTENTS

When reporting multiple services on FQHC claims, the 052X revenue line should include the total charges for all of the services provided during the encounter. For preventive services with a grade of A or B from the USPSTF, the charges for these services must be deducted from the total charge for purposes of calculating beneficiary coinsurance correctly. For example, if the total charge for the visit is $350.00, and $50.00 of that is for a qualified preventive service, the beneficiary coinsurance and deductible is based on $300.00 of the total charge.

| Example A | | | | |
|---|---|---|---|---|
| **Line** | **Rev Code** | **HCPCS code** | **Date of Service** | **Charges** |
| 1 | 0521 | Office Visit | 01/01 | 300.00 |
| 2 | 0636 | Penicillin Injection | 01/01 | 125.00 |
| 3 | 0271 | Wound Cleaning | 01/01 | 125.00 |
| 4 | 0771 | Preventive Service Code | 01/01 | 50.00 |

When reporting multiple services on the same day that are unrelated, modifier 59 must be used to report these services, e.g., treatment for an ear infection in the morning and treatment for injury to a limb in the afternoon.

| Example B | | | | | |
|---|---|---|---|---|---|
| **Line** | **Rev Code** | **HCPCS code** | **Modifier** | **Date of Service** | **Charges** |
| 1 | 0521 | Office Visit | 01/01 | 150.00 | |
| 2 | 0479 | Removal of Wax From Ear | 01/01 | 100.00 | |
| 3 | 0521 | Office Visit | 59 | 01/01 | 450.00 |
| 4 | 0271 | Wound Cleaning | 01/01 | 150.00 | |
| 5 | 0279 | Bone Setting With Casting | 01/01 | 300.00 | |

When reporting an additional encounter for IPPE, the revenue lines should be reflected as follows:

| Example C | | | | |
|---|---|---|---|---|
| **Line** | **Rev Code** | **HCPCS code** | **Date of Service** | **Charges** |
| 1 | 0521 | Office Visit | 01/01 | 75.00 |
| 2 | 0419 | Breathing Treatment | 01/01 | 75.00 |
| 3 | 0521 | IPPE (G0402) | 01/01 | 150.00 |

As of January 01, 2011, for data collection and analysis for the PPS, FQHCs are required to report separate revenue lines for influenza virus or pneumococcal pneumonia vaccines (PPV) on the 77x claims. The charges of these vaccines and the administration shall be carved out of the office visit and reported on a separate line as outlined in example A. The cost for these services will continue to be reimbursed through cost reporting. Coinsurance and deductible do not apply to either of these vaccines.

Hepatitis B vaccine is included in the encounter rate. The charges for the vaccine and its administration will be carved out of the office visit and reported on a separate line as outlined in example A. An encounter cannot be billed if vaccine administration is the only service the FQHC provides. For additional information on incident to services, please see Chapter 13, Section 60 of the "Medicare Benefit Policy Manual" at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c13.pdf on the CMS website.

Laboratory and technical components should continue to be billed as non FQHC services.



RETURN TO TABLE OF CONTENTS

### Summary of Differences

The chart below displays a list of elements and notes the differences between RHCs and FQHCs:

| Element | RHCs | FQHCs |
|---|---|---|
| **Revenue Codes** | 052X series | All except: 002x-024x, 029x, 045x, 054x, 056x, 060x, 065x, 067x-072x, 080x-088x, 093x, or 096-310x |
| **HCPCS code** | Required for Preventive Services only excluding Flu and PPV | Required for **all** services rendered during encounter/visit |
| **Modifier 59** | Not applicable at this time | Should be used to report two distinct unrelated visits on the same day |
| **DSMT and MNT** | Not separately payable | All inclusive payment rate |

### November 2013 Manual Updates

In November 2013, CR 8504 updated Chapter 13 of the "Medicare Benefit Policy Manual" to reflect numerous updates that were effective on January 1, 2014. The MLN Matters® article MM8504, which relates to CR 8504 is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8504.pdf on the CMS website.

### The FQHC PPS

FQHCs will transition to the FQHC PPS based on their cost reporting periods. For FQHCs with cost reporting periods beginning before October 1, 2014, MACs shall continue to pay the FQHCs using the current AIR system. For FQHCs with cost reporting periods beginning on or after October 1, 2014, MACs shall pay the FQHCs using the FQHC PPS.

