HOME HEALTH & HOSPICE

Medicare Bulletin

Jurisdiction 15

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For Home Health Providers

MM8597: Correction CR - Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131

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: MM8597
Related CR Release Date: February 14, 2014
Related CR Transmittal #: R2878CP
Related Change Request (CR) #: CR 8597
Effective Date: May 15, 2014
Implementation Date: May 15, 2014

Provider Types Affected

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

What You Need to Know

This article, based on CR 8597, provides the removal of language that was erroneously included in CR 8404 and in the Medicare Claims Processing Manual, Chapter 30, Sections 50.3 and 50.6.2. It also provides clarified manual instructions regarding home health agency issuance of the Advance Beneficiary Notice of Noncoverage (ABN) to dual eligible beneficiaries.

Background

The ABN is an Office of Management and Budget (OMB)-approved written notice issued by providers and suppliers for items and services provided under Medicare Part B, including hospital outpatient services, and care provided under Part A by home health agencies (HHAs), hospices, and religious non-medical healthcare institutes only.

Key Points of CR 8597

- With the exception of Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) suppliers, providers and suppliers who are not enrolled in Medicare cannot issue the ABN to beneficiaries. DMEPOS suppliers not enrolled as Medicare suppliers are required by statute to provide ABN notification prior to furnishing any items or services to Medicare beneficiaries.
- An example of an approved customization of the ABN which can be used by providers of laboratory services (Sample Lab ABN) is now available for download at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html.
- When issuing ABNs to dual eligibles or beneficiaries having a secondary insurer, HHAs are permitted to direct the beneficiary to select a particular option box on the notice to facilitate coverage by another payer. This is an exception to the usual ABN issuance guidelines prohibiting the notifier from selecting one of the options for the beneficiary. When a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer, HHAs should instruct beneficiaries to select Option 1 on the ABN. HHAs may add a statement in the “Additional Information” section to help a dual eligible better understand the payment situation such as, “We will submit a claim for this care with your other insurance,” or “Your Medical Assistance plan will pay for this care.” HHAs may also use the “Additional Information” on the ABN to

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include agency specific information on secondary insurance claims or a blank line for the beneficiary to insert secondary insurance information. Agencies can pre-print language in the "Additional Information" section of the notice.

- Some States have specific rules established regarding HHA completion of liability notices in situations where dual eligibles need to accept liability for Medicare noncovered care that will be covered by Medicaid. Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is recognized as the "payer of last resort," meaning other Federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid picks up any remaining charges. In the past, some States directed HHAs to select the third checkbox on the HHABN to indicate the choice to bill Medicare. On the ABN, the first check box under the "Options" section indicates the choice to bill Medicare and is similar to the third checkbox on the outgoing HHABN. Note: **If there has been a State directive to submit a Medicare claim for a denial, HHAs must mark the first check box when issuing the ABN.**
- HHAs serving dual eligibles should comply with existing HHABN State policy within their jurisdiction as applicable to the ABN unless the State instructs otherwise. The appropriate option selection for dual eligibles will vary depending on the State's Medicaid directive. If the HHA's State Medicaid office does NOT want a claim filed with Medicare prior to filing a claim with Medicaid, the HHA should direct the beneficiary to choose Option 2. When Option 2 is chosen based on State guidance, but the HHA is aware that the State sometimes asks for a Medicare claim submission at a later time, the HHA must add a statement in the "Additional Information" box such as "Medicaid will pay for these services. Sometimes, Medicaid asks us to file a claim with Medicare. We will file a claim with Medicare if requested by your Medicaid plan."

Additional Information

The official instruction, CR 8597, issued to your MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2878CP.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 Providers

MM8653: April 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: MM8653
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Related CR Transmittal #: R2894CP
Related Change Request (CR) #: CR 8653
Effective Date: April 1, 2014
Implementation Date: April 7, 2014

Provider Types Affected

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

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Provider Action Needed

This article is based on Change Request (CR) 8653 which describes changes to and billing instructions for various payment policies implemented in the April 2014 OPPS update. The April 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, and Revenue Code additions, changes, and deletions identified in CR 8653. Be sure your billing staff are aware of these changes.

Background

Change Request (CR) 8653 describes changes to and billing instructions for various payment policies implemented in the April 2014 OPPS update. The April 2014 I/OCE and OPPS Pricer will reflect the HCPCS, APC, HCPCS Modifier, Status Indicators (SIs), and Revenue Code additions, changes, and deletions identified CR 8653.

