KENTUCKY & OHIO PART B

Medicare Bulletin

Jurisdiction 15

Reaching Out to the Medicare Community

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Bulletin

Jurisdiction 15

KENTUCKY & OHIO

NEWS FLASH

Articles contained in this edition are current as of **March 28, 2015**.

Chronic Care Management (CPT Code 99490)

CGS has received multiple questions regarding CPT code 99490 (Chronic Care Management). To assist you in determining whether you are submitting this code correctly and documenting your services appropriately, please refer to the following questions and answers:

1. CPT for 99490 is defined as "clinical staff time directed by a physician or other Qualified Health Care Provider (QHCP)". Can you define what constitutes "clinical staff"? RN, LPN, Certified MA, pharmacist, etc.

   - Page 2 of the CMS Chronic Care Management (CCM) Fact Sheet (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf) states: "Eligible practitioners must act within their State licensure, scope of practice, and Medicare statutory benefit. The CCM service may be billed most frequently by primary care physicians, although specialty physicians who meet all of the billing requirements may bill the service. The CCM service is not within the scope of practice of limited license physicians and practitioners such as clinical psychologists, podiatrists, or dentists, therefore these practitioners cannot furnish or bill the service. However, CMS expects referral to or consultation with such physicians and practitioners by the billing provider to coordinate and manage care."
   - Please note: "Only one practitioner can furnish and be paid for the service during a calendar month."

2. Is your expectation the same as noted in the introduction section of CPT?

   - Yes; additional rules and guidelines are available in the narrative section of the CPT manual. CGS follows these rules unless otherwise directed.

3. Since this is a non-face-to-face code, does "incident to" apply, or will this be covered under general supervision?

   - In the Medicare Physician Fee Schedule Database (http://www.cms.gov/apps/physician-fee-schedule/overview.aspx), the physician supervision indicator for CPT code 99490 is listed as "09," which is defined in the CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 23 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf), as "concept does not apply." Note that the services counted toward the 20 minutes must be provided by clinical staff.

4. Do you have a list of recommended chronic conditions that supports the requirement for patients to be eligible?

   - As stated on page 2 of the CMS CCM Fact Sheet (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf): Examples of chronic conditions include, **but are not limited to,** the following:
     - > Alzheimer's disease and related dementia;
     - > Arthritis (osteoarthritis and rheumatoid);
     - > Asthma;
     - > Atrial fibrillation;
     - > Autism spectrum disorders;
     - > Cancer;
     - > Chronic Obstructive Pulmonary Disease;
     - > Depression;
     - > Diabetes;
     - > Heart failure;
     - > Hypertension;
     - > Ischemic heart disease;
     - > Osteoporosis
     - > Additional resources are located on page 10 of the CMS CCM Fact Sheet (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf).
     - > Documentation in the patient's medical record should support that the patient's chronic conditions meet the standards per the CPT narrative; they must "place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline."

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5. The CCM code is per calendar month and the non-face-to-face work would be done throughout the month. What date of service will you require; last date of the month?
   - As stated on page 1 of the CMS CCM Fact Sheet (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf): Chronic care management services consist ofat least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
   - Page 9 of the CMS CCM Fact Sheet (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf) states: CPT code 99490 cannot be billed during the same calendar month as CPT codes 99495–99496 (Transitional Care Management), Healthcare Common Procedure Coding System (HCPCS) codes G0181/G0182 (home health care supervision/hospice care supervision), or CPT codes 90951–90970 (certain End-Stage Renal Disease services). Also consult CPT instructions for additional codes that cannot be billed during the same service period as CPT code 99490. There may be additional restrictions on billing for practitioners participating in a CMS sponsored model or demonstration program.
   - Claims should be submitted with the date of service on which the 20-minute requirement was met.
6. Since this is a timed code, would you expect to see start and stop times documented in order to support the 20 minutes?
   - Yes, time must be documented as either total time OR start/stop times.
7. There is a requirement that patients be able to reach providers 24/7. Does an answering machine meet the expectation?
   - No. As stated on page 4 of the CMS CCM Fact Sheet: Access to care is a key requirement in order to submit claims for chronic care management. Providers must "ensure 24-hour-a-day, 7 day-a-week access to care management services," and patients must have "a means to make timely contact with health care practitioners in the practice who have access to the patient's health record to address his or her chronic care needs." An answering machine does not meet this requirement.
8. What is the definition of comprehensive, regarding the care plan?
   - As stated on page 5 of the CMS CCM Fact Sheet: A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:
     > Problem list;
     > Expected outcome and prognosis;
     > Measurable treatment goals;
     > Symptom management;
     > Planned interventions and identification of the individuals responsible for each intervention;
     > Medication management;
     > Community/social services ordered;
     > A description of how services of agencies and specialists outside the practice will be directed/coordinated;
     > Schedule for periodic review and, when applicable, revision of the care plan.
   - Also, keep in mind if you have specific questions about appropriate coding that you cannot resolve on your own, the appropriate first step would be to review the HCPCS or CPT codes and/or the regulation governing payment for the year of service.

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Providers are expected to make appropriate coding decisions based on Medicare instructions (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html) and other information available.

Additional Resources:

- CMS Fact Sheet for Chronic Care Management (D:\Users\GC24\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\DSK231S1\ohttp:\www.cms.gov\Outreach-and-Education\Medicare-Learning-Network-MLN\MLNProducts\Downloads\ChronicCareManagement.pdf)
- CGS Fact Sheets: http://www.cgsmedicare.com/partb/mr/checklists.html
- CMS Evaluation and Management Services Guide (D:\Users\GC24\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\DSK231S1\o http:\www.cms.gov\Outreach-and-Education\Medicare-Learning-Network-MLN\MLNProducts\downloads\eval_mgmt_serv_guide-ICN006764.pdf)

Kentucky & Ohio

Medicare Physician Fee Schedule (MPFS): How Are Fees Calculated?

Medicare contractors, including CGS, reimburse some services based on the CMS Medicare Physician Fee Schedule (MPFS). CMS calculates fee schedule amounts and provides these amounts directly to Medicare contractors, including CGS, and these amounts become the basis for payment for services that are paid based on the MPFS. This article explains how the fees are calculated based on a standard formula and the following variables:

- Geographic Practice Cost Index (GPCI)
- Practice Expense (PE), which differs for facility vs. non-facility settings and is adjusted based on the GPCI
- Malpractice Insurance (MP), which is adjusted based on the GPCI
- Conversion Factor (CF), which adjusts fees by state
- In the formula below, RVU stands for Relative Value Units

Formula

The formula for calculating the MPFS, from the CMS website , uses the Fully Implemented Non-Facility PE RVU instead of the Transitioned Non-Facility PE RVU:

```
2015 Non-Facility Pricing Amount =
[(Work RVU * Work GPCI) +
(Fully Implemented Non-Facility PE RVU * PE GPCI) +
(MP RVU * MP GPCI)] * Conversion Factor (CF)

Conversion Factor (CF) for January-March 2015 = $35.7547
```

Examples: How does the math work?

Ohio example: CPT code 99213, non-facility setting

Work RVU: 0.97
Work GPCI: 1.00
Fully Implemented Non-Facility PE RVU: 1.01
PE GPCI: 0.918
MP RVU: 0.06
MP GPCI: 0.993
[(0.97 * 1.00) + (1.01 * 0.918) + (0.06 * 0.993)] * .35.7547 = MPFS amount

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(0.97 + 0.92718 + 0.05958) * .35.7547 = MPFS amount
1.956576 .35.7547 = $69.9633668 (round to $69.96)

Kentucky example: CPT code 96422, non-facility setting

Work RVU: 0.17
Work GPCI: 1.00
Fully Implemented Non-Facility PE RVU: 4.51
PE GPCI: 0.872
MP RVU: 0.10
MP GPCI: 0.795
[(0.17 * 1.00) + (4.51 * 0.872) + (0.10 * 0.795)] * $35.7547 = MPFS amount
(0.17 + 3.93272 + 0.0795) * $35.7547 = MPFS amount
4.18222 * $35.7547 = $149.534021 (round to $149.53)

Ohio example: CPT code 45378 (no modifiers), facility setting

Work RVU: 3.69
Work GPCI: 1.00
Fully Implemented Facility PE RVU: 1.94
PE GPCI: 0.918
MP RVU: 0.56
MP GPCI: 0.993
[(3.69 * 1.00) + (1.94 * 0.918) + (0.56 * 0.993)] * $35.7547 = MPFS amount
(3.69 + 1.78092 + 0.55608) * $35.7547 = MPFS amount
6.027 * $35.7547 = $215.493577 (round to $215.49)

Reference:

- To access MPFS amounts directly, refer to the CMS PFS Look-Up Tool (http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx), or
- Use the CGS tool to search the MPFS:
  - Kentucky and Ohio fees: http://www.cgsmedicare.com/partb/fees/index.html
- CMS MLN Matters article MM9081 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9081.pdf), "Emergency Update to the Calendar Year (CY) 2015 Medicare Physician Fee Schedule Database (MPFSDB)"

Kentucky & Ohio

myCGS Web Portal: eClaims

myCGS, our secure web portal, is a self-service application created specifically for CGS J15 providers. Registered users have access to the following information and functions:

- Beneficiary eligibility, including Medicare entitlement, preventive benefits, Medicare Secondary Payer (MSP) information and Medicare Advantage Plan enrollment
- Checking the status of claims
- View and/or print remittance advices (RAs)
- Access to financial information, including payment floor amounts and last three Medicare check amounts
- Submission of Redeterminations (first-level appeal) and track the status of submitted requests
- Submit authorization for immediate offset (eOffset) of demanded overpayments
- Submit requests for Reopening of previously processed claims

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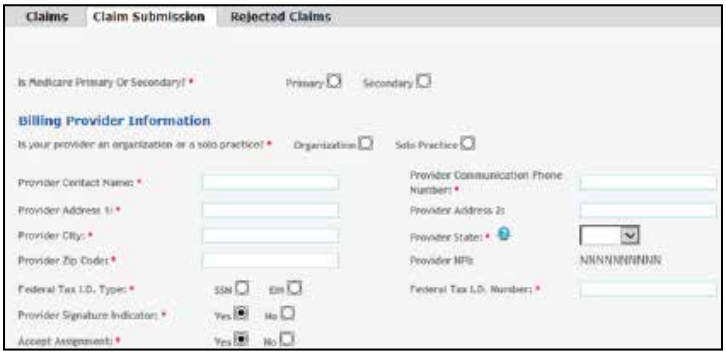
myCGS was recently enhanced to accept Part B claims!

eClaim submissions are available to ALL Part B providers registered to use myCGS. This includes current electronic claim submitters as well as providers who are authorized to submit paper CMS-1500 claim forms to CGS. The exciting part about the eClaim enhancement is – IT'S FREE!!! And all eClaims are processed as electronic claims, which can be paid in as few as 14 days versus 29 days for paper claims!