Under the FQHC PPS, Medicare will pay FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically-necessary, face-to-face FQHC visit is furnished to a Medicare beneficiary. Medicare will allow for an additional payment when an illness or injury occurs subsequent to the initial visit, or when a mental health visit is furnished on the same day as a medical visit.

The PPS rate will be adjusted when a FQHC furnishes care to a patient who is new to the FQHC or to a beneficiary receiving an initial preventive physical examination (IPPE) or an annual wellness visit (AWV). CMS is establishing specific payment codes to be used under the FQHC PPS based on descriptions of services that will correspond to the appropriate PPS rates.

The PPS rates will also be adjusted to account for geographic differences in the cost of inputs by applying FQHC geographic adjustment factors (FQHC GAFs). In calculating the total payment amount, the FQHC GAF will be based on the locality of the site where the services are furnished. For FQHC organizations with multiple sites, the FQHC GAF may vary depending on the location of the FQHC delivery site.

Complete details of the FQHC PPS are available in MLN Matters® article MM8743, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm8743.pdf on the CMS website.

### Additional Information

Additional information on vaccines can be found in the "Medicare Claims Processing Manual" (Chapter 1, section 10) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf on the CMS website, and additional coverage requirements for the pneumococcal vaccine, hepatitis B vaccine, and influenza



RETURN TO TABLE OF CONTENTS

virus vaccine can be found in the "Medicare Benefit Policy Manual" (Chapter 15) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf on the CMS website.

*Hospital*

## MM8776: July 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS)

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

**MLN Matters® Number:** MM8776
**Related CR Release Date:** May 23, 2014
**Related CR Transmittal #:** R2971CP
**Related Change Request (CR) #:** CR 8776
**Effective Date:** July 1, 2014
**Implementation Date:** July 7, 2014

### 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 MACs for services provided to Medicare beneficiaries.

### Provider Action Needed

This article is based on CR 8776 which describes changes to and billing instructions for various payment policies implemented in the July 2014 Outpatient Prospective Payment System (OPPS) update. Make sure your billing staffs are aware of these changes.

### Background

CR 8776 describes changes to and billing instructions for various payment policies implemented in the July 2014 OPPS update. The July 2014 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, Status Indicator (SI), and Revenue Code additions, changes, and deletions identified in CR 8776.

The July 2014 revisions to I/OCE data files, instructions, and specifications are provided in the forthcoming CR 8764. The MLN Matters® article related to CR 8764 is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8764.pdf on the CMS website.

Key changes to and billing instructions for various payment policies implemented in the July 2014 OPPS update are as follows:

### Changes to Device Edits for July 2014

The most current list of device edits is available under "Device and Procedure Edits" at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/ on the CMS website. Failure to pass these edits will result in the claim being returned to the provider.

### New Brachytherapy Source Payment

The Social Security Act (Section 1833(t)(2)(H); see http://www.socialsecurity.gov/OP_Home/ssact/title18/1833.htm) mandates the creation of additional groups of covered outpatient department (OPD) services that classify devices of brachytherapy consisting



RETURN TO TABLE OF CONTENTS

of a seed or seeds (or radioactive source) ("brachytherapy sources") separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the brachytherapy sources furnished. Cesium-131 chloride solution is a new brachytherapy source.

The HCPCS code assigned to this source as well as payment rate under OPPS are listed in Table 1 below.

**Table 1—New Brachytherapy Source Code Effective July 1, 2014**

| HCPCS | Effective date | SI | APC | Short Descriptor | Long descriptor | Payment | Minimum Unadjusted Copayment |
|---|---|---|---|---|---|---|---|
| **C2644** | 7/01/2014 | U | 2644 | Brachytx cesium-131 chloride | Brachytherapy source, cesium-131 chloride solution, per millicurie | $18.97 | $3.80 |

## Category III Current Procedural Terminology (CPT) Codes

The American Medical Association (AMA) releases Category III CPT codes twice per year: 1.) in January, for implementation beginning the following July, and 2.) in July, for implementation beginning the following January.

For the July 2014 update, CMS is implementing in the OPPS 27 Category III CPT codes that the AMA released in January 2014 for implementation on July 1, 2014. Of the 27 Category III CPT codes shown in Table 2 below, 17 of the Category III CPT codes are separately payable under the hospital OPPS. The SIs and APCs for these codes are shown in Table 2 below. Payment rates for these services can be found in Addendum B of the July 2014 OPPS Update that is posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html on the CMS website.

