Medicare Bulletin

Jurisdiction 15

HOME HEALTH & HOSPICE

Reaching Out to the Medicare Community

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Medicare Bulletin

Jurisdiction 15

HOME HEALTH PROVIDERS

HOSPICE PROVIDERS

HOME HEALTH & HOSPICE PROVIDERS

For Home Health Providers

Submit the Correct Document Control Number (DCN) When Requesting an Ordering/Referring Denial Reopening

CGS has seen an increase in provider telephone inquiries regarding ordering/referring denial reopening adjustments that have gone to the Return to Provider (RTP) file because the incorrect DCN was submitted on the hardcopy adjustment UB-04 claim (XX7). These reopening adjustments are being submitted for claims that originally denied in the Fiscal Intermediary Standard System (FISS) with reason code 37236 or 37237. To determine the correct DCN to report on the hardcopy UB-04 claim:

- From the FISS Main Menu, select 01 "Inquiries"
- From the Inquiry Menu, select 12 "Claim Summary"
- From the Claim Summary Inquiry screen, enter your National Provider Identifier (NPI) in the NPI field, and the beneficiary's Medicare number in the HIC field.
- Enter '329' in the TOB (type of bill) field.
- Enter the dates of service (From Date and To Date) of the denied claim.
- Select the denied claim.
- Go to Page 02 and press F2 to access MAP171D.
- The DCN of the denied claim will appear in the upper left corner of MAP171D, in the "DCN" field. This is the number that must be entered into 'Document Control Number (DCN)' field on the 'Medicare HHH Reopening Adjustment Request Form.'

For additional information, refer to the "Reopenings" Web page at http://www.cgsmedicare.com/hhh/appeals/Reopenings.html on the CGS website.

For Home Health Providers

Widespread Home Health Probe Results: Utah Home Health Providers

In the October 2013 CGS Home Health & Hospice Medicare Bulletin, available at http://www.cgsmedicare.com/hhh/pubs/mb_hhh/2013/10_2013/PDFs/HHH_Bulletin_Oct13.pdf, CGS published the article "Widespread Home Health Probe – Utah Home Health Providers" (page 12), which notified home health agencies in Utah about a new statewide service specific probe. The edit, 5012W, selected 100 claims billed with 10 or more therapy visits from October to November 2013. This probe was initiated based on analysis of billing data which identified greater aberrancies among home health providers in the state of Utah in comparison to the universe of CGS providers in the following areas:

- Average reimbursement per claim;
- Average total visits;
- Average total therapy visits;
- Percent of claims with therapy services; and
- Percent of claims with 20+ therapy visits.

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In addition, an OIG report titled "Inappropriate and Questionable Billing by Medicare Home Health Agencies" (http://oig.hhs.gov/oei/reports/oei-04-11-00240.pdf) identified the state of Utah as one of eight states that had high percentages of agencies with questionable billing practices.

CGS has completed its analysis of this probe, which resulted in a 79% error rate, based on the dollar amount denied. Below is a table showing the denial reasons, and volume of claims denied for each reason.

Denial Reason Code	Denial Reason	# of Claims Denied
5FFTF	Missing/incomplete/untimely face-to-face encounter	37
5HMED	Medical necessity not supported in medical record	23
5HORD	Missing/incomplete/untimely orders	8
56900	No timely response to ADR	5
5HNOA	No OASIS assessment submitted to the state	4
5HPLN	Missing/incomplete/untimely plan of care	3
5HHBD	Homebound status not supported in the record	3
5HRHC, 5HRHD, 5HRHF, or 5HSUP	HIPPS code reduced – clinical domain. Incorrect diagnosis, functional domain or non-routine supplies	2
5HDOC	Services were not documented	1

As a result of the high error rate, CGS will be implementing a service specific edit for home health providers in Utah that selects claims with at least 10 therapy visits.

Provider Action to Prepare and Reduce Risk of Future Denials

Home health agencies (HHAs) should take action now to ensure that they have procedures and processes in place to appropriately identify and respond to claims that are selected for Medical Review by this edit. Providers may access the following resources to ensure they are prepared in the event that a claim is selected for an additional development request (ADR).

- "Additional Development Request (ADR) Process" Web page, http://www.cgsmedicare.com/hhh/medreview/adr_process.html
- "Additional Development Request (ADR) Quick Resource Tool," http://www.cgsmedicare.com/hhh/education/materials/pdf/ADR_QRT.pdf

To educate home health agencies on the top denials by medical review, and to prevent future denials, CGS has developed several Home Health Denial Fact Sheets. Below is a list of those currently available, along with the link to access these critical resources.