Submitting eClaims allows Part B providers to:

- Submit ALL types of Part B claims To CGS, including Medicare Secondary Payer (MSP) claims
- Attach up to five documents to the eClaim
- Make corrections to eClaims that are rejected due to our front-end editing
- Track the status of each claim submitted through myCGS
- Take advantage of benefits of submitting electronic claims, including FASTER processing and payments
- Save money by using this FREE claim submission option!

If you need additional information regarding eClaim submission, please refer to the following resources:

- myCGS User Manual: Chapter 2: Claims Tab - http://www.cgsmedicare.com/pdf/mycgs/chapter2.pdf
- myCGS Claim Submission Job Aid - http://www.cgsmedicare.com/partb/edi/pdf/mycgs_claim_submission_job_aid.pdf
- MSP eClaims - http://www.cgsmedicare.com/partb/pubs/news/2015/0215/cope28475.html

If you are not a registered myCGS user, please refer to information this and other functions available to you at http://www.cgsmedicare.com/partb/myCGS/index.html.

Kentucky & Ohio

SE1507: Physician Feedback, Quality and Resource Use Reports (QRURs) and Value-Based Modifier Program – Overview & Implementation

The Centers for Medicare & Medicaid Services (CMS) has issued 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/2015-MLN-Matters-Articles.html

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Provider Types Affected

This MLN Matters® Special Edition is intended for physicians and non-physician practitioners (Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists), Occupational Therapists, Physical Therapists, Speech-Language Pathologists, and Audiologists submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This Special Edition Article provides an overview of the Physician Feedback and Value-Based Modifier Program. Under the Value Modifier Program, performance on quality and cost measures can translate into payment incentives for providers who provide high quality, efficient care, while providers who underperform may be subject to a downward adjustment.

CAUTION – What You Need to Know

Beginning on January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) began applying a Value-Based Payment Modifier (Value Modifier) to physician payments under the Medicare Physician Fee Schedule for physicians in groups with 100 or more Eligible Professionals (EPs). EPs consist of physicians, practitioners, physical or occupational therapists, qualified speech-language pathologists, and qualified audiologists. A group is defined by its Medicare-enrolled Taxpayer Identification Number (TIN). The Value Modifier Program is being gradually phased in as follows:

- In 2015, the payment adjustments will apply to physicians in groups of 100 or more Eligible Professionals (EPs), based on a 2013 performance period.
- In 2016, the payment adjustments will apply to physicians in groups of 10 or more EPs based on 2014 performance;
- In 2017, the payment adjustments will apply to physician solo practitioners and physicians in groups of 2 or more EPs based on 2015 performance; and
- Beginning 2018, the payment adjustments will also apply to non-physician EPs who are solo practitioners or are in groups of 2 or more EPs. Please note that the performance period for the Value Modifier that will be applied in 2018 will be proposed and finalized in the CY 2016 Medicare Physician Fee Schedule proposed and final rules, respectively.

For more information on future years of the Value Modifier, please visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html on the CMS website.

GO – What You Need to Do

Participate in the Physician Quality Reporting System (PQRS) every year to avoid an automatic downward payment adjustment under the Value Modifier during the associated payment year. The data reported to PQRS for a given calendar year are used to calculate the Value Modifier for the calendar year that follows it by 2 years. For example, PQRS quality data for Calendar Year 2013 were used to calculate the Value Modifier affecting payments in 2015.

PQRS quality data are reported during the first quarter of the year following a given performance year. Physician groups should register to participate in the PQRS Group Practice Reporting Option (GPRO) in the fall of each year, to report data for that year.

Beginning with the 2016 Value Modifier, based on 2014 performance, EPs in a group have the option to participate in PQRS as individuals providing at least 50% of the group report. Use the information provided in your group's Quality and Resource Use Report (QRUR), as described below, to improve your performance on the quality and cost measures that are

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used to calculate the Value Modifier. Also, make sure that your billing staff is aware of these new payment adjustments.

Download your QRUR to understand how you performed on the cost and quality measures used to calculate the Value Modifier. Information on how to access these reports, which contain valuable information on the quality and cost of care provided to the Medicare beneficiaries you or your group serve is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html on the CMS website.

Background

The Social Security Act requires that CMS establish a Value Modifier that provides for differential payment under the Medicare Physician Fee Schedule (MPFS) based upon the quality of care furnished compared to cost during a performance period. By law, the Value Modifier is to be applied to:

- Specific physicians and groups of physicians that CMS determines appropriate starting January 1, 2015; and
- All physicians and groups of physicians by January 1, 2017.

Accordingly, CMS established the Physician Feedback/Value-Based Payment Modifier Program to provide comparative performance information to individual physicians and groups, as part of Medicare's efforts to improve the quality and efficiency of medical care.

The program (which is specific to Fee-For-Service Medicare—not Medicare Advantage) contains two primary components:

- The Physician Quality and Resource Use Reports (QRURs), and
- The Value-Based Incentive Payment Modifier (Value Modifier).

What is a Quality and Resource Use Report?

CMS has already provided annual QRURs to groups with at least one physician and physicians who are solo practitioners, to provide feedback on the quality of care furnished to Medicare beneficiaries and the cost of that care. Beginning in 2015, CMS will provide QRURs based on 2014 performance to all groups and solo practitioners, including non-physician groups and solo practitioners. Groups and solo practitioners can use the information provided in the QRURs to improve the care they provide to Medicare beneficiaries and to improve performance on quality and cost measures used to calculate the Value Modifier. The QRURs include information about a TINs' performance on PQRS quality measures, 3 claims-based outcome measures, and claims-based cost measures. The reports contain detailed information on care provided both inside a group and outside the group to help improve care coordination and efficiency.

For more information about QRURs, see http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Background.html on the CMS website.

What is the Value-based Payment Modifier (Value Modifier)?

The Value Modifier can be upward, downward, or neutral (meaning no adjustment), and it applies to the Medicare paid amount of physician payments under the Medicare Physician Fee Schedule.

Beginning on January 1, 2015, CMS is applying the Value Modifier to Medicare Physician Fee Schedule Payments made to physicians in group practices with 100 or more EPs billing under a single TIN. In 2015, groups of 100 or more EPs that met the minimum PQRS reporting requirement had the option to elect whether they wished to have their Value Modifier calculated based on quality performance. For those groups who elected this "quality tiering approach," CMS determined each group's Value Modifier adjustment for 2015 based on their performance on PQRS measures and claims-based outcome and cost measures in 2013.

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The Value Modifier payment adjustment for CY 2015 ranges from a downward adjustment of negative 1 percent (for low quality/high cost care) to an upward adjustment of positive 2.X (for low cost/high quality care). The "X" in the upward adjustment represents an adjustment factor that is used to redistribute payment reductions (taken from groups that do not successfully report and those that perform poorly on quality and cost measures) to those groups that perform well.

In future years, the quality tiering approach will be mandatory, but in 2016 and 2017, group sizes that are new to the Value Modifier will only be eligible for upward or neutral adjustments under quality tiering. Policies for the 2018 Value Modifier will be made in the 2018 Physician Fee Schedule rule. As the Value Modifier's application to smaller group sizes and groups of non-physician EPs is gradually phased in, the maximum available incentives and maximum downward adjustments are gradually increased.

More information on the Value Modifier is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html on the CMS website.

What Payments are Affected by the Value-Modifier?

In 2015 CMS applies the Value Modifier adjustment at the TIN level to the items and services billed by physicians in the group, not to other eligible professionals that also may bill under the TIN. A 'Physician' is defined for the Value Modifier Program as: a Doctor of Medicine; Doctor of Osteopathy; Doctor of Podiatric Medicine; Doctor of Optometry; Doctor of Dental Surgery; Doctor of Dental Medicine; or Doctor of Chiropractic.

Beginning with 2018 payments, the Value Modifier will apply to non-physician EP's payments as well. These include Non-Physician Practitioners (e.g., Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists), Occupational Therapists, Physical Therapists, Speech-Language Pathologists, and Audiologists. The Value Modifier is applied to the Medicare paid amounts for the items and services billed under the MPFS so that beneficiary cost-sharing is not affected.

Application of the Value Modifier at the TIN level means that if a physician changes groups from TIN A in the performance period (CY 2013) to TIN B in the payment adjustment period (CY 2015), then CMS would apply TIN B's Value Modifier to the physician's payments for items and services provided during 2015 and billed under TIN B.

What If I Think There is an Error in My Value Modifier?

If a physician group believes that CMS has made an error in the calculation of the group's Value Modifier, then the group may request a correction through our informal review process. For the 2016 Value Modifier and beyond, informal review must be requested no later than 60 days after receipt of the QRUR. If, upon review, CMS determines that we have made an error in the calculation of the quality composite and we are unable to recalculate it, then we will classify the TIN as "average quality." For the 2016 Value Modifier and beyond, if we are able to receive and utilize corrected quality data, then we will recalculate the quality composite. If we determine we made an error in the calculation of the cost composite then we will re-compute the cost composite to correct the error.