**Table 2 – 27 Category III CPT Codes Implemented as of July 1, 2014**

| CY 2014 CPT Code | CY 2014 Long Descriptor | July 2014 OPPS Status Indicator | July 2014 OPPS APC |
|---|---|---|---|
| **0347T** | Placement of interstitial device(s) in bone for radiostereometric analysis (RSA) | Q2 | 0420 |
| **0348T** | Radiologic examination, radiostereometric analysis (RSA); spine, (includes, cervical, thoracic and lumbosacral, when performed) | X | 0261 |
| **0349T** | Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow and wrist, when performed) | X | 0261 |
| **0350T** | Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee and ankle, when performed) | X | 0261 |
| **0351T** | Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real time intraoperative | N | N/A |
| **0352T** | Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real time or referred | B | N/A |
| **0353T** | Optical coherence tomography of breast, surgical cavity; real time intraoperative | N | N/A |
| **0354T** | Optical coherence tomography of breast, surgical cavity; interpretation and report, real time or referred | B | N/A |
| **0355T** | Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), colon, with interpretation and report | T | 0142 |
| **0356T** | Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each | S | 0698 |
| **0358T** | Bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report | Q1 | 0340 |



RETURN TO TABLE OF CONTENTS

| Table 2 – 27 Category III CPT Codes Implemented as of July 1, 2014 | | | |
|---|---|---|---|
| **CY 2014 CPT Code** | **CY 2014 Long Descriptor** | **July 2014 OPPS Status Indicator** | **July 2014 OPPS APC** |
| **0359T** | Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report | V | 0632 |
| **0360T** | Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient | V | 0632 |
| **0361T** | Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service) | N | N/A |
| **0362T** | Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient | V | 0632 |
| **0363T** | Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure) | N | N/A |
| **0364T** | Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time | S | 0322 |
| **0365T** | Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time (List separately in addition to code for primary procedure) | N | N/A |
| **0366T** | Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time | S | 0325 |
| **0367T** | Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time (List separately in addition to code for primary procedure) | N | N/A |
| **0368T** | Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time | S | 0322 |
| **0369T** | Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure) | N | N/A |
| **0370T** | Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present) | S | 0324 |
| **0371T** | Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present) | S | 0324 |
| **0372T** | Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients | S | 0325 |



RETURN TO TABLE OF CONTENTS

| Table 2 – 27 Category III CPT Codes Implemented as of July 1, 2014 | | | |
|---|---|---|---|
| CY 2014 CPT Code | CY 2014 Long Descriptor | July 2014 OPPS Status Indicator | July 2014 OPPS APC |
| 0373T | Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient | S | 0323 |
| 0374T | Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure) | N | N/A |

## Billing for Drugs, Biologicals, and Radiopharmaceuticals

### a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2014

In the CY 2014 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2014 release of the OPPS Pricer. The updated payment rates, effective July 1, 2014, will be included in the July 2014 update of the OPPS Addendum A and Addendum B, which will be posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html on the CMS website.

### b. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2014

Three drugs and biologicals have been granted OPPS pass-through status effective July 1, 2014. These items, along with their descriptors and APC assignments, are identified below in Table 3.

| Table 3 – Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2014 | | | |
|---|---|---|---|
| HCPCS Code | Long Descriptor | APC | Status Indicator |
| C9022* | Injection, elosulfase alfa, 1mg | 1480 | G |
| C9134* | Factor XIII (antihemophilic factor, recombinant), Tretten, per 10 i.u. | 1481 | G |
| J1446 | Injection, tbo-filgrastim, 5 micrograms | 1447 | G |

**Note:** The HCPCS codes identified with an "*" indicate that these are new codes effective July 1, 2014.

### c. New HCPCS Codes Effective July 1, 2014, for Certain Drugs and Biologicals

Two new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biological listed in Table 4) in the hospital outpatient setting for July 1, 2014. These codes are listed below in Table 4, and they are effective for services furnished on or after July 1, 2014.

| Table 4 – New HCPCS Codes for Certain Drugs and Biologicals Effective July 1, 2014 | | | |
|---|---|---|---|
| HCPCS Code | Long Descriptor | APC | Status Indicator Effective 7/1/14 |
| Q9970* | Injection, ferric carboxymaltose, 1 mg | 9441 | G |
| Q9974** | Injection, Morphine Sulfate, Preservative-Free For Epidural Or Intrathecal Use, 10 mg | N/A | N |

* HCPCS code C9441 (Injection, ferric carboxymaltose, 1 mg) will be deleted and replaced with HCPCS code Q9970 effective July 1, 2014.