- 5FFTF – Missing/Incomplete/Untimely Face-to-Face Encounter, http://www.cgsmedicare.com/hhh/education/materials/pdf/HH_5FFTF_FactSheet.pdf
- 5HHBD – Homebound Status, http://www.cgsmedicare.com/hhh/education/materials/pdf/hh_5hhbd_factsheet.pdf
- 5HMED – Medical necessity, http://www.cgsmedicare.com/hhh/education/materials/pdf/HH_5HMED_FactSheet.pdf
- 5HNOA – No OASIS, http://www.cgsmedicare.com/hhh/education/materials/pdf/hh_5hnoa_factsheet.pdf
- 5HPLN/5HORD – Missing plan of care or orders, http://www.cgsmedicare.com/hhh/education/materials/pdf/HH_5HPLN-5HORD_FactSheet.pdf

Please share this information with your staff. If you have any questions, contact the CGS Provider Contact Center, at **1.877.299.4500** (Option 1).

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For Hospice Providers

New Hospice Denial Fact Sheet Quick Resource Tool

CGS has developed a new hospice fact sheet to assist hospice clinical staff in avoiding medical review denials. The fact sheet, "5PPOC: Plan of Care" is available at http://cgsmedicare.com/hhh/education/materials/hospice_qrt.html on the "Hospice Quick Resource Tools" Web page. In addition, the fact sheet is also accessible from the Hospice Denial Reason Codes Web page at http://cgsmedicare.com/hhh/medreview/HOS_DRC.html on the CGS website.

- **5PPOC: Plan of Care** - http://cgsmedicare.com/hhh/education/materials/pdf/hospice_5PPOC_factsheet.pdf

For Hospice Providers

Reason Code 34952: Service Facility NPI is Required

CGS has identified a new reason code in our Claim Submission Error (CSE) data for May 2014. The reason code 34952 indicates that a service facility National Provider Identifier (NPI) is required on the claim, but was not reported.

As a reminder, per Change Request 8358, effective for dates of service on/after April 1, 2014, hospice providers are now required to report a service facility NPI when billing any of the following place of service HCPCS codes:

- Q5003 – hospice care provided in nursing long term care facility (LTC) or non-skilled nursing facility (NF)
- Q5004 – hospice care provided in skilled nursing facility (SNF)
- Q5005 – hospice care provided in inpatient hospital
- Q5007 – hospice care provided in long term care hospital (LTCH)
- Q5008 – hospice care provided in inpatient psychiatric facility