Who Can I Contact for Further Information?

Physician Value Help Desk (for Value Modifier questions)

Monday – Friday: 8:00 a.m. – 8:00 p.m. EST

Phone: 1.888.734.6433, press option 3

QualityNet Help Desk (for PQRS questions: 1.866.288.8912 (TTY 1.877.715.6222)

7:00 a.m.–7:00 p.m. CST M-F or qnetsupport@hcqis.org

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You will be asked to provide basic information such as name, practice, address, phone, and e-mail address.

Additional Information

More information about the full implementation of the CMS Physician Feedback/Value-Based Payment Modifier Program is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html on the CMS website.

A summary of the 2015 Physician Value-based payment modifier policies can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/CY2015ValueModifierPolicies.pdf on the CMS website.

You can review the timeline (2012-2017) for the Physician Feedback/Value-Based Payment Modifier Program at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Background.html on the CMS website.

More information about the Value Modifier program is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html on the CMS website.

You can find out more about the PQRS program at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html on the CMS website.

Kentucky & Ohio

SE1508: Guidance on the Physician Quality Reporting System (PQRS) 2013 Reporting Year and 2015 Payment Adjustment for Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and Critical Access Hospitals (CAHs)

The Centers for Medicare & Medicaid Services (CMS) has issued 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/2015-MLN-Matters-Articles.html

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Provider Types Affected

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

What You Need to Know

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

Frequently Asked Questions - RHCs and FQHCs

Question: If I furnish professional Medicare Part B services **only** at an RHC or an FQHC, are the services eligible for PQRS?

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Answer: No, if you furnish Medicare Part B professional services only at an RHC or an FQHC, such services are not eligible for either the PQRS incentive payment or for the PQRS negative payment adjustment.

Question: I'm an Eligible Professional (EP) and I furnish professional Medicare Part B services at an RHC/FQHC and also furnish services at a non-RHC/FQHC setting. Are the non-RHC/FQHC services eligible for the 2015 PQRS incentive payment or for the PQRS negative payment adjustment?

Answer: Yes, for an EP who furnishes professional Medicare Part B services at an RHC/FQHC and also furnishes services at a non-RHC/FQHC setting, the non-RHC/FQHC services may be eligible for the PQRS incentive payment or the negative payment adjustment. The PQRS program applies a negative payment adjustment to practices with EPs, identified on claims by their individual National Provider Identifier (NPI) and Tax Identification Number (TIN), or group practices participating via the Group Practice Reporting Option (GPRO) (referred to as PQRS group practices) who do **not** satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule services furnished to Medicare Part B Fee-For-Service beneficiaries. A negative payment adjustment may be triggered in future year(s) if an EP furnishes services, but does not report them.

Question: Under what circumstances are professional Medicare Part B services furnished by an EP at a setting outside an RHC/FQHC subject to the 2015 PQRS 1.5 percent negative payment adjustment if he or she has not satisfactorily reported 2013 PQRS quality measures?

Answer: There are two circumstances under which professional Medicare Part B services furnished by an EP at a setting outside an RHC/FQHC may be subject to the 2015 PQRS negative payment adjustment if he or she has not satisfactorily reported 2013 PQRS quality measures:

1. The non-RHC/FQHC services furnished by the EP are billed under his or her own TIN/NPI combination as reported via Provider Enrollment, Chain, and Ownership System (PECOS). The 2015 PQRS payment adjustment applies to the EP as an individual, **not** to the clinic or the facility; and
2. The non-RHC/FQHC services an EP furnished are billed under a group practice's TIN, which may be registered to participate in the 2013 PQRS under the GPRO registration or self- nomination. The 2015 PQRS payment adjustment applies to the EP under the group practice's TIN, which applies to the entire group practice.

For more information about how the 2015 PQRS 1.5 percent negative payment adjustment applies to RHC/FQHC providers, refer to "Listserv 2015 PQRS Payment Adjustment and Providers who Rendered Services at RHCs/FQHCs," located at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/CMS_listserv_2015_PQRS_PA_RHC_FQHC_final.pdf and "FAQ on 2015 PQRS Payment Adjustment and Providers who Render Services at RHCs/FQHCs," located at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/CMS_FAQ_2015_PQRS_PA_RHC_FQHC_final.pdf on CMS website.

To find timeline information, refer to "2015 – 2017 Physician Quality Reporting System (PQRS) Timeline" located at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015-17_CMS_PQRS_Timeline.pdf on the CMS website. To find general PQRS information, including information about payment adjustments, visit http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html on the CMS website.

For additional questions, contact the QualityNet Help Desk at 1.866.288.8912 (TTY 1.877.715.6222) or via qnetsupport@hcqis.org. The Help Desk is available from 7:00 a.m. to 7:00 p.m. Central Time Monday through Friday.

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Frequently Asked Questions - CAHs

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

Answer: Not in 2013. An EP who furnishes Medicare Part B services at a CAH and the CAH is paid under Method II is not eligible for the 2013 PQRS incentive payment or for the 2015 PQRS negative payment adjustment if he or she has not satisfactorily reported 2013 PQRS quality measures. Please note that this applies only to Tax ID and the rendering NPI used for Medicare billings on UB-04 claims.

An EP who furnishes Medicare Part B services at a CAH and the CAH is paid under Method II may be eligible for PQRS beginning in 2014 for the 2014 PQRS incentive payment and will be subject to the 2016 PQRS negative adjustment payment if he or she does not report by the deadline specified for each reporting method. Any physician-reported NPI, at either the claim level or the line level of a UB-04 claim, is considered eligible to participate in PQRS.

Question: I'm a CAH provider paid under Method II. Am I required to report line item rendering NPI information?

Answer: Yes, a CAH provider paid under Method II is required to report the rendering NPI at the line level if it is different than the rendering NPI at the claim level. For more information about this billing standard requirement, refer to MLN Matters Article® MM7578 titled "Fiscal Intermediary Shared System (FISS) and Common Working File (CWF) System Enhancement for Storing Line Level Rendering Physicians/Practitioners National Provider Identifier (NPI) Information," located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7578.pdf on the CMS website.

Additional Information

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

Kentucky & Ohio

MM8858 Revised: International Classification of Diseases, 10th Revision (ICD-10) Testing - Acknowledgement Testing with Providers

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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM8858 Revised
Related CR Release Date: February 24, 2015
Related CR Transmittal #: R1472OTN
Related Change Request (CR) #: CR 8858
Effective Date: 30 Days From Issuance (See test dates)
Implementation Date: November 17 through 21, 2014, for the November Testing Week; March 2 through 6, 2015 for the March Testing Week; June 1 through 5, 2015, for the June Testing Week;

Note: This article was revised on February 27, 2015, to reflect the revised CR8858, issued on February 24. In the article, the CR release date, transmittal number, and the Web address for accessing CR8858 are revised. All other information remains the same.

Provider Types Affected

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

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Health & Hospice (HH&H) MACs and Durable Medical Equipment (DME) MACs, for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8858 instructs MACs to promote three specific acknowledgement testing weeks with providers, and provide data and statistics to the Centers for Medicare & Medicaid Services (CMS) to demonstrate readiness for the International Classification for Disease 10th Edition Clinical Modification (ICD-10) transition. Make sure that your billing staffs are aware of these ICD-10 testing opportunities.

Background

The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing ICD-10. All covered entities must be fully compliant on October 1, 2015.

CR8858 instructs all MACs and the DME MAC Common Electronic Data Interchange (CEDI) contractor to promote ICD-10 Acknowledgement Testing with trading partners during three separate testing weeks, and to collect data about the testing. These testing weeks will be:

- November 17 – 21, 2014
- March 2 – 6, 2015
- June 1 – 5, 2015

The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing standards during the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 5010 implementation. While submitters may acknowledgement test ICD-10 claims at any time through implementation, the ICD-10 testing weeks have been created to generate awareness and interest, and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

These testing weeks will allow trading partner's access to MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on the CMS website, the CEDI website and each MAC's website.

Key Points of the Testing Process for CR8858

- Test claims with ICD-10 codes must be submitted with current dates of service since testing does not support future dates of service.
- Claims will be subject to existing NPI validation edits.
- MACs and CEDI will be staffed to handle increased call volume during this week.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected by Medicare.
- Test claims will be subject to all existing EDI front-end edits, including Submitter authentication and NPI validation.
- Testing will not confirm claim payment or produce a remittance advice.
- MACs and CEDI will be appropriately staffed to handle increased call volume on their Electronic Data Interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during this week.
- Your MAC will announce and promote these testing weeks via their listserv messages and their website.

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Additional Information

The official instruction, CR8858 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1472OTN.pdf on the CMS website.

The EDI help desk numbers for institutional claim submitters are available at http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/EDIHelplinePartA.pdf on the CMS website and the numbers for professional claims submitters are available at http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/EDIHelplinePartB.pdf on the CMS website.

Kentucky & Ohio

MM8871: Screening for Hepatitis C Virus (HCV) in Adults

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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM8871 *Revised*
Related CR Release Date: March 11, 2015
Related CR Transmittal #: R3215CP and R177NCD
Related Change Request (CR) #: CR 8871

Effective Date: June 2, 2014
Implementation Date: January 5, 2015, for non-shared MAC edits and CWF analysis; April 6, 2015, for remaining shared system edits

Note: This article was revised on March 13, 2015, to reflect the revised CR8871 issued on March 11. The article was revised to (1) replace "January 1, 2015 MPFSDB" with "January 1, 2016 CLFS" on page 3, (2) remove 50 (FQHC) and 72 (RHC) from the list of place of service codes in the middle of page 5, (3) clarify payment method for Type of Bill 13X, (4)add clarifying language for FQHC and RHC, and remove incorrect language regarding claims processing for FQHC and RHC, (5) clarify MAC claims processing prior to January 1, 2016, instead of January 1, 2015 on page 3 All other information remains the same.