The April 2014 revisions to I/OCE data files, instructions, and specifications are provided in the April 2014 I/OCE CR8658.Upon release of CR8658, a related MLN Matters® article can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8658.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

The key changes in the April 2014 update to the hospital OPPS are summarized in the following sections.

Changes to Device Edits for April 2014

The most current list of device edits can be found under “Device and Procedure Edits” at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/ on the Centers for Medicare & Medicaid Services (CMS) website. Failure to pass these edits will result in claims being returned to the provider.

No Cost/ Full Credit and Partial Credit Devices

Effective January 1, 2014, CMS will no longer recognize the modifier FB (Item provided without cost to provider, supplier, or practitioner, or credit received for replaced device) or the modifier FC (Partial credit received for replaced device), which are used to identify a device that is furnished without cost or with a full or partial credit. Also effective January 1, 2014, for claims with APCs that require implantable devices and have significant device offsets (greater than 40 percent), the amount of the device credit will be specified in the amount portion for value code “FD” (Credit Received from the Manufacturer for a Replaced Medical Device) and will be deducted from the APC payment from the applicable procedure. The OPPS payment deduction for the applicable APCs referenced above will be limited to the total amount of the device offset when the FD value code appears on a claim. The offset amounts for the above referenced APCs, along with the offsets for other APCs, are available under the ‘Annual Policy Files’ link on the left column at http://www.cms.gov/HospitalOutpatientPPS/ on the CMS OPPS website.

CMS is updating the *Medicare Claims Processing Manual* (Chapter 4, Sections 61.3.1 through 61.3.4) and adding Sections 61.3.5 through 61.3.6 to Chapter 4 of that manual to reflect these changes to the reporting guidelines for no cost/ full credit and partial credit devices, and these revised and added sections are included as an attachment to CR 8653. Those added sections are as follows:

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61.3.5 - Reporting and Charging Requirements When a Device is Furnished Without Cost to the Hospital or When the Hospital Receives a Full or Partial Credit for the Replacement Device Beginning January 1, 2014

Effective January 1, 2014, when a hospital furnishes a new replacement device received without cost or with a credit of 50 percent or more of the cost of a new replacement from a manufacturer, due to warranty, recall, or field action, the hospital must report the amount of the device credit in the amount portion for value code "FD" (Credit Received from the Manufacturer for a Replaced Medical Device). Also effective January 1, 2014, hospitals must report one of the following condition codes when the value code "FD" is present on the claim:

- **49 Product Replacement within Product Lifecycle**—Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.
- **50 Product Replacement for Known Recall of a Product**—Manufacturer or FDA has identified the product for recall and therefore replacement.

61.3.6 - Medicare Payment Adjustment Beginning January 1, 2014 (Rev. 1657, Issued: 12-31-08, Effective: 01-01-14, Implementation: 01-05-09)

Effective January 1, 2014, Medicare payment is reduced by the amount of the device credit for specified procedure codes reported with value code "FD." The payment deduction is limited to the full device offset when the FD value code appears on a claim. Payment is only reduced for procedure codes that map to the APCs on the list of APCs subject to the adjustment that are reported with value code "FD" and that are present on claims with specified device HCPCS codes.

The OPPS Pricer deducts the lesser of the device credit or the full unadjusted device offset amount from the Medicare payment for a procedure code in an APC subject to the adjustment when billed with value code "FD" on the claim. This deduction is made from the Medicare payment after the multiple procedure discounting and terminated procedure discounting factors are applied, units of service are accounted for, and after the APC payment has been wage adjusted.

When two or more procedures assigned to APCs subject to the adjustment are reported with value code "FD," the OPPS Pricer will apportion the device credit to the applicable line on the claim for each procedure assigned to an APC subject to the adjustment. When value code "FD" is reported on a claim where multiple APCs would be subject to the adjustment, the OPPS Pricer apportions the device credit to each of those lines. The percentage of the device credit apportioned to each applicable line is based on the percentage that the unadjusted payment of each applicable line represents, relative to the total unadjusted payment for all applicable lines.

Note: The tables of APCs and devices to which the offset reductions apply, and the full and partial offset amounts, are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS website.

New Services

New services listed in Table 1 below, are assigned for payment under the OPPS, effective April 1, 2014.