The service facility NPI must be reported in Loop 2310E (when billing in the 5010 electronic claim format) or the SERV FAC NPI field in the Fiscal Intermediary Standard System (FISS) on Claim Page 03.

```
MAP1713     PAGE 03          CGS J15 MAC - HHH REGION          ACPFA052  MM/DD/YY
AXB1234     SC               INST CLAIM ENTRY                  C201423P  HH:MM:SS
HIC                TOB 811   S/LOC S B0100    PROVIDER
NDC   CODE                                                  OFFSITE ZIPCD:
 CD     ID     PAYER                  OSCAR          RI AB            EST AMT DUE
A
B
C
DUE FROM PATIENT                              SERV FAC NPI
MEDICAL RECORD NBR                    COST RPT DAYS         NON COST RPT DAYS
DIAG CODES 01            02          03          04             05
06           07            08          09                    END OF POA IND
ADMITTING DIAGNOSIS          E CODE             HOSPICE TERM ILL IND
IDE
PROCEDURE CODES AND DATES 01                02
03                  04              05                  06
ESRD HOURS     ADJUSTMENT REASON CODE     REJECT CODE         NONPAY CODE
ATT PHYS         NPI               L                       F           M     SC
OPR PHYS         NPI               L                       F           M     SC
OTH OPR          NPI               L                       F           M     SC
REN PHYS         NPI               L                       F           M     SC
REF PHYS         NPI               L                       F           M     SC
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Claims that do not include an NPI in the SERV FAC NPI field when required will be sent to the returned to the provider (RTP) file (status/location T B9997) for correction. Providers can reduce claims processing times and avoid payment delays by ensuring this information is reported on the claim when required.

For additional information about billing hospice claims, refer to the "Hospice Claims Filing" Web page at http://www.cgsmedicare.com/hhh/education/materials/Hospice_CF.html on the CGS website.

For Home Health and Hospice Providers

CGS Website Updates

CGS has recently made updates to their website, giving providers additional resources to assist with billing Medicare-covered services appropriately.

Please review the following updates:

- The "Ordering/Referring Denial Reopenings" section of the **"Reopenings"** Web page at http://www.cgsmedicare.com/hhh/appeals/Reopenings.html was updated to include information to ensure the correct Document Control Number (DCN) is submitted on the "HHH Reopening Adjustment Request Form."
- The **"ICD-10-CM/PCS"** Web page at http://www.cgsmedicare.com/hhh/claims/5010.html was updated to include information about the new ICD-10 compliance date of September 30, 2015, and the cancellation of the July ICD-10 end-to-end testing during the week of July 21 through July 25, 2014. The **"ICD-10-CM/PCS Frequently Asked Questions"** at http://www.cgsmedicare.com/hhh/education/faqs/ICD-10.html were also updated to reflect this information.
- The **"Home Health & Hospice 2014 Holiday/Training Closure Schedule"** at http://www.cgsmedicare.com/hhh/help/pdf/Holiday_Schedule.pdf was updated to show the Provider Contact Center (PCC) training day change from Tuesday to Thursday.
- The **"Hospice Quick Resource Tools"** Web page at http://cgsmedicare.com/hhh/education/materials/hospice_qrt.html was updated to include a link to the new "5PPOC: Plan of Care" denial fact sheet (http://cgsmedicare.com/hhh/education/materials/pdf/hospice_5PPOC_factsheet.pdf)
- The Fiscal Intermediary Standard System (FISS) Guide, **"Chapter Three: Inquiry Menu"** which is available at http://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter3_Inquiry_Menu.pdf was updated. The updated information shows in red font.
- The **"Centers for Medicare & Medicaid Services (CMS) Educational Resources"** Web page at http://www.cgsmedicare.com/hhh/education/CMS_Resources.html has been updated to include links that allow providers to subscribe to CMS electronic mailing lists.

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For Home Health and Hospice Providers

eOffset Using myCGS: Clarification of Valid Requests

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

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

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

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

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

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

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

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

For Home Health and Hospice Providers

Medicare Credit Balance Quarterly Reminder

This article is a reminder submit the Quarterly Medicare Credit Balance Report. The next report is due in our office postmarked by **July 30, 2014**, for the quarter ending **June 30, 2014**. A Medicare credit balance is an amount determined to be refundable to the Medicare program for an improper or excess payment made to a provider because of patient billing or claims processing errors.