Provider Types Affected

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

What You Need to Know

Change Request (CR) 8871 states, effective June 2, 2014, the Centers for Medicare & Medicaid Services (CMS) will cover screening for Hepatitis C Virus (HCV) consistent with the grade B recommendations by the United States Preventive Services Task Force (USPSTF) for the prevention or early detection of an illness or disability and is appropriate for individuals entitled to benefits under Medicare Part A or enrolled under Part B. Make sure your billing staffs are aware of these changes.

Background

Hepatitis C Virus (HCV) is an infection that attacks the liver and is a major cause of chronic liver disease. Inflammation over long periods of time (usually decades) can cause scarring, called cirrhosis. A cirrhotic liver fails to perform the normal functions of the liver which leads to liver failure. Cirrhotic livers are more prone to become cancerous and liver failure leads to serious complications, even death. HCV is reported to be the leading cause of chronic hepatitis, cirrhosis, and liver cancer, and a primary indication for liver transplant in the Western World.

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Prior to June 2, 2014, CMS did not cover screening for HCV in adults. Pursuant to §1861(ddd) of the Social Security Act, CMS may add coverage of "additional preventive services" through the National Coverage Determination (NCD) process.

Effective June 2, 2014, CMS will cover screening for HCV with the appropriate U.S. Food and Drug Administration (FDA) approved/cleared laboratory tests (used consistently with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations) and point-of-care tests (such as rapid anti-body tests that are performed in outpatient clinics and physician offices) when ordered by the beneficiary's primary care physician or practitioner within the context of a primary care setting, and performed by an eligible Medicare provider for these services, for beneficiaries who meet either of the following conditions:

1. Adults at high risk for HCV infection. "High risk" is defined as persons with a current or past history of illicit injection drug use, and persons who have a history of receiving a blood transfusion prior to 1992. Repeat screening for high risk persons is covered annually only for persons who have had continued illicit injection drug use since the prior negative screening test.
2. Adults who do not meet the high risk definition as defined above, but who were born from 1945 through 1965. A single, once-in-a-lifetime screening test is covered for these individuals.

The determination of "high risk for HCV" is identified by the primary care physician or practitioner who assesses the patient's history, which is part of any complete medical history, typically part of an annual wellness visit and considered in the development of a comprehensive prevention plan. The medical record should be a reflection of the service provided.

General Claims Processing Requirements for Claims with Dates of Service on and After June 2, 2014:

1. New HCPCS G0472, short descriptor - Hep C screen high risk/other and long descriptor- Hepatitis C antibody screening for individual at high risk and other covered indication(s), will be used. HCPCS G0472 will appear in the January 2016 recurring updates of the Clinical Laboratory Fee Schedule (CLFS) and the Integrated Outpatient Code Editor (IOCE) with a June 2, 2014, effective date. MACs shall apply contractor pricing to claims with dates of service June 2, 2014, through December 31, 2015, that contain HCPCS G0472. MACs will not automatically adjust claims that may be processed in error, but will adjust such claims that you bring to their attention.
2. Beneficiary coinsurance and deductibles do not apply to HCPCS G0472.
3. For services provided to beneficiaries born between the years 1945 and 1965 who are not considered high risk, HCV screening is limited to once per lifetime, claims shall be submitted with:
   - HCPCS G0472.
4. For those determined to be high-risk initially, claims must be submitted with:
   - HCPCS G0472; and
   - ICD-9 diagnosis code V69.8, other problems related to life style/ICD-10 diagnosis code Z72.89, other problems related to lifestyle (once ICD-10 is implemented).
5. Screening may occur on an annual basis if appropriate, as defined in the policy. Claims for adults at high risk who have had continued illicit injection drug use since the prior negative screening shall be submitted with:
   - HCPCS G0472;
   - ICD diagnosis code V69.8/Z72.89; and

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- ICD diagnosis code 304.91, unspecified drug dependence, continuous/F19.20, other psychoactive substance abuse, uncomplicated (once ICD-10 is implemented).

Note: Annual is defined as 11 full months must pass following the month of the last negative HCV screening.

Institutional Billing Requirements

Effective for claims with dates of service on and after June 2, 2014, institutional providers may use types of bill (TOB) 13X, 71X, 77X, and 85X when submitting claims for HCV screening, HCPCS G0472. Medicare will deny G0472 service line-items on other TOBs using the following messages:

- Claim Adjustment Reason Code (CARC) 170 -Payment denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remarks Code (RARC) N95 - This provider type/provider specialty may not bill this service.
- Group Code CO (contractual obligation) – If claim received without a GZ modifier.

The service is paid on the following basis:

- Outpatient hospitals – TOB 13X - based on the Outpatient Prospective Payment System.
- Rural Health Clinics (RHCs) - TOB 71X - and Federally Qualified Health Centers (FQHCs) - 77X - For RHCs and FQHCs that are authorized to bill under the All-Inclusive Rate (AIR) system, payment for the professional component is included in the AIR. For FQHCs authorized to bill under the FQHC Prospective Payment System (PPS), payment for the professional component is included in the FQHC PPS rate. HCV screening is not a stand-alone payable visit for RHCs and FQHCs.
- Critical Access Hospitals (CAHs) - TOB 85X – based on reasonable cost; and
- CAH Method II – TOB 85X - based on 115 percent of the lesser of the MPFS amount or actual charge as applicable with revenue codes 096X, 097X, or 098X.

Note: Separate guidance shall be issued for FQHCs that are authorized to bill under the prospectivepayment system.

Professional Billing Requirements

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCPCS G0472, only when services are submitted by the following provider specialties found on the provider's enrollment record:

01 - General Practice

08 - Family Practice

11 - Internal Medicine

16 - Obstetrics/Gynecology

37 - Pediatric Medicine

38 - Geriatric Medicine

42 - Certified Nurse Midwife

50 - Nurse Practitioner

89 - Certified Clinical Nurse Specialist

97 - Physician Assistant

Medicare will deny claims submitted for these services by providers other than the specialty types noted above. When denying such claims, Medicare will use the following messages:

- CARC 184 - The prescribing/ordering provider is not eligible to prescribe/order the service.

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NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

- RARC N574 - Our records indicate the ordering/referring provider is of a type/specialty that cannot order/refer. Please verify that the claim ordering/referring information is accurate or contact the ordering/referring provider.
- Group Code CO if claim received without GZ modifier.

For professional claims with dates of service on or after June 2, 2014, CMS will allow coverage for HCV screening, HCPCS G0472, only when submitted with one of the following place of service (POS) codes:

11 - Physician's Office
22 - Outpatient Hospital
49 - Independent Clinic
71 - State or Local Public Health Clinic
81 - Independent Laboratory

Medicare will deny claims submitted without one of the POS codes noted above with the following messages:

- CARC 171 - Payment denied when performed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N428 - Not covered when performed in this place of service.
- Group Code – CO if claim received without GZ modifier.

Other Billing Information for Both Professional and Institutional Claims

On both institutional and professional claims, Medicare will deny claims line-items for HCPCS G0472 with dates of service on or after June 2, 2014, where it is reported more than once-in-a-lifetime for beneficiaries born from 1945 through 1965 and who are not high risk. Medicare will also line-item deny when more than one HCV screening is billed for the same high-risk beneficiary prior to their annual eligibility criteria being met. In denying these claims, Medicare will use:

- CARC 119 - Benefit maximum for this time period or occurrence has been reached.
- 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.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code - CO if claim received without GZ modifier.

When applying the annual frequency limitation, MACs will allow both a claim for a professional service and a claim for a facility fee.

In addition, remember that the initial HCV screening for beneficiaries at high risk must also contain ICD-9 diagnosis code V69.8 (ICD-10 code Z72.89 once ICD-10 is implemented).

Then, for the subsequent annual screenings for high risk beneficiaries, you must include ICD-9 code V69.8 **and** 304.91 (ICD-10 of Z72.89 and F19.20 once ICD-10 is implemented). Failure to include the diagnosis code(s) for high risk beneficiaries will result in denial of the line item. In denying these payments, Medicare will use the following:

- CARC 119 - Benefit maximum for this time period or occurrence has been reached. (for initial high risk screening), or,
- CARC 167 - This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. (for subsequent annual high risk screening)

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- 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.gov/mcd/search.asp on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- Group Code CO if claim received without GZ modifier.

Additional Information

The official instruction, CR8871, was issued to your MAC regarding this change via two transmittals. The first transmittal updates the "Medicare Claims Processing Manual" and it is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3215CP.pdf on the CMS website. The second transmittal updates the "NCD Manual" and it is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R177NCD.pdf on the CMS website.

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

Kentucky & Ohio

MM9011 Revised: Incorporation of Revalidation Policies into Pub. 100-08, "Program Integrity Manual (PIM)," Chapter 15

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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM 9011 *Revised*
Related CR Release Date: February 25, 2015
Related CR Transmittal #: R578PI
Related Change Request (CR) #: CR 9011
Effective Date: May 15, 2015
Implementation Date: May 15, 2015

Note: This article was revised on February 27, 2015, to reflect the revised CR9011, issued on February 25. In the article, the CR release date, transmittal number, and the Web address for accessing CR9011 are revised. All other information remains the same.

Provider Types Affected

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9011 to incorporate various existing Medicare enrollment revalidation policies into Chapter 15 of the "Program Integrity Manual" (PIM).

Background

CR9011 incorporates various existing revalidation policies into the PIM. As these policies were previously established via business requirements, those business requirements are not being repeated in this article. The new polices announced in CR9011 are as follows:

- When processing a voluntary termination of a reassignment, the MAC will contact the group to confirm that the group member's Provider Transaction Access Number (PTAN) is being

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terminated from all locations and, if multiple group member PTANs exist for multiple group locations, each PTAN is terminated.