Table 1 – New Services Payable under OPPS Effective April 1, 2014

HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9739	4/01/2014	T	0162	Cystoscopy prostatic imp 1-3	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	$2,007.32	$401.47

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Table 1 – New Services Payable under OPPS Effective April 1, 2014							
HCPCS	Effective date	SI	APC	Short Descriptor	Long descriptor	Payment	Minimum Unadjusted Copayment
C9740	4/01/2014	T	1564	Cysto impl 4 or more	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants	$4,750.00	$950.00

Extended Assessment and Management (EAM) Composite APC (8009)

Effective January 1, 2014, CMS will provide payment for all qualifying extended assessment and management encounters through newly created composite APC 8009 (Extended Assessment and Management (EAM) Composite). Any clinic visit, Level 4 or Level 5 Type A Emergency Department (ED) visit, or Level 5 Type B ED visit furnished by a hospital in conjunction with observation services of eight or more hours will qualify for payment through APC 8009. Effective January 1, 2014, CMS will no longer provide payment for extended assessment and management encounters through APCs 8002 (Level I Extended Assessment and Management Composite) and 8003 (Level I Extended Assessment and Management Composite).

CMS is updating the "Medicare Claims Processing Manual" (Pub. 100-04, Chapter 4, Sections 10.2.1 and 290.5) to reflect these changes to the EAM Composite APC reporting guidelines. These updated sections are included as an attachment to CR 8653.

Billing for Drugs, Biologicals, and Radiopharmaceuticals

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

In the Calendar Year (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. You can review the CY 2014 OPPS/ASC final rule at http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf on the Internet. 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 April 2014 release of the OPPS Pricer.

The updated payment rates, effective April 1, 2014 will be included in the April 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 April 1, 2014

Two drugs and biologicals have been granted OPPS pass-through status effective April 1, 2014. These items, along with their descriptors and APC assignments, are identified in Table 2 below.

Table 2 – Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2014				
HCPCS Code	Short Descriptor	Long descriptor	APC	Status Indicator
C9021*	Injection, obinutuzumab, 10 mg	Injection, obinutuzumab	1476	G
Q4121	Theraskin, per square centimeter	Theraskin	1479	G

Note: The HCPCS code identified with an "*" indicates that this is a new code effective April 1, 2014.

c. Revised Status Indicator for HCPCS Codes A9545, J1446, J7178, and Q0181

Effective April 1, 2014, the status indicator for HCPCS code A9545 (Iodine I-131 tositumomab, therapeutic, per treatment dose) will change from SI=K (Paid under OPPS;

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separate APC payment) to SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

Effective January 1, 2014, the status indicator for HCPCS code J1446 (Injection, TBO-Filgrastim, 5 micrograms) will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (Paid under OPPS; separate APC payment).

Effective January 1, 2014, the status indicator for HCPCS code J7178 (Injection, human fibrinogen concentrate, 1 mg) will change from SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.) to SI=K (Paid under OPPS; separate APC payment).

Effective January 1, 2014, the status indicator for HCPCS code Q0181 (Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as) will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=N (Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.).

These codes are listed in Table 3 below, along with the effective date for the revised status indicator.

Table 3 – Drugs and Biologicals with Revised Status Indicators

HCPCS Code	Long Descriptor	APC	Status Indicator	Effective Date
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose		E	4/1/2014
J1446	Injection, TBO-Filgrastim, 5 micrograms	1477	K	1/1/2014
J7178	Injection, human fibrinogen concentrate, 1 mg	1478	K	1/1/2014
Q0181	Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as		N	1/1/2014

d. Updated Payment Rate for Q4127 Effective April 1, 2013, through June 30, 2013

The payment rate for Q4127 was incorrect in the April 2013 OPPS Pricer. The corrected payment rate is listed in Table 4 below, and it has been installed in the April 2014 OPPS Pricer, effective for services furnished on April 1, 2013 through June 30, 2013. MACs will adjust claims that were previously processed incorrectly if you bring such claims to the attention of your MAC.

Table 4 – Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2013 through June 30, 2013

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q4127	G	1449	Talymed	$13.78	$2.76

e. Updated Payment Rate for Q4127 Effective July 1, 2013, through September 30, 2013

The payment rate for Q4127 was incorrect in the July 2013 OPPS Pricer. The corrected payment rate is listed in Table 5 below, and it has been installed in the April 2014 OPPS Pricer, effective for services furnished on July 1, 2013, through September 30, 2013. MACs will adjust claims that were previously processed incorrectly if you bring such claims to the attention of your MAC.