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Each provider must submit a quarterly Medicare Credit Balance Report (CMS-838) and certification for each individual PTAN, which is available at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS838.pdf. The report must be postmarked by the date indicated above. If the report is received with a postmark date later than the date indicated above, we are required to withhold 100 percent of all payments being sent to your facility. This withholding will remain in effect until the reporting requirements are met. If no credit balance exists for your facility during a quarter, a signed Medicare Credit Balance Report certification is still required. Please include your Medicare provider number on the certification form.

Refer to the Medicare Credit Balance Report (CMS-838) form for complete instructions. However, for additional assistance in completing the form, refer to the "Tips on Completing a Credit Balance Report (Form CMS-838)" Web page at https://www.cgsmedicare.com/hhh/financial/838_form_tips.html on the CGS website.

To ensure timely receipt and processing, please send to the appropriate address listed below:

Credit Balance Reports (CMS-838)/Certification with Checks

- **If you are sending a check** with the CMS-838 to repay the credit balance amount, please send the check, payable to "Medicare Fund," with either a **copy of the CMS-838**, or a letter indicating that the check is associated with the CMS-838, to the following address:

  CGS – J15 Home Health and Hospice
  PO Box 957124
  St. Louis, MO 63195-7124

  In addition, send the original CMS-838/Certification, with a copy of the check to the following address:

  J15—HHH Correspondence
  CGS Administrators, LLC
  PO Box 20014
  Nashville, TN 37202

Credit Balance Reports/Certification – Adjustment Submitted

- **If you have or will be submitting an adjustment,** please send the CMS-838 to the following address:

  J15—HHH Correspondence
  CGS Administrators, LLC
  PO Box 20014
  Nashville, TN 37202

If you have any Credit Balance related questions, or are unable to access our website at http://www.cgsmedicare.com/hhh/financial/CMS-588.html to obtain a paper copy of the CMS-838 form, please contact the Medicare Credit Balance telephone line at **1.866.590.6703**.

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For Home Health and Hospice Providers

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.

For Home Health and Hospice Providers

MLN Connects™ Provider e-News

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

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

For Home Health and Hospice Providers

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

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

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

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

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For Home Health and Hospice Providers

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

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

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

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

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

CR 8664 Summary of Changes

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

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

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

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

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

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

HCPCS Code	G9361
Procedure Status	M
Short Descriptor	Doc comm risk calc
Effective Date	01/01/2014
Work RVU	0
Full Non-Facility PE RVU	0
Full Non-Facility NA Indicator	(blank)
Full Facility PE RVU	0
Full Facility NA Indicator	(blank)
Malpractice RVU	0
Multiple Procedure Indicator	9
Bilateral Surgery Indicator	9
Assistant Surgery Indicator	9
Co-Surgery Indicator	9
Team Surgery Indicator	9
PC/TC	9
Site of Service	9
Global Surgery	XXX
Pre	0.00
Intra	0.00
Post	0.00
Physician Supervision Diagnostic Indicator	09
Diagnostic Family Imaging Indicator	99
Non-Facility PE used for OPPS Payment Amount	0.00
Facility PE used for OPPS Payment Amount	0.00
MP Used for OPPS Payment Amount	0.00

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Type of Service	9
Long Descriptor	Medical indication for induction [Documentation of reason(s) for elective delivery or early induction (e.g., hemorrhage and placental complications, hypertension, preeclampsia and eclampsia, rupture of membranes-premature, prolonged maternal conditions complicating pregnancy/delivery, fetal conditions complicating pregnancy/delivery, malposition and malpresentation of fetus, late pregnancy, prior uterine surgery, or participation in clinical trial)]

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

HCPCS Code		Physician Supervision of Diagnostic Procedures (Phys Diag Supv)	Effective Date
70450-TC	Ct head/brain w/o dye - Phys Diag Supv Correction (TC)	01	01/01/2014
70460-TC	Ct head/brain w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
70551-TC	Mri brain stem w/o dye - Phys Diag Supv Correction (TC)	01	01/01/2014
70552-TC	Mri brain stem w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
70553-TC	Mri brain stem w/o & w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
72141-TC	Mri neck spine w/o dye - Phys Diag Supv Correction (TC)	01	01/01/2014