- Many enrolled providers may actually be subparts of other enrolled providers, and some of those subparts entered their "doing business as name" as their LBN when applying for their NPIs. Once a contractor determines for certain that this situation exists, the contractor shall ask the provider to correct its NPPES information. The provider can (1) change its LBN in NPPES to read in accordance with the IRS CP-575, and (2) report its "doing business as" name in NPPES as an "Other Name" and indicate the type of other name as a "doing business as" name.

Additional Information

The official instruction for CR9011 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R578PI.pdf on the CMS website.

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

Kentucky & Ohio

MM9065 Revised: Incorporation of Certain Provider Enrollment Policies in CMS-6045-F into Pub. 100-08, Program Integrity Manual (PIM), Chapter 15

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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9065 *Revised*
Related CR Release Date: March 4, 2015
Related CR Transmittal #: R582PI
Related Change Request (CR) #: CR 9065
Effective Date: May 28, 2015
Implementation Date: May 28, 2015

Note: This article was revised on March 6, 2015, to reflect the revised CR9065 issued on March 4. In the article, we replaced the reference to 42 CFR § 405.879 on page 2 with 42 CFR § 405.809. In addition, the CR release date, transmittal number, and the Web address for CR9065. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9065, on which this article is based, incorporates provisions in Final Rule CMS-6045-F into the "Medicare Program Integrity Manual" or PIM. CR9065 also addresses several minor provider enrollment policy issues that have arisen recently. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) Final Rule (CMS-6045-F entitled "Medicare Program; Requirements for the Medicare Incentive Reward Program and Provider Enrollment") was published in the Federal Register, Vol. 79 , No. 234 on December 5, 2014.

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See http://www.gpo.gov/fdsys/pkg/FR-2014-12-05/html/2014-28505.htm on the Internet. As mentioned, CR9065 incorporates provisions in CMS-6045-F into the PIM in Chapter 15 (Medicare Enrollment)), which is included as an attachment to CR9065. One such change outlined in CR9065 is that if a supplier submits a Corrective Action Plan (CAP) for a revocation based in part on 42 CFR § 424.535(a)(1), the MAC shall (A) only consider the portion of the CAP pertaining to (a)(1); and (B) notify the supplier in its decision letter (or, if the MAC wishes, via letter or e-mail prior to issuing the decision letter) that under 42 CFR § 405.809, the CAP was/will be reviewed only with respect to the (a)(1) revocation reason. See the full Manual revision attached to CR9065 for details on other updates.

Additional Information

The official instruction, CR9065, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R582PI.pdf on the CMS website.

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

Kentucky & Ohio

MM9072: New Waived Tests

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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9072
Related CR Release Date: February 27, 2015
Related CR Transmittal #: R3207CP
Related Change Request (CR) #: CR 9072
Effective Date: April 1, 2015
Implementation Date: April 6, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9072 informs MACs about the changes in the new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, Centers for Medicare & Medicaid Services (CMS) must notify its MACs of the new tests to allow MACs to accurately process claims.

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The CPT codes that CMS considers to be laboratory tests under CLIA (and thus requiring certification) change each year. Make sure your billing staffs are aware of these changes.

Background

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

Listed below are the latest tests approved by FDA as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW

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to be recognized as a waived test. The CPT code, effective date, and description for the latest tests approved by the FDA as waived tests under CLIA are the following:

- G0434QW, September 18, 2014, CLIAwaived Inc. Rapid Drug Test Cup {Cassette Dip Card format};
- 86308QW, September 23, 2014, AimStep Mono {Whole Blood};
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep Marijuana Panel Dip;
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep Marijuana Quick Cup;
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep Marijuana Strip;
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep Marijuana Turn-Key Split Cup;
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep Methamphetamine Panel Dip;
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep Methamphetamine Quick Cup;
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep Methamphetamine Strip;
- G0434QW, September 26, 2014, Polymed Therapeutics FaStep Methamphetamine Turn-Key Split Cup;
- G0434QW, October 9, 2014, Chemtron Biotech, Inc. Chemtrue Single/Multi-Panel Drug Screen Dip Card Tests;
- G0434QW, October 9, 2014, Chemtron Biotech, Inc. Chemtrue Single/Multi-Panel Drug Screen Cassette Tests;
- G0434QW, October 9, 2014, Chemtron Biotech, Inc. Chemtrue Multi-Panel Drug Screen Dip Card Tests;
- G0434QW, October 9, 2014, Chemtron Biotech, Inc. Chemtrue Multi-Panel Drug Screen Dip Card with OPI 2000 Test;
- G0434QW, October 17, 2014, Healgen Oxazepam Test Strip;
- G0434 QW, October 17, 2014, Healgen Oxazepam Test Dip Card;
- G0434QW, October 17, 2014, Healgen Oxazepam Test Cup;
- G0434QW, October 17, 2014, Healgen Oxazepam Test Cassette;
- G0434QW, October 17, 2014, Healgen Morphine Test Strip;
- G0434QW, October 17, 2014, Healgen Morphine Test Dip Card;
- G0434QW, October 17, 2014, Healgen Morphine Test Cup;
- G0434QW, October 17, 2014, Healgen Morphine Test Cassette;
- G0433QW, October 29, 2014, Chembio Diagnostic Systems, Inc. DPP HIV 1/2 Assay {Oral Fluid}; and
- 87389QW [from December 5, 2014 to December 31, 2014], Oregenics, Alere Determine HIV-1/2 Ag/Ab Combo {fingerstick Whole Blood}; and
- 87806QW [on and after January 1, 2015] , Oregenics, Alere Determine HIV-1/2 Ag/Ab Combo {fingerstick Whole Blood};
- G0434QW, December 10, 2014, Transmetron Invitro Pro Drug Test Cups;
- G0434QW, December 10, 2014, Coastline Medical Management Coastline Explorer Cup {Cassette Dip Card Format};
- 86780QW, December 15, 2014, Diagnostics Direct LLC Syphilis Health Check {FingerStick Whole Blood};

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- G0434QW, December 19, 2014, On-Site Testing Specialists, Inc. On-Site Testing Specialist Single/Multi-Panel Drug Screen Dip Card Tests;
- G0434QW, December 19, 2014, On-Site Testing Specialists, Inc. On-Site Testing Specialist Single/Multi-Panel Drug Screen Dip Card with OPI 2000 Tests; and
- 87502QW, January 5, 2015, Alere i Influenza A & B Test {Direct Nasal swab only}.

From December 5, 2014, to December 31, 2014, the CPT code 87389QW has been assigned for the detection of antigen to HIV-1, and antibodies to HIV-1 and HIV-2 performed using the Oregenics, Alere Determine HIV-1/2 Ag/Ab Combo {fingerstick Whole Blood}. On and after January 1, 2015, the CPT code assigned to Oregenics, Alere Determine HIV-1/2 Ag/Ab Combo {fingerstick Whole Blood} will be 87806QW.

The new CPT code 86780QW has been assigned for the immunochromatographic assay for the detection of Treponema pallidum (syphilis) antibodies in whole blood performed using the Diagnostics Direct LLC Syphilis Health Check {FingerStick Whole Blood}.

The new CPT code 87502QW has been assigned for the differential and qualitative detection of influenza A and influenza B viral nucleic acids using isothermal nucleic acid amplification technology performed using the Alere i Influenza A & B Test {Direct Nasal swab only}.

Additional Information

The official instruction, CR9072 issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3207CP.pdf on the CMS website.

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

Kentucky & Ohio

MM9078: National Coverage Determination (NCD) for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers

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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9078
Related CR Release Date: February 20, 2015
Related CR Transmittal #: R3204CP and R179NCD
Related Change Request (CR) #: CR 9078
Effective Date: August 13, 2013
Implementation Date: July 6, 2015

Note: This article was revised on February 27, 2015, to reflect the revised CR9011, issued on February 25. In the article, the CR release date, transmittal number, and the Web address for accessing CR9011 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 single chamber and dual chamber permanent cardiac pacemaker services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9078 informs MACs that the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD) and concluded that

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implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Make sure that your billing staffs are aware of these changes.

Background

Permanent cardiac pacemakers refer to a group of self-contained, battery-operated, implanted devices that send electrical stimulation to the heart through one or more implanted leads. Single chamber pacemakers typically target either the right atrium or right ventricle. Dual chamber pacemakers stimulate both the right atrium and the right ventricle. On August 13, 2013, CMS issued an NCD, in which CMS concluded that implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible, symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example, syncope, seizures, congestive heart failure, dizziness, or confusion). The following indications are covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Documented non-reversible symptomatic bradycardia due to sinus node dysfunction.
2. Documented non-reversible symptomatic bradycardia due to second degree and/or third degree atrioventricular block.

The following indications are non-covered for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Reversible causes of bradycardia such as electrolyte abnormalities, medications or drugs, and hypothermia.
2. Asymptomatic first degree atrioventricular block. *(exception)
3. Asymptomatic sinus bradycardia.
4. Asymptomatic sino-atrial block or asymptomatic sinus arrest. *(exception)
5. Ineffective atrial contractions (for example, chronic atrial fibrillation or flutter, or giant left atrium) without symptomatic bradycardia. *(exception)
6. Asymptomatic second degree atrioventricular block of Mobitz Type I unless the QRS complexes are prolonged or electrophysiological studies have demonstrated that the block is at or beyond the level of the His Bundle (a component of the electrical conduction system of the heart).
7. Syncope of undetermined cause. *(exception)
8. Bradycardia during sleep.
9. Right bundle branch block with left axis deviation (and other forms of fascicular or bundle branch block) without syncope or other symptoms of intermittent atrioventricular block. *(exception)
10. Asymptomatic bradycardia in post-myocardial infarction patients about to initiate long-term beta-blocker drug therapy.
11. Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of tachycardia. *(exception)
12. A clinical condition in which pacing takes place only intermittently and briefly, and which is not associated with a reasonable likelihood that pacing needs will become prolonged.