** HCPCS code J2275 (Injection, morphine sulfate (preservative-free sterile solution), per 10 mg) and will be replaced with HCPCS code Q9974 effective July 1, 2014. The SI for HCPCS code J2275 will change to E, "Not Payable by Medicare," effective July 1, 2014.



RETURN TO TABLE OF CONTENTS

### d. Revised SIs for HCPCS Codes J2271 and Q2052

Effective July 1, 2014, the SI for HCPCS code J2271 (Injection, morphine sulfate, 100mg) will change:

1. From SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.),
2. To SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

Effective April 1, 2014, the SI for HCPCS code Q2052 (Services, supplies, and accessories used in the home under the Medicare intravenous immune globulin (IVIG) demonstration) will change:

1. From SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.)
2. To SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

### e. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2013, through December 31, 2013

The payment rate for one HCPCS code was incorrect in the October 2013 OPPS Pricer. The corrected payment rate is listed in Table 5 below, and it has been installed in the July 2014 OPPS Pricer, effective for services furnished on October 1, 2013, through December 31, 2013. Your MAC will adjust any claims incorrectly processed if you bring those claims to the attention of your MAC.

**Table 5– Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2013 through December 31, 2013**

| HCPCS Code | Status Indicator | APC | Short Descriptor | Corrected Payment Rate | Corrected Minimum Unadjusted Copayment |
|---|---|---|---|---|---|
| **J2788** | K | 9023 | Rho d immune globulin 50 mcg | $25.15 | $5.03 |

### f. Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2014, through March 31, 2014

The payment rate for one HCPCS code was incorrect in the January 2014 OPPS Pricer. The corrected payment rate is listed below in Table 6, and it has been installed in the July 2014 OPPS Pricer, effective for services furnished on January 1, 2014, through March 31, 2014. Your MAC will adjust any claims incorrectly processed if you bring those claims to the attention of your MAC.

**Table 6 – Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2014, through March 31, 2014**

| HCPCS Code | Status Indicator | APC | Short Descriptor | Corrected Payment Rate | Corrected Minimum Unadjusted Copayment |
|---|---|---|---|---|---|
| **J0775** | K | 1340 | Collagenase, clost hist inj | $38.49 | $7.70 |

## Operational Change to Billing Lab Tests for Separate Payment

As delineated in MLN Matters Special Edition Article (SE)1412, issued on March 5, 2014, (see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1412.pdf), effective July 1, 2014, OPPS hospitals should begin using modifier L1 on type of bill (TOB) 13X when seeking separate payment for outpatient lab tests under the Clinical Laboratory Fee Schedule (CLFS) in the following circumstances:

1. A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or



RETURN TO TABLE OF CONTENTS

2. A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day.

"Unrelated" means the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services, for a different diagnosis. Hospitals should no longer use TOB 14X in these circumstances.

CMS is providing related updates to the "Medicare Claims Processing Manual" (Publication 100-04; Chapter 2, Section 90; and Chapter 16, Sections 30.3, 40.3, and 40.3.1) which are included as an attachment to CR 8766.

### Clarification of Payment for Certain Hospital Part B Inpatient Labs

As recently provided in CR 8445, Transmittal 2877, published on February 7, 2014 (see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8445.pdf on the CMS website), and CR 8666, Transmittal 182, published on March 21, 2014 (see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8666.pdf on the CMS website), hospitals may only bill for a limited set of Part B inpatient services when beneficiaries who have Part B coverage are treated as hospital inpatients, and:

1. They are not eligible for or entitled to coverage under Part A, or
2. They are entitled to Part A but have exhausted their Part A benefits.

CMS is clarifying its general payment policy that, for hospitals paid under the OPPS, these Part B inpatient services are separately payable under Part B, and are excluded from OPPS packaging, if the primary service with which the service would otherwise be bundled is not a payable Part B inpatient service.