Table 5 – Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2013 through September 30, 2013

HCPCS Code	Status Indicator	APC	Short Descriptor	Corrected Payment Rate	Corrected Minimum Unadjusted Copayment
Q4127	G	1449	Talymed	$13.78	$2.76

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

The payment rates for three HCPCS codes were incorrect in the October 2013 OPPS Pricer. The corrected payment rates are listed in Table 6 below, and they have been installed in the April 2014 OPPS Pricer, effective for services furnished on October 1, 2013, through December 31, 2013. MACs will adjust claims that were previously processed incorrectly if you bring such claims to the attention of your MAC.

Table 6 – 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
A9600	K	0701	Sr89 strontium	$1,196.47	$239.29
J2323	K	9126	Natalizumab injection	$12.99	$2.60
Q4127	G	1449	Talymed	$13.78	$2.76

g. Reassignment of Skin Substitute Products that are New for CY 2014 from the Low Cost Group to the High Cost Group

In the CY 2014 OPPS/ASC final rule, CMS finalized a policy to package payment for skin substitute products into the associated skin substitute application procedure. You can review the CY 2014 OPPS/ASC final rule at http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf on the Internet. For packaging purposes, CMS created two groups of application procedures: application procedures that use high cost skin substitute products (billed using Current Procedural Terminology (CPT) codes 15271-15278) and application procedures that use low cost skin substitute products (billed using HCPCS codes C5271-C5278). Assignment of skin substitute products to the high cost or low cost groups depended upon a comparison of the July 2013 payment rate for the skin substitute product to $32, which is the weighted average payment per unit for all skin substitute products using the skin substitute utilization from the CY 2012 claims data and the July 2013 payment rate for each product. Skin substitute products with a July 2013 payment rate that was above $32 per square centimeter are paid through the high cost group and those with a July 2013 payment rate that was at or below $32 per square centimeter are paid through the low cost group for CY 2014. As a reminder, for CY 2015, CMS will follow the usual policy with regard to the specific quarterly ASP data sets used for proposed and final rule-making in that CMS will use April 2014 ASP data to establish the proposed rule low/high cost threshold, and CMS will use July 2014 ASP data to establish the final low/high cost threshold for CY 2015.

CMS also finalized a policy that for any new skin substitute products approved for payment during CY 2014, CMS will use the $32 per square centimeter threshold to determine mapping to the high or low cost skin substitute group. Any new skin substitute products without pricing information were assigned to the low cost category until pricing information becomes available. There were nine new skin substitute products that were effective January 1, 2014, and that were assigned to the low cost payment group because pricing information was not available for these products at the time of the January 2014 update. There is now pricing information available for three of these nine products. Table 7 below, shows the 3 new products and their low/high cost status based on the comparison of the price per square centimeter for each product to the $32 square centimeter threshold for CY 2014.

Table 7– Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2014

HCPCS Code	Long Descriptor	Status Indicator	Low/High Cost Status
Q4143	Repriza, Per Square Centimeter	N	Low
Q4147	Architect Extracellular Matrix, Per Square Centimeter	N	High
Q4148	Neox 1k, Per Square Centimeter	N	High

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h.Billing Guidance for the Topical Application of Mitomycin During or Following Ophthalmic Surgery

Hospital outpatient departments should only bill HCPCS code J7315 (Mitomycin, ophthalmic, 0.2 mg) or HCPCS code J3490 (unclassified drugs) for the topical application of mitomycin during or following ophthalmic surgery. J7315 may be reported only if the hospital uses mitomycin with the trade name Mitosol®. Any other topical mitomycin should be reported with J3490. Hospital outpatient departments are not permitted to bill HCPCS code J9280 (Injection, mitomycin, 5 mg) for the topical application of mitomycin.

New HCPCS Code Effective April 1, 2014

One new HCPCS code has been created for reporting services, supplies, and accessories used in the home under the Medicare intravenous immune globulin (IVIG) demonstration. This code is listed in Table 8 below, and it is effective for services furnished on or after April 1, 2014.

Table 8– New HCPCS Codes Effective April 1, 2014

HCPCS Code	Long Descriptor	Short Descriptor	Status Indicator Effective 4/1/14
Q2052	Services, supplies and accessories used in the home under the Medicare intravenous immune globulin (ivig) demonstration	Ivig demo, services/supplies	N

Changes to OPPS Pricer Logic

Effective January 1, 2014, for claims with APCs, which require implantable devices and have significant device offsets (greater than 40 percent), a device offset cap will be applied to the applicable procedure line based on the credit amount listed in the "FD" (Credit Received from the Manufacturer for a Replaced Medical Device) value code. The credit amount in value code "FD," which reduces the post wage-adjusted APC line payment for the applicable procedure, will be capped by the device offset amount for that APC. The offset amounts for the above referenced APCs, along with the offsets for other APCs, is available under the 'Annual Policy Files' link on the left column at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS OPPS website.