MACs will determine coverage under section 1862(a)(1)(A) of the Social Security Act for any other indications for the implantation and use of single chamber or dual chamber cardiac pacemakers that are not specifically addressed in this NCD. NOTES: MACs shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the practitioner and/or

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provider of the service that documentation is on file verifying the patient has non-reversible symptomatic bradycardia (symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example, syncope, seizures, congestive heart failure, dizziness, or confusion)).

NOTE: The final decision memorandum addresses Medicare policy specific to implanted permanent cardiac pacemakers, single chamber or dual chamber, for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Medicare coverage of removal/replacement of implanted permanent cardiac pacemakers, single chamber or dual chamber, for the above-noted indications, were not addressed in the final decision. Therefore, it is expected that MACs will continue to apply the reasonable and necessary standard in determining local coverage within their respective jurisdictions for removal/replacement of implanted permanent cardiac pacemakers, single chamber or dual chamber.

Cardiac Pacemaker Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) Codes

Professional claims

Effective for claims with dates of service on or after August 13, 2013, MACs shall pay for implanted permanent cardiac pacemakers, single chamber or dual chamber, for one of the following CPT codes if the claim contains at least one of the designated diagnosis codes in addition to the –KX modifier:

- 33206 - Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial;
- 33207 - Insertion or replacement of permanent pacemaker with transvenous electrode(s) – ventricular; or
- 33208 - Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial and ventricular.

Institutional claims

Effective for claims with dates of service on or after August 13, 2013, MACs shall pay for implanted permanent cardiac pacemakers, single chamber or dual chamber, for the following HCPCS codes if the claim contains at least one of the designated CPT codes, and at least one of the designated diagnosis codes, in addition to the –KX modifier:

- C1785 – Pacemaker, dual chamber, rate-responsive (implantable);
- C1786 – Pacemaker, single chamber, rate-responsive (implantable);
- C2619 – Pacemaker, dual chamber, nonrate-responsive (implantable);
- C2620 – Pacemaker, single chamber, nonrate-responsive (implantable);
- 33206 – Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial
- 33207 – Insertion or replacement of permanent pacemaker with transvenous electrode(s) – ventricular
- 33208 – Insertion or replacement of permanent pacemaker with transvenous electrode(s) – atrial and ventricular

MACs have discretion to cover or not cover the following CPT codes:

- 33227 – Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system; or
- 33228 – Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system.

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Cardiac Pacemaker ICD-9/ICD-10 Diagnosis Codes

Professional claims

Claims with dates of service on and after August 13, 2013, for implanted permanent cardiac pacemakers, single chamber or dual chamber, are covered if submitted with one of the following CPT codes: 33206, 33207, or 33208, and that contain at least one of the following ICD-9/ICD-10 diagnosis codes (upon ICD-10 implementation) listed below in addition to the –KX modifier:

- 426.0 Atrioventricular block, complete/ I44.2 Atrioventricular block, complete;
- 426.12 Mobitz (type) II atrioventricular block/ I44.1 Atrioventricular block, second degree;
- 426.13 Other second degree atrioventricular block/ I44.1 Atrioventricular block, second degree;
- 427.81 Sinoatrial node dysfunction/ I49.5 Sick sinus syndrome; or
- 746.86 Congenital heart block/ Q24.6 – Congenital heart block.

The following diagnosis codes can be covered at your MACs discretion if submitted with at least one of the CPT codes and diagnosis codes listed above in addition to the –KX modifier:

- 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block;
- 426.11 First degree atrioventricular block/ I44.0 Atrioventricular block first degree;
- 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block/I45.19 Other right bundle-branch block;
- 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia;
- 427.31 Atrial fibrillation/ I48.1 Persistent atrial fibrillation/ I48.91, Unspecified atrial fibrillation;
- 427.32 Atrial flutter/ I48.3 Typical atrial flutter/ I48.4 Atypical atrial flutter or I48.91 Unspecified atrial fibrillation; or
- 780.2 Syncope and collapse/R55 Syncope and collapse (R55 is the ICD-10 dx code but is not payable upon implementation of ICD-10 and is only included here for information purposes).

Institutional claims

For coverage of claims with dates of service on and after August 13, 2013, for implanted permanent cardiac pacemakers, single chamber or dual chamber, using HCPCS codes: C1785, C1786, C2619, C2620, 33206, 33207, or 33208, the claim must contain at least one of the following procedure codes:

- 37.81 Initial insertion of single chamber device, not specified as rate responsive
- 37.82 Initial insertion of single chamber device, rate responsive
- 37.83 Initial insertion of single chamber device

and at least one of the following diagnosis codes in addition to the –KX modifier:

- 426.0 Atrioventricular block, complete;
- 426.12 Mobitz (type) II atrioventricular block;
- 426.13 Other second degree atrioventricular block;
- 427.81 Sinoatrial node dysfunction; or
- 746.86 Congenital heart block.

The following diagnosis codes can be covered, at the MAC's discretion, if submitted with at least one of the diagnosis codes listed above in addition to the –KX modifier:

- 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block;

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- 426.11 First degree atrioventricular block/ I44.0 Atrioventricular block first degree;
- 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block/ I45.19 Other right bundle-branch block;
- 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia;
- 427.31 Atrial fibrillation/ I48.1 Persistent atrial fibrillation/ I48.91, Unspecified atrial fibrillation;
- 427.32 Atrial flutter/ I48.3 Typical atrial flutter/ I48.4 Atypical atrial flutter or I48.91 Unspecified atrial fibrillation; or
- 780.2 Syncope and collapse/R55 Syncope and collapse (R55 is the ICD-10 dx code but is not payable upon implementation of ICD-10 and is only included here for information purposes).

Professional claims

MACs shall return claims lines for implanted permanent cardiac pacemakers, single chamber or dual chamber, containing one of the following CPT codes: 33206, 33207, or 33208, as unprocessable when the -KX modifier is not present. When returning such claims, MACs shall use the following messages:

- Claim Adjustment Reason Code (CARC) 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.
- Remittance Advice Remarks Code (RARC) N517 - Resubmit a new claim with the requested information.

Institutional claims

MACs shall return to providers claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, when any of the following are not present on the claim: At least one HCPCS code: C1785, C1786, C2619, or C2620, at least one CPT code: 33206, 33207, 33208, 33227, 33228, at least one diagnosis code: 426.0/I44.2, 426.12/I44.1, 426.13/I44.1, 427.81/I49.5, 746.86/Q24.6, at least one procedure code: 37.81/0JH604Z, 0JH634Z, 0JH804Z, 0JH834Z, 37.82/0JH605Z, 0JH635Z, 0JH805Z, 0JH835Z, 38.83/0JH606Z, 0JH636Z, 0JH806Z, 0JH836Z, and the -KX modifier is not present on the claim.

Cardiac Pacemaker Non-covered ICD-ICD-10 Diagnosis Code

For claims with dates of service on or after implementation of ICD-10, for implanted permanent cardiac pacemakers, single chamber or dual chamber, using one of the following HCPCS and/or CPT codes: C1785, C1786, C2619, C2620, 33206, 33207, or 33208, ICD-10 diagnosis code R55 is not covered even if the claim contains one of the valid diagnosis codes listed above.

MACs will use the following messages when denying claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, containing one of the following HCPCS and/or CPT codes: C1785, C1786, C2619, C2620, 33206, 33207, or 33208, and ICD-10 diagnosis code R55 with the following messages:

- CARC 96: Non-covered charge(s).
- RARC N569: Not covered when performed for the reported diagnosis.
- Group Code CO assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed Advance Beneficiary Notice (ABN) is on file.
- Group Code PR assigning financial liability to the beneficiary, if a claim is received with occurrence code 32 indicating a signed ABN is on file, or occurrence code 32 is present with modifier GA.

Additional Information

The official instruction, CR 9078, was issued to your MAC via two transmittals. The first transmittal updates the “Medicare Claims Processing Manual” and it is available

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at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3204CP.pdf on the CMS website. The second updates the Medicare "National Coverage Determination Manual" and it is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R179NCD.pdf on the CMS website.

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

Kentucky & Ohio

MM9087 Revised: ICD-10 Conversion/Coding Infrastructure Revisions/ICD-9 Updates to |National Coverage Determinations (NCDs)—2nd 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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9087 *Revised*
Related CR Release Date: March 6, 2015
Related CR Transmittal #: R1478OTN
Related Change Request (CR) #: CR 9087
Effective Date: April 6, 2015 - For designated ICD-9 updates and all local system edits (ICD-9 and ICD-10); July 1, 2015 - For all ICD-9 shared system edits; October 1, 2015 - For all ICD-10 shared system edits (or whenever ICD-10 is implemented)

Implementation Date: April 6, 2015 - For designated ICD-9 updates and all local system edits; July 6, 2015 - For ICD-9 and ICD-10 shared system edits

Note: This article was revised on March 13, 2015, to add a link to the attachments to CR9087. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 9087 which is the second 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 CR7818, CR8109, CR8197, and CR 8691. Links to related MLN Matters® Articles MM7818, MM8109, MM8197, and MM8691 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 updates. No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Make sure that your billing staffs are aware of these spreadsheets attached to CR9087 for the following 13 NCDs:

NCD	NCD Title
20.29	Hyperbaric Oxygen Therapy
20.9.1	Ventricular Assist Devices

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NCD	NCD Title
50.3	Cochlear Implantation
80.2	Photodynamic Therapy
80.2.1	Ocular Photodynamic Therapy (OPT)
80.3	Photosensitive Drugs
80.3.1	Verteporfin
110.10	Intravenous Iron Therapy
150.3	Bone (Mineral) Density Studies
160.18	Vagus Nerve Stimulation
180.1	Medical Nutrition Therapy
210.2	Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer
250.3	Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases

Background

CR9087's purpose is to 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, POS/TOB/provider specialties, and so forth. The requirements described in CR9087 reflect the operational changes that are necessary to implement the conversion of the Medicare shared system diagnosis codes specific to the attached Medicare NCD spreadsheets.