72142-TC	Mri neck spine w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
72146-TC	Mri chest spine w/o dye - Phys Diag Supv Correction (TC)	01	01/01/2014
72147-TC	Mri chest spine w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
72148-TC	Mri lumbar spine w/o dye - Phys Diag Supv Correction (TC)	01	01/01/2014
72149-TC	Mri lumbar spine w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
72156-TC	Mri neck spine w/o & w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
72157-TC	Mri chest spine w/o & w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
72158-TC	Mri lumbar spine w/o & w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
72191-TC	Ct angiograph pelv w/o&w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
74174-TC	Ct angio abd&pelv w/o&w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
74175-TC	Ct angio abdom w/o & w/dye - Phys Diag Supv Correction (TC)	02	01/01/2014
93880-TC	Extracranial bilat study - Phys Diag Supv Correction (TC)	01	01/01/2014
93882-TC	Extracranial uni/ltd study - Phys Diag Supv Correction (TC)	01	01/01/2014
77001-TC	Fluoroguide for vein device - Phys Diag Supv Correction (TC)	03	01/01/2014
77002-TC	Needle localization by xray - Phys Diag Supv Correction (TC)	03	01/01/2014
77003-TC	Fluoroguide for spine inject - Phys Diag Supv Correction (TC)	03	01/01/2014

Additional Information

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

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

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For Home Health and Hospice Providers

MM8684: Claim Status Category and Claim Status Codes Update

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

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

Provider Types Affected

This MLN Matters® article is intended for physicians, providers, and suppliers submitting claims to Medicare administrative contractors (MACs), including durable medical equipment Medicare administrative contractors (DME MACs) and home health & hospice MACs (HH&H MACs), for services to Medicare beneficiaries.

Provider Action Needed

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

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (e.g. previous HIPAA named versions included 004010X093A1, more recent HIPAA named versions). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/ on the Internet.

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

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

Additional Information

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

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

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For Home Health and Hospice Providers

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

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

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

Provider Types Affected

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

Provider Action Needed

This article is based on CR 8764 which informs MACs about the changes to the I/OCE instructions and specifications for the I/OCE that is used under the OPPS and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a HHA not under the HH PPS or to a hospice patient for the treatment of a non-terminal illness. Make sure your billing staffs are aware of these changes.

Background

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

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

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Effective Date	Modification
7/1/2014	Documentation change only: modified Appendix N, List B (PHP Services) to note the add-on codes in a separate list as part of "PHP List C", referred to in Appendix C-a (Partial Hospitalization Logic effective v10.0).

Additional Information

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

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

For Home Health and Hospice Providers

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

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

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

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

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further modified by section 101 of the "Protecting Access to Medicare Act of 2014" on April 1, 2014, for MPFS rates to be effective January 1, 2014, to December 31, 2014.

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

HCPCS	Short Descriptor	Procedure Status
Q9970	Inj Ferric Carboxymaltos 1mg	E
Q9974	Morphine epidural/intratheca	E
S0144	Inj, Propofol, 10mg	I
S1034	Art pancreas system	I
S1035	Art pancreas inv disp sensor	I
S1036	Art pancreas ext transmitter	I
S1037	Art pancreas ext receiver	I
0347T	Ins bone device for rsa	C
0348T	Rsa spine exam	C
0349T	Rsa upper extr exam	C
0350T	Rsa lower extr exam	C
0351T	Intraop oct brst/node spec	C
0352T	Oct brst/node i&r per spec	C
0353T	Intraop oct breast cavity	C
0354T	Oct breast surg cavity i&r	C
0355T	Gi tract capsule endoscopy	C
0356T	Insrt drug device for iop	C
0358T	Bia whole body	C
0359T	Behavioral id assessment	C
0360T	Observ behav assessment	C
0361T	Observ behav assess addl	C
0362T	Expose behav assessment	C
0363T	Expose behav assess addl	C
0364T	Behavior treatment	C
0365T	Behavior treatment addl	C
0366T	Group behavior treatment	C
0367T	Group behav treatment addl	C