Coverage Determinations

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

Additional Information

The official instruction, CR 8653, issued to your MAC regarding these changes is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2894CP.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 Providers

SE1410 (Revised): Special Instructions for the International Classification of Diseases, Clinical Modification 10th Edition (ICD-10-CM) Coding on Home Health Episodes that Span October 1, 2014

The Centers for Medicare & Medicaid Services (CMS) issued the following ***Special Edition Medicare Learning Network® (MLN) Matters*** on February 24, 2014. CMS then revised the article on February 27 and March 4, 2014. The following article reflects both revisions. 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

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Note: This article was revised on February 27, 2014, to correct an entry in the table on page 4. The last row and third column of the table should have indicated "OASIS-C." All other information is unchanged.

Note: This article was revised on March 4, 2014, to remove references to the General Equivalence Mappings. These changes are on page 3 and in the table on page 4. All other information is unchanged.

Provider Types Affected

This MLN Matters® article is intended for physicians, providers, suppliers, and other covered entities who submit claims to Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in home health (HH) care settings.

Provider Action Needed

This MLN Matters® Special Edition (SE) 1410 alerts providers that on October 1, 2014, all Medicare claims submissions of diagnosis codes will change from the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) to the 10th Edition (ICD-10-CM). All entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must make this transition requiring systems changes throughout the entire health care industry.

Background

In 2011CMS issued CR 7492, which provided information on reporting guidelines and claims submissions requirements for ICD-10-CM. Particularly, CR 7492 provided instructions regarding claims with service dates that span the ICD-10 effective date. Recently, CMS issued an updated article (SE1408) at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf, which provides special billing instructions for home health agencies (HHAs) to apply to HH claims where the episode begins in August or September 2014 and ends in October 2014. MLN Matters® article SE1408 also provides details for coding other types of claims for services that span the ICD-10 implementation date of October 1, 2014. This article provides further details regarding HH claims for episodes that span he October 1 date.

Key Points of This Article

Three factors affect how ICD-10-CM must be used on these episodes for services that span the October 1 date:

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1. The claim "From" date (episode start date);
2. The Outcome and Assessment Information Set (OASIS) assessment completion date (OASIS item M0090 date); and
3. The claim "Through" date.

Episodes Starting Before October 1, 2014, with OASIS Completion Dates Before October 1, 2014

In the case of initial HH episodes, the OASIS assessment must be completed within 5 days of the start of care. The assessment completion date (M0090 date) determines whether the HH Grouper software that determines the payment group for the episode will apply ICD-9-CM or ICD-10-CM codes to the episode. In the case where the episode start of care date is before October 1, 2014, and the M0090 date is also before October 1, 2014, ICD-9-CM codes will be used on the OASIS and to determine the payment group code (the Health Insurance Prospective Payment System (HIPPS) code).

For HH claims (type of bill 032x), ICD-10-CM reporting is required based on the claim "Through" date. On Requests for Anticipated Payment (RAPs), Medicare billing instructions require that the "From" and "Through" dates are the same. So if the episode begins in September 2014, the "From" and "Through" dates on the RAP would report the same date in September. These RAPs would report ICD-9-CM diagnosis codes using codes matching the OASIS assessment.

If the HH episode spans into October 2014, the corresponding final claim for the episode will be required to report ICD-10-CM codes. HH claims cannot be split into periods before and after October 1, 2014, so these claims will have claim "Through" dates of October 1, 2014, or later. The HIPPS code on the final claim must match the HIPPS code that was reported on the RAP. The HIPPS code on the RAP was based on the ICD-9-CM codes matching the OASIS assessment.

CR 7492 stated that CMS will:

> "Allow HHAs to use the payment group code derived from ICD-9-CM codes on claims which span 10/1, but require those claims to be submitted using ICD-10-CM codes."

This means that HHAs do not have to re-group the episode based on the ICD-10-CM codes. But this could result in some inconsistency between the HIPPS code and the ICD-10-CM codes on the claim. CMS will alert medical reviewers at our MACs to ensure that the ICD-10-CM codes on these claims are not used in making determinations. CMS will also alert researchers using CMS data files of this inconsistency. The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes that were used on the RAP and which are stored in the OASIS system.