Please note that there are 10 spreadsheets attached to CR9087. These spreadsheets relate to 13 NCDs, and provide pertinent policy/coding information necessary to implement ICD-10. Further, you should be aware that NCD policies may contain specific covered, non-covered and/or discretionary diagnosis coding. These spreadsheets are designated as such and are based on current NCD policies and their corresponding edits. Nationally covered and non-covered diagnosis code editing is finite and cannot be revised without subsequent discussions with CMS. Discretionary code lists are to be regarded as CMS' compilation of discretionary codes based on current analysis/interpretation. Local MACs may or may not expand discretionary lists based on their individual local authority within their respective jurisdictions. Nothing contained in CR9087 should be construed as new policy.

Some coding details are as follows:

1. The ICD-10 diagnosis/procedure codes associated with the NCDs attached to CR9087 are not to be implemented until October 1, 2015, or until ICD-10 is implemented.
2. Your MAC will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages, where appropriate:
   - Remittance Advice Remark Code (RARC) N386 (This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered), along with Claim Adjustment Reason Code (CARC) 50 (These are noncovered services because this is not deemed a "medical necessity" by the payer), CARC 96 (Non-covered charge(s). At least one Remark Code must be provided [may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT]), and/or CARC 119 (Benefit maximum for this time period or occurrence has been reached).
3. When denying claims associated with the attached NCDs, except where otherwise indicated, your MACs will use:
   - Group Code PR (Patient Responsibility) assigning financial responsibility to the beneficiary (if a claim is received with occurrence code 32 (Advance Beneficiary Notice), or with occurrence code 32 and a GA modifier (The provider or supplier has

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provided an Advance Beneficiary Notice (ABN) to the patient), indicating a signed ABN is on file).

- Group Code CO (Contractual Obligation) assigning financial liability to the provider (if a claim is received with a GZ modifier (The provider or supplier expects a medical necessity denial; however, did not provide an Advance Beneficiary Notice (ABN) to the patient), indicating no signed ABN is on file).

Note: For modifier GZ, use CARC 50 and MSN 8.81 (If the provider/supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment, you may be entitled to a refund of any amounts you paid. However, if the provider/supplier requests a review of this claim within 30 days, a refund is not required until we complete our review. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your provider/supplier).

Additional Information

The official instruction, CR9087 issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1478OTN.pdf on the CMS website. The spreadsheet attachments to CR9087 are available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1478OTN.zip on the CMS website.

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.

MM8691 is available for review at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8691.pdf on the CMS website.

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

Kentucky & Ohio

MM9095 Revised: Removal of Multiple National Coverage Determinations Using an Expedited Process

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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9095 *Revised*
Related CR Release Date: March 27, 2015
Related CR Transmittal #: R181NCD
Related Change Request (CR) #: CR 9095
Effective Date: December 18, 2014
Implementation Date: April 6, 2015

Note: This article was revised on March 28, 2015, to reflect the revised CR9095 issued on March 27. 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.

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Provider Types Affected

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

Provider Action Needed

Effective December 18, 2014, Change Request (CR) 9095 removes Sections 50.6 - Tinnitus masking, 160.4 - Stereotactic Cingulotomy as a Means of Psychosurgery, 160.6 - Carotid Sinus Nerve Stimulator, 160.9 - Electroencephalographic (EEG) Monitoring During Open-Heart Surgery, 190.4 - Electron Microscope, 220.7 - Xenon Scan, and 220.8 - Nuclear Radiology Procedure from the Medicare "National Coverage Determinations Manual" or the NCD Manual. Providers and their staffs should be aware that removing an NCD results in coverage determinations being at the discretion of local MACs within their respective jurisdictions.

Background

CR9095 removes seven NCDs from Publication 100-03, NCD Manual, pursuant to the expedited process that was established in an August 7, 2013, Federal Register (FR) notice (78 FR 48164). The FR notice is available at http://www.cms.gov/Medicare/Coverage/DeterminationProcess/Downloads/FR08072013.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

A CMS decision memorandum dated December 18, 2014, contains a summary of the expedited removal process and explicitly removes seven NCDs from the NCD Manual sections as follows:

- 50.6 - Tinnitus masking;
- 160.4 - Stereotactic Cingulotomy as a Means of Psychosurgery;
- 160.6 - Carotid Sinus Nerve Stimulator;
- 160.9 - Electroencephalographic (EEG) Monitoring During Open-Heart Surgery;
- 190.4 - Electron Microscope;
- 220.7 - Xenon Scan; and
- 220.8 - Nuclear Radiology Procedure.

You can review the CMS decision memorandum at http://www.cms.gov/medicare-coverage-database/details/medicare-coverage-document-details.aspx?MCDId=29&mcdtypename=National+Coverage+Determinations+Proposed+for+Removal&MCDIndexType=7&bc=AgAEAAAAAAAAAA%3d%3d& on the CMS website.

In the absence of an NCD, MACs should revert to historical standing policy and consider whether any Medicare claims for these services are reasonable and necessary under the Social Security Act (Section 1862(a)(1)(A); see http://www.ssa.gov/OP_Home/ssact/title18/1862.htm) consistent with the existing guidance for making such decisions when there is no NCD.

Additional Information

The official instruction, CR9095, issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R181NCD.pdf on the CMS website.

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

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MM9100 Revised: April 2015 Update of the Ambulatory Surgical Center (ASC) Payment System

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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9100 *Revised*
Related CR Release Date: March 11, 2015
Related CR Transmittal #: R3214CP
Related Change Request (CR) #: April 1, 2015
Effective Date: April 1, 2015
Implementation Date: April 6, 2015

Note: This article was revised on March 13, 2015, to reflect the revised CR9100 issued on March 11. The CR was revised to correct the short descriptor for Q9975. In addition, the CR transmittal number, release date, 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 and Ambulatory Surgical Centers (ASCs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9100 describes changes to and billing instructions for various payment policies implemented in the April 2015 ASC payment system update and includes updates to the Healthcare Common Procedure Coding System (HCPCS). Make sure your billing staffs are aware of these changes.

Key Points of CR9100

1. **New Device Pass-Through Category and Device Offset from Payment**

   Additional payments may be made to the ASC for covered ancillary services, including certain implantable devices with pass-through status under the Outpatient Prospective Payment System (OPPS). Section 1833(t)(6)(B) of the Social Security Act (the Act) requires that, under the OPPS, categories of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. Section 1833(t)(6)(B)(ii)(IV) of the Act requires that additional categories be created for transitional pass-through payment of new medical devices not described by current or expired categories of devices. This policy was implemented in the 2008 revised ASC payment system.

   CMS is establishing one new HCPCS device pass-through category as of April 1, 2015 for the OPPS and the ASC payment systems. The table, below, provides a listing of new coding and payment information concerning the new device category for transitional pass-through payment. HCPCS code C2623 (Catheter, transluminal angioplasty, drug-coated, non-laser) is assigned ASC PI= J7 (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced).

New Device Pass-Through Code HCPCS			
HCPCS	**Short Descriptor**	**Long descriptor**	**ASC PI**
C2623	Cath, translumin, drug-coat	Catheter, transluminal angioplasty, drug-coated, non-laser	J7

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a. **Device Offset from Payment:**

The C2623 device should always be billed with CPT Code 37224 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty), or CPT Code 37226 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed).

The Centers for Medicare & Medicare Services (CMS) has determined that a portion of the OPPS payment associated with the cost of HCPCS code C2623 is reflected in the OPPS payment for CPT codes 37224 and 37226. The ASC Code Pair File will be used to establish the reduced ASC payment amount for CPT codes 37224 and 37226, only when billed with HCPCS code C2623.

b. **Billing Instructions for CPT codes 37224 and 37226:**

Pass-through category C2623 (Catheter, transluminal angioplasty, drug-coated, non-laser), is to be billed, and paid for, as a pass-through device only when provided with CPT Code 37224 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty), or CPT Code 37226 (Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed) beginning on and after C2623's effective date of April 1, 2015.

2. **New Services**

No New services have been assigned for payment in the ASC payment system effective April 1, 2015.

3. **Drugs, Biologicals, and Radiopharmaceuticals**

a. **New April 2015 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals.**

For April 2015, six new HCPCS codes, shown in the table below, have been created for reporting drugs and biologicals in the ASC setting, where there have not previously been specific codes available.

New April 2015 HCPCS Codes Effective for Certain Drugs, Biologicals, and Radiopharmaceuticals

HCPCS Code[1]	Long Descriptor	ASC PI
C9445	Injection, c-1 esterase inhibitor (recombinant), Ruconest, 10 units	K2
C9448	Netupitant 300mg and palonosetron 0.5 mg, oral	K2
C9449	Injection, blinatumomab, 1 mcg	K2
C94502	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg	K2
C9451	Injection, peramivir, 1 mg	K2
C9452	Injection, ceftolozane 50 mg and tazobactam 25 mg	K2

Notes:

1. HCPCS codes listed in the above table are new codes effective April 1, 2015.
2. HCPCS code C9450 is associated with Iluvien® and should not be used to report any other fluocinolone acetonide intravitreal implant (e.g., Retisert®). ASCs should note that the dosage descriptor for Iluvien is 0.01 mg. Because each implant is a fixed dose containing 0.19 mg of fluocinlone acetonide, ASCs should report 19 units of C9450 for each implant.

b. **Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2015**

For CY 2015, payment for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated

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with the drug, biological or therapeutic radiopharmaceutical. Additionally, in CY 2015, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items.

Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2015, are available the April 2015 ASC Addendum BB, which is at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html on the CMS website.