0368T	Behavior treatment modified	C
0369T	Behav treatment modify addl	C
0370T	Fam behav treatment guidance	C
0371T	Mult fam behav treat guide	C
0372T	Social skills training group	C
0373T	Exposure behavior treatment	C
0374T	Expose behav treatment addl	C

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

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

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Also, Section 651 of Medicare Modernization Act (MMA) required the Secretary of Health and Human Services to conduct a demonstration for up to 2 years to evaluate the feasibility and advisability of expanding coverage for chiropractic services under Medicare. The demonstration expanded Medicare coverage to include: "(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and (B) diagnostic and other services that a chiropractor is legally authorized to perform by the state or jurisdiction in which such treatment is provided." The demonstration, which ended on March 31, 2007, was required to be budget neutral as section 651(f)(1)(B) of MMA mandates the Secretary to ensure that "the aggregate payments made by the Secretary under the Medicare program do not exceed the amount which the Secretary would have paid under the Medicare program if the demonstration projects under this section were not implemented." The costs of this demonstration were higher than expected and CMS has been recovering costs by deducting 2 percent from payments for chiropractic services. Since CMS has determined that the costs are fully recovered, the July update eliminates the 2 percent reduction for CPT codes 98940, 98941, and 98942 that was utilized for the first half of CY 2014, effective July 1, 2014.

Additional Information

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

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

For Home Health and Hospice Providers

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

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

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

Provider Types Affected

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

Provider Action Needed

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

Background

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

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Status Indicator (SI), and Revenue Code additions, changes, and deletions identified in CR 8776.

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

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

Changes to Device Edits for July 2014

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

New Brachytherapy Source Payment

The Social Security Act (Section 1833(t)(2)(H); see http://www.socialsecurity.gov/OP_Home/ssact/title18/1833.htm) mandates the creation of additional groups of covered outpatient department (OPD) services that classify devices of brachytherapy consisting of a seed or seeds (or radioactive source) ("brachytherapy sources") separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the brachytherapy sources furnished. Cesium-131 chloride solution is a new brachytherapy source.

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

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

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

Category III Current Procedural Terminology (CPT) Codes

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

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

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

CY 2014 CPT Code	CY 2014 Long Descriptor	July 2014 OPPS Status Indicator	July 2014 OPPS APC
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	Q2	0420
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes, cervical, thoracic and lumbosacral, when performed)	X	0261

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Table 2 – 27 Category III CPT Codes Implemented as of July 1, 2014			
CY 2014 CPT Code	**CY 2014 Long Descriptor**	**July 2014 OPPS Status Indicator**	**July 2014 OPPS APC**
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow and wrist, when performed)	X	0261
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee and ankle, when performed)	X	0261
0351T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; real time intraoperative	N	N/A
0352T	Optical coherence tomography of breast or axillary lymph node, excised tissue, each specimen; interpretation and report, real time or referred	B	N/A
0353T	Optical coherence tomography of breast, surgical cavity; real time intraoperative	N	N/A
0354T	Optical coherence tomography of breast, surgical cavity; interpretation and report, real time or referred	B	N/A
0355T	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), colon, with interpretation and report	T	0142
0356T	Insertion of drug-eluting implant (including punctal dilation and implant removal when performed) into lacrimal canaliculus, each	S	0698
0358T	Bioelectrical impedance analysis whole body composition assessment, supine position, with interpretation and report	Q1	0340
0359T	Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report	V	0632
0360T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient	V	0632
0361T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)	N	N/A
0362T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient	V	0632