CMS has adjusted its claims processing logic to make separate payment for Laboratory services paid under the CLFS pursuant to this policy that would otherwise be OPPS-packaged beginning in 2014. Hospitals should consult their MAC for reprocessing of any 12X TOB claims with dates of service on or after January 1, 2014 that were denied and should be paid under this policy.

### 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, Medicare contractors determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

### Additional Information

The official instruction, CR 8776 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2971CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.



RETURN TO TABLE OF CONTENTS

# MM8691: ICD-10 Conversion/Coding Infrastructure Revisions/ICD-9 Updates to National Coverage Determinations (NCDs) - Maintenance CR

The Centers for Medicare & Medicaid Services (CMS) has issued the following ***Medicare Learning Network® (MLN) Matters*** article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

**MLN Matters® Number:** MM8691 **Related CR Transmittal #:** R1388OTN
**Related CR Release Date:** May 23, 2014 **Related Change Request (CR) #:** CR 8691
**Effective Date:** July 1, 2014 (ICD-9 updates, local system edits), October 1, 2014 (designated ICD-9 shared system edits), October 1, 2015 (or whenever ICD-10 is implemented) (ICD-10 updates)determined for ICD-10
**Implementation Date:** July 7, 2014 (designated ICD-9 updates, local system edits, October 6, 2014 (or whenever ICD-10 is implemented (ICD-10 updates)to be determined for ICD-10

## 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 (HH&H MACs) and durable medical equipment MACs (DME MACs), for services to Medicare beneficiaries.

## Provider Action Needed

This article is based on CR 8691 which is the first maintenance update of ICD-10 conversions and coding updates specific to National Coverage Determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR 7818, CR 8109, and CR 8197. Links to related MLN Matters® Articles MM7818, MM8109, and MM8197 are available in the additional information section of this article. Some are the result of revisions required to other NCD-related CRs released separately that also included ICD-10.

Edits to ICD-10 coding specific to NCDs will be included in subsequent, quarterly recurring updates. No policy-related changes are included with these recurring updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Make sure that your billing staffs are aware of these changes to the following 29 NCDs:

20.5 ECU Using Protein A Columns, 20.7 PTA, 20.20 ECP Therapy, 20.29 HBO Therapy, 50.3 Cochlear Implants, 70.2.1 Diabetic Peripheral Neuropathy, 80.2 Photodynamic Therapy, 80.2.1 OPT, 80.3 Photosensitive Drugs, 80.3.1 Verteporfin, 100.1 Bariatric Surgery, 110.8.1 Stem Cell Transplants, 110.4 Extracorpreal Photopheresis, 110.10 IV Iron Therapy, 150.3 Bone Mineral Density, 160.18 VNS, 160.24 Deep Brain Stimulation, 160.27 TENS for CLBP, 180.1 MNT, 190.1 Histocompatibility Testing, 190.8 Lymphocyte Mitogen Response Assay, 190.11 Home PT/INR, 210.1 PSA Screening Tests, 210.2 Screening Pap/Pelvic Exams, 210.3 Colorectal Cancer Screens, 210.10 Screening for STIs, 250.4 Treatment for AKs, 250.3 IVIG for Autoimmune Blistering Disease, 250.5 Dermal Injections for Facial LDS



RETURN TO TABLE OF CONTENTS

### Background

The purpose of CR 8691 is to both create and update NCD editing, both hard-coded shared system edits as well as local MAC edits, that contain either ICD-9 diagnosis/procedure codes or ICD-10 diagnosis/procedure codes, or both, plus all associated coding infrastructure such as HCPCS/CPT codes, reason/remark codes, frequency edits, Place of Service (POS)/Type of Bill (TOB)/provider specialties, etc. The requirements described in CR 8691 reflect the operational changes that are necessary to implement the conversion of the Medicare systems from ICD-9 to ICD-10 specific to the 29 NCD spreadsheets attached to CR8691.

### Additional Information

The official instruction, CR 8691 issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1388OTN.pdf on the CMS website. **Note that there are 29 spreadsheets attached to CR 8691 and those spreadsheets relate to 9 NCDs and provide pertinent policy/coding information necessary to implement ICD-10.**

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.866.590.6703** and choose Option 1.

MM7818 is available for review at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7818.pdf on the CMS website.

MM8109 is available for review at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8109.pdf on the CMS website.

MM8197 is available for review at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8197.pdf on the CMS website.



RETURN TO TABLE OF CONTENTS