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

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

Suppliers who think they may have received an incorrect payment for drugs and biologicals impacted by these corrections may request MAC adjustment of the previously processed claims.

a. **Revised ASC Payment Indicator for HCPCS Codes J0365**

Effective April 1, 2015, the ASC payment indicator for HCPCS code J0365 (Injection, aprotonin, 10,000 kiu) will change from K2 to Y5. This code is listed in the following table 3, along with the effective date for the revised status indicator

Drugs and Biologicals with Revised ASC Payment Indicators			
HCPCS Code	**Long Descriptor**	**ASC PI**	**Effective Date**
J0365	Injection, aprotonin, 10,000 kiu	Y5	4/1/2015

b. **Other Changes to CY 2015 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals**

Effective April 1, 2015, HCPCS code Q9975 (Factor VIII FC Fusion Recomb) will replace HCPCS code C9136 Factor viii (Eloctate). The payment indicator for Q9975 will remain K2. Code C9136 has a termination date of March 31, 2015.

The following table describes the HCPCS code change and effective date.

New HCPCS Codes for Certain Drugs and Biologicals Effective April 1, 2015				
HCPCS Code	**Short Descriptor**	**Long Descriptor**	**ASC PI**	**Effective Date**
Q9975	Factor VIII FC Fusion Recomb	Injection, factor viii, fc fusion protein, (recombinant), per i.u.	K2	04/01/2015

5. **Billing Guidance for Corneal Allograft Tissue**

ASCs can bill for corneal allograft tissue used for coverage (CPT code 66180) or revision (CPT code 66185) of a glaucoma aqueous shunt with HCPCS code V2785. Contractors pay for corneal tissue acquisition reported with HCPCS code V2785 based on acquisition/invoice cost.

6. **Coverage Determinations**

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

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7. **Claim Adjustment**

Your MAC will adjust, as appropriate, claims that you bring to their attention that:

1. Have dates of service January 1, 2015- March 31, 2015, and were originally processed prior to the installation of the revised January 2015 ASC DRUG File.
2. Have dates of service July 1, 2014- September 30, 2014, and were originally processed prior to the installation of the revised July 2014 ASC DRUG File.
3. Have dates of service October 1, 2014- December 30, 2014, and were originally processed prior to the installation of the revised October 2014 ASC DRUG File.

Additional Information

The official instruction, CR9100 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3214CP.pdf on the CMS website.

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

Kentucky & Ohio

MM9104: Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April Calendar Year (CY) 2015 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/2015-MLN-Matters-Articles.html

MLN Matters® Number: MM9104
Related CR Release Date: February 27, 2015
Related CR Transmittal #: R3205CP
Related Change Request (CR) #: CR 9104
Effective Date: April 1, 2015
Implementation Date: April 6, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9104 informs MACs about the release of payment files based upon the CY 2015 Medicare Physician Fee Schedule (MPFS) Final Rule. Make sure that your billing staffs are aware of these changes.

Background

Payment files were issued to MACs based upon the Calendar Year (CY) 2015 MPFS Final Rule, published in the Federal Register on December 19, 2014, to be effective for services furnished between January 1, 2015, and December 31, 2015.

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

Under current law, the conversion factor will be adjusted for services furnished on or after April 1, 2015. The files with the new conversion factor will be provided with the April quarterly update.

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In the final rule, Centers for Medicare & Medicaid Services (CMS) announced a conversion factor of $28.2239 for this period, resulting in an average reduction of 21.2 percent from the CY 2014 rates. In most prior years, Congress has taken action to avert large across-the-board reductions in Provider Fee Schedule rates before they went into effect. CMS supports legislation to permanently change the Sustainable Growth Rate to provide more stability for Medicare beneficiaries and providers while promoting efficient, high quality care.

Changes for certain CPT/HCPCS codes included in the April update to the 2015 MPFSDB are as follows:

- J1826 - Procedure Status = E
- J9010 - Procedure Status = N
- 77063 - Type of Service = 1
- 93355 - Multiple Surgery Indicator = 2 and Type of Service = 4
- 93644 -Type of Service = 2

Code G0279 has a new short descriptor of "Tomosynthesis, mammo".

In addition, the following codes have a procedure status of "I": 80300, 80301, 80302, 80303, 80304, 80320, 80321, 80322, 80323, 80324, 80325, 80326, 80327, 80328, 80329, 80330, 80331, 80332, 80333, 80334, 80335, 80336, 80337, 80338, 80339, 80340, 80341, 80342, 80343, 80344, 80345, 80346, 80347, 80348, 80349, 80350, 80351, 80352, 80353, 80354, 80355, 80356, 80357, 80358, 80359, 80360, 80361, 80362, 80363, 80364, 80365, 80366, 80367, 80368, 80369, 80370, 80371, 80372, 80373, 80374, 80375, 80376, and 80377.

Effective for services on or after April 1, 2015, the following codes will have a procedure status of "X": 81500, 81503, 81506, 81508, 81509, 81510, 81511, 81512, and 81599.

Also, effective for services on or after April 1, 2015, new code Q9975 is added with a short descriptor of "Factor VIII FC Fusion Recomb" and a long descriptor of "Injection, Factor VIII, FC Fusion Protein (Recombinant), per iu". The procedure status code for Q9975 is "E" and it has a global surgery modifier of "XXX".

Finally, S8032 was transposed as S0832 in the January 2015 MPFS; S0832 has been replaced with S8032 in the April 2015 MPFS.

Note: MACs will not search their files to either retract payment for claims already paid or to retroactively pay claims which were impacted by the above changes. MACs will adjust claims that you bring to their attention.

Additional Information

The official instruction, CR9104 issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3205CP.pdf on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

Kentucky & Ohio

News Flash Items

- **Seasonal Flu Vaccinations**: For information on coverage and billing of the influenza vaccine and its administration, please refer to MLN Matters® Article #MM8890 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8890.pdf), "Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season" and MLN Matters® Article #SE1431 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/

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MLNMattersArticles/Downloads/SE1431.pdf), "2014-2015 Influenza (Flu) Resources for Health Care Professionals."

Also, check out the following resources from the Centers for Disease Control and Prevention (CDC): Influenza (Flu) (http://www.cdc.gov/FLU/) Web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza, antiviral information, CDC flu mobile app, Q&As, toolkit for long term care employers, and other free resources. Review the CDC's Antiviral Drugs (http://www.cdc.gov/flu/professionals/antivirals/index.htm) website for information about how antiviral medications can be used to prevent or treat influenza when influenza activity is present in your community, and view the updated "Influenza Antiviral Medications: Summary for Clinicians." A CDC Health Update reminding clinicians about the importance of flu antiviral medications was distributed via the CDC Health Alert Network on January 9, 2015, and is available at http://emergency.cdc.gov/HAN/han00375.asp on the Internet.

- **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.
- **February is American Heart Month:** A time to raise awareness about heart disease and heart disease management and prevention strategies. Initiatives such as Million Hearts® (http://millionhearts.hhs.gov/resources/toolkits.html), a national initiative to prevent a million heart attacks and strokes by 2017, provide health care professionals and other partners with resources that you can use to help enhance your prevention efforts. Medicare provides coverage for a variety of preventive services that can help identify risk factors and provide information and tools that can assist your Medicare patients in making informed decisions about heart-healthy lifestyle choices. Read more (http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Health-Observance-Mesages-New-Items/2015-02-12-American-Heart-Month.html?DLPage=1&DLSort=0&DLSortDir=descending).
- **National Nutrition Month:** The Centers for Medicare & Medicaid Services reminds health care professionals that March is National Nutrition Month®- a time to "Bite into a Healthy Lifestyle" with informed food choices now and throughout the year. Medicare provides coverage for a variety of nutrition-related health services that can help eligible beneficiaries reach their nutrition and dietary goals. Read more (http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Health-Observance-Mesages-New-Items/2015-03-05-National-Nutrition-Month.html?DLPage=1&DLSort=0&DLSortDir=descending) to learn about nutrition-related health services covered by Medicare.
- **Coding for ICD-10-CM: More of the Basics MLN Connects™ Video:** In this MLN Connects® video on Coding for ICD-10-CM: More of the Basics (https://www.youtube.com/watch?v=s86pXhhOG7c&list=UUhHTRPxz8awulGaTMh3SAkA), Sue Bowman from the American Health Information Management Association (AHIMA) and Nelly Leon-Chisen from the American Hospital Association (AHA) provide a basic introduction to ICD-10-CM coding. The objective of this video is to enhance viewers' understanding of the characteristics and unique features of ICD-10-CM, as well as similarities and differences between ICD-9-CM and ICD-10-CM. Run time: 36 minutes.
- NEW product from the Medicare Learning Network® (MLN)
  - Provider Compliance Tips for Computed Tomography (CT) Scans (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-

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Multimedia-Items/2014-12-15-Provider-Compliance.html?DLPage=3&DLSort=2&DLSortDir=ascending) Podcast, ICN 909016, downloadable only

- "Medicare Basics Commonly Used Acronyms" Educational Tool, ICN 908999, downloadable http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Acronyms-Educational-Tool-ICN908999.pdf

- REVISED product from the Medicare Learning Network®
  - "Medicare Physician Fee Schedule" (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedcrePhysFeeSchedfctsht.pdf) Fact Sheet (ICN 006814)
  - "Medicare Learning Network® (MLN) Suite of Products & Resources for Rural Health Providers," (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Rural-Health-Suite-ICN908465.pdf) Educational Tool, ICN 908465, Downloadable.
  - "Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians" Web-based Training (WBT) http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html
  - "Telehealth Services" Fact sheet ICN 901705 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf
- RELEASED product from the Medicare Learning Network®
  - "The 2013 Physician Quality Reporting System (PQRS)" (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/2013-PQRS-Updates-ICN909056.pdf) Booklet, ICN 909056, Downloadable only

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.

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