0363T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)	N	N/A
0364T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time	S	0322
0365T	Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	N	N/A
0366T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time	S	0325

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Table 2 – 27 Category III CPT Codes Implemented as of July 1, 2014			
CY 2014 CPT Code	**CY 2014 Long Descriptor**	**July 2014 OPPS Status Indicator**	**July 2014 OPPS APC**
0367T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)	N	N/A
0368T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time	S	0322
0369T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)	N	N/A
0370T	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	S	0324
0371T	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)	S	0324
0372T	Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients	S	0325
0373T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient	S	0323
0374T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure)	N	N/A

Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

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

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

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

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

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

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

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

Table 4 – New HCPCS Codes for Certain Drugs and Biologicals Effective July 1, 2014

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 7/1/14
Q9970*	Injection, ferric carboxymaltose, 1 mg	9441	G
Q9974**	Injection, Morphine Sulfate, Preservative-Free For Epidural Or Intrathecal Use, 10 mg	N/A	N

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

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

d. Revised SIs for HCPCS Codes J2271 and Q2052

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

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

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

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

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

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

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

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

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

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

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Table 6 – Updated Payment Rates for Certain HCPCS Codes Effective January 1, 2014, through March 31, 2014					
HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
J0775	K	1340	Collagenase, clost hist inj	$38.49	$7.70

Operational Change to Billing Lab Tests for Separate Payment

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

1. A hospital collects specimen and furnishes only the outpatient labs on a given date of service; or
2. A hospital conducts outpatient lab tests that are clinically unrelated to other hospital outpatient services furnished the same day.

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

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

Clarification of Payment for Certain Hospital Part B Inpatient Labs

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

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

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

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

Coverage Determinations

The fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program.

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MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, Medicare contractors determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional Information

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

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

For Home Health and Hospice Providers

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

- Products from the Medicare Learning Network® (MLN)
  - REVISED "Advance Payment Accountable Care Organization" Fact Sheet, ICN 907403, downloadable at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Advance_Payment_Factsheet_ICN907403.pdf
  - NEW "Information on the National Physician Payment Transparency Program: Open Payments," Podcast, ICN 908961, downloadable only at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/ICN908961-Podcast.html
- Want to stay connected about the latest new and revised Medicare Learning Network® (MLN) products and services? Subscribe to the MLN Educational Products electronic mailing list! For more information about the MLN and how to register for this service, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MLNProducts_ListServ.pdf and start receiving updates immediately!
- 2015 GEMs, Reimbursement Mappings, and ICD-10 Files Now Available -The 2015 General Equivalence Mappings (GEMs), Reimbursement Mappings, ICD-10-CM files, and ICD-10-PCS files are now available on the 2015 ICD-10-CM and GEMs Web page at http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html and 2015 ICD-10-PCS and GEMs Web page at http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-PCS-and-GEMs.html. The mappings can be used to convert policies from ICD-9-CM to ICD-10 codes. The GEMs provide both forward (ICD-9-CM to ICD-10) and backward (ICD-10 to ICD-9-CM) mappings. There are no new, revised, or deleted ICD-10-CM or ICD-10-PCS codes.

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For Home Health and Hospice Providers

Provider Contact Center (PCC) Availability and the July 4th Holiday

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our customer service representatives (CSRs). The list below indicates when the home health and hospice PCC at **1.877.299.4500** will be closed for training.

Date	PCC Closed
Thursday, July 10, 2014	PCC Closed 8:00 a.m. – 10:00 a.m. ET
Thursday, July 24, 2014	PCC Closed 8:00 a.m. – 10:00 a.m. ET

The Interactive Voice Response (IVR) (**1.877.220.6289**) is available for assistance in obtaining patient eligibility information, claim and deductible information, and general information. For information about the IVR, access the IVR User Guide at http://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf on the CGS website. In addition, CGS' Internet portal, myCGS, is available to access eligibility information through the Internet. For additional information, go to http://www.cgsmedicare.com/hhh/index.html and click the "myCGS" button on the left side of the Web page.

July 4th Holiday

The CGS office will be closed on Friday, July 4, 2014. Our data center has informed us that the Fiscal Intermediary Standard System (FISS) and access to the eligibility screens, ELGA/ELGH will not be available on July 4th. In addition, the system will not cycle that night, which means that claims will not be sent to the Common Working File (CWF) on July 4, 2014. Medicare Remittance Advices, Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfer (EFTs) will no be produced July 4, 2014.

For your reference, access the **"Home Health & Hospice 2014 Holiday/Training Closure Schedule"** at http://www.cgsmedicare.com/hhh/help/pdf/Holiday_Schedule.pdf for a complete list of PCC closures.

For Home Health and Hospice Providers

Provider Contact Center Reminders

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

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

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

- IVR User Guide - http://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf
- myCGS - http://www.cgsmedicare.com/hhh/myCGS/index.html

For Home Health and Hospice Providers

Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all nonregulatory changes to Medicare including transmittals, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The purpose of the Quarterly Provider Update is to:

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

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

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

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at **1.877.299.4500** and choose Option 1.

For Home Health and Hospice Providers

Stay Informed and Join the CGS ListServ Notification Service

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

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

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

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

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

For Home Health and Hospice Providers

Submit Your Redetermination Requests through the myCGS Web Portal!

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

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

Submitting a Redetermination Request using myCGS

1. Select the 'Forms' tab.

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

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

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

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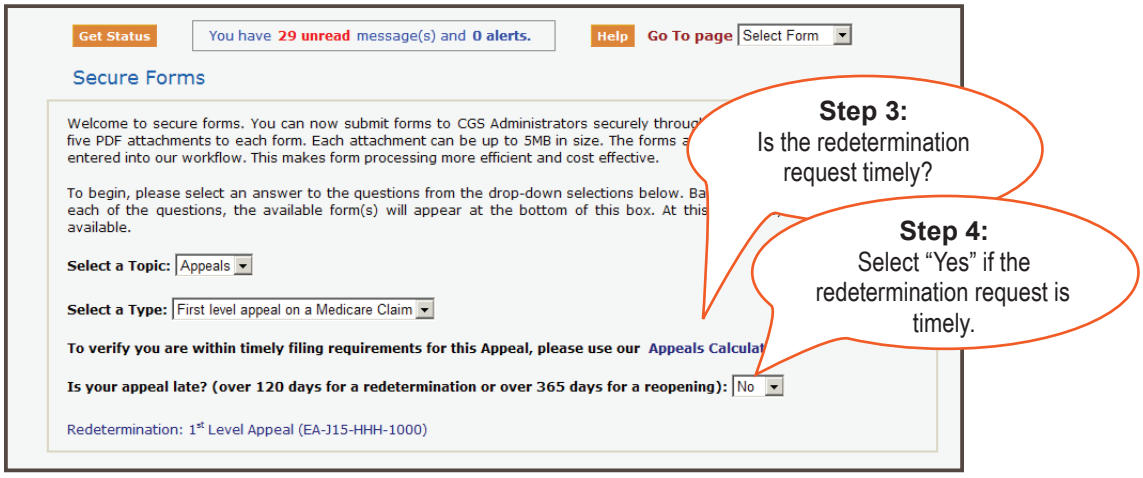
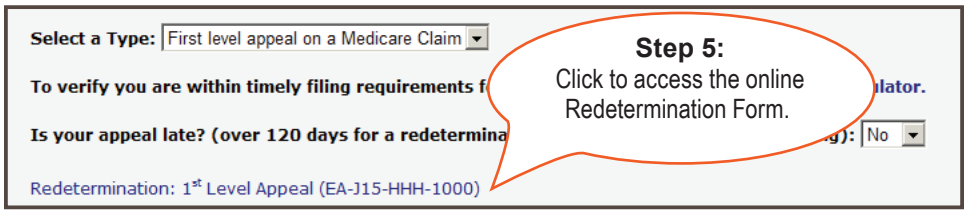


4. Once you have determined that your request is timely, select "Yes" from the drop-down menu. If your appeal is untimely, you cannot submit your redetermination request via the myCGS portal.
5. Click on the "Redetermination: 1st Level Appeal" link to access the online Redetermination Form.



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

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

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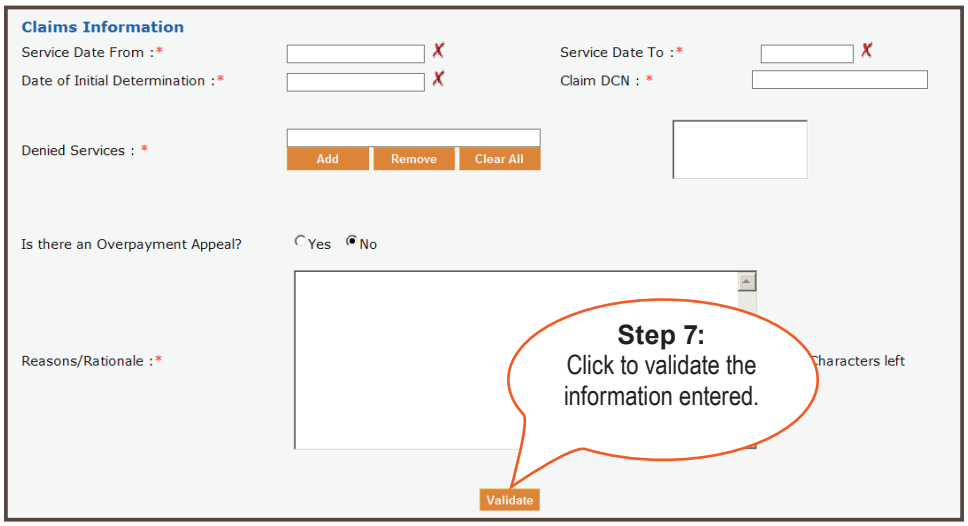
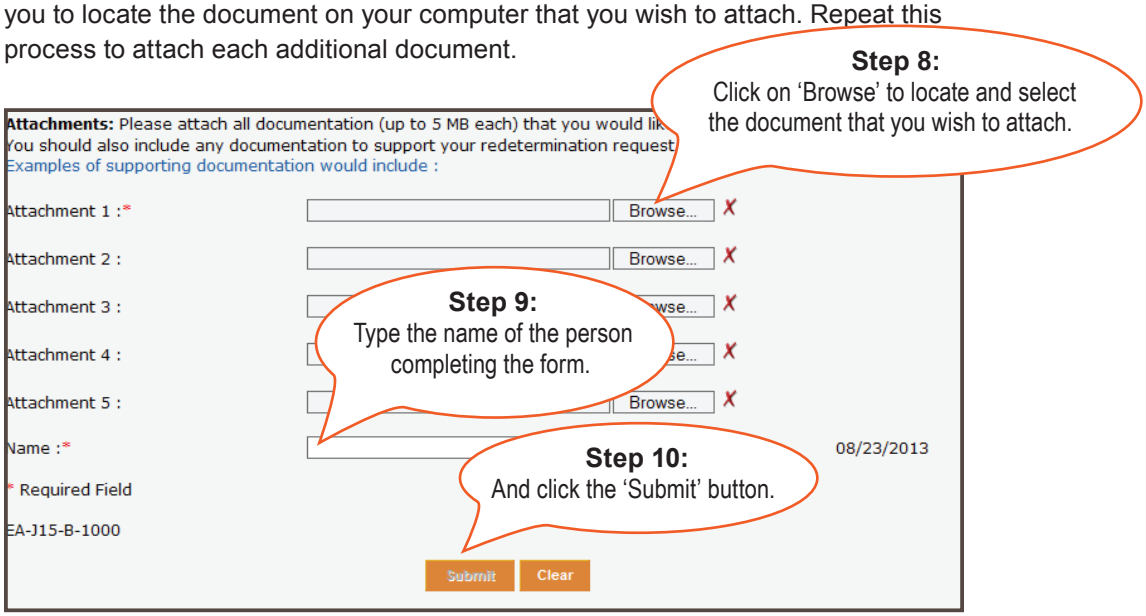


NOTE: The 'Attachments' section of the Redetermination form allows you to attach documentation (e.g., medical records, notes, orders, etc.) you would like CGS to consider when processing your redetermination request. You can attach up to 5 documents (up to 5 MB each). At least one document is required.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

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



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

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

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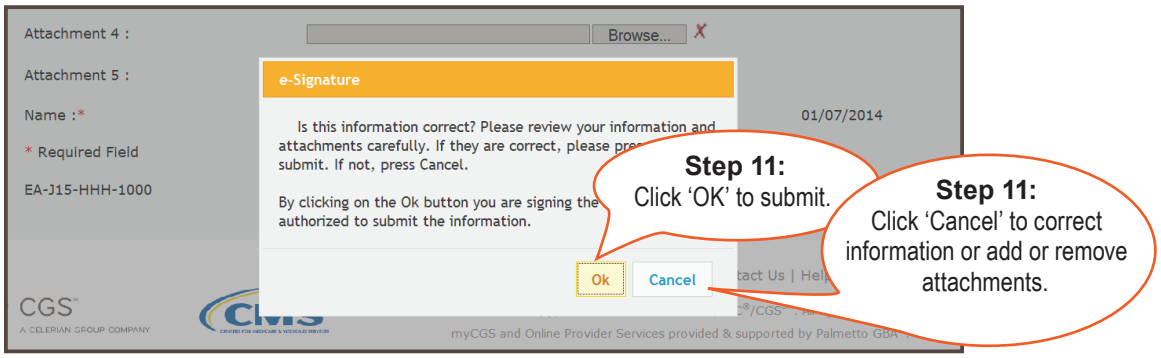
If any information needs to be corrected, or if any attachments need to be added or deleted, click 'Cancel' to return to the form.



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

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

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