These same procedures will apply to resumption of care assessments (M0100 = 03) and to recertification (M0100 = 04) and follow-up (M0100 = 05) assessments when the episode start date and the M0090 date on those assessments are both before October 1, 2014, but the episode ends in October 2014 (see table on next page).

Episodes Starting Before October 1, 2014, with OASIS Completion Dates in October 2014

There may be cases where the episode start of care date is before October 1, 2014, and, due to the 5 day completion window, the M0090 date is in October 2014. For example, an initial episode with a start of care date of September 28, 2014, could have an M0090 date of October 2, 2014. In these cases, ICD-10-CM codes will be used on the OASIS and to determine the HIPPS code.

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The RAP for this example would have "From" and "Through" dates of September 28, 2014. As a result, these RAPs would need to report ICD-9-CM diagnosis codes even though ICD-10-CM codes were used on the OASIS assessment.

Since RAPs are not subject to medical review and are replaced in Medicare claims history by the final claim, there is no need to account for adverse impacts in these situations. The ICD-9-CM codes are simply required in order for the RAP to be processed. The corresponding final claim for the episode will report ICD-10-CM codes matching the OASIS assessment.

Recertification Episodes Beginning in the First Days of October 2014

In the case of recertification episodes, the M0090 date can be up to 5 days earlier than the episode start date. So, a recertification episode starting on October 2, 2014, could have an M0090 date of September 28, 2014. ICD-9-CM codes are used on the OASIS assessment and will be used to determine the HIPPS code. But in this case, both the RAP and claim will require ICD-10-CM codes since the "Through" date on both will be after October 1, 2014.

The coding used to support the payment of the HIPPS code will be the ICD-9-CM codes which are stored in the OASIS system. In these cases also, CMS will alert medical reviewers at our MACs and researchers using CMS data files to prevent adverse impacts.

The following table summarizes the above scenarios:

Type of OASIS Assessment	RAP "From/ Through" Dates	OASIS M0090 Date/ OASIS Version	Claim "Through" Date	Diagnosis Coding Used on OASIS	Diagnosis Coding Used on RAP	Diagnosis Coding Used on Claim
Start of Care/ Resumption of Care	9/28/2014	9/30/2014 OASIS-C	11/26/2014	ICD-9-CM	ICD-9-CM	ICD-10-CM
Recertification	9/28/2014	9/25/2014 OASIS-C	11/26/2014	ICD-9-CM	ICD-9-CM	ICD-10-CM
Start of Care/ Resumption of Care	9/28/2014	10/2/2014 OASIS-C1	11/26/2014	ICD-10-CM	ICD-9-CM	ICD-10-CM
Recertification	10/2/2014	9/28/2014 OASIS-C	11/30/2014	ICD-9-CM	ICD-10-CM	ICD-10-CM

Additional Information

To find additional information about ICD-10, visit http://www.cms.gov/Medicare/Coding/ICD10/index.html on the CMS website.

The ICD-10-related implementation date is now October 1, 2014, as announced in final rule CMS-0040-F issued on August 24, 2012. This final rule is available at http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html on 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 Hospice Providers

Change Request 8358: Frequently Asked Questions (FAQs)

Through a cooperative effort, the Home Health & Hospice (HH&H) Medicare Administrative Contractors (MACs) have developed an extensive list of FAQs to assist hospice providers in implementing data reporting changes mandated by Change Request (CR) 8358, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8358.pdf

Answers to the most common questions can be answered by this document, including when drugs must be reported, and how they are reported on a claim. The FAQs can be accessed from the CGS "Frequently Asked Questions" Web page, at http://www.cgsmedicare.com/hhh/education/faqs/index.html, below the "Hospice Billing" header, and is labeled "Change Request 8358."

Providers should review this document before calling the CGS Provider Contact Center with any questions related to CR 8358.

For Hospice Providers

MM8569: Enforcement of the 5 Day Payment Limit for Respite Care under the Hospice Medicare Benefit

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: MM8569
Related CR Release Date: February 5, 2014
Related CR Transmittal #: R2867CP
Related Change Request (CR) #: CR 8569
Effective Date: July 1, 2014
Implementation Date: July 7, 2014

Provider Types Affected

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

Provider Action Needed

This article, based on CR 8569, instructs MACs to implement system edits to prevent payment of respite care for more than 5 days at a time for any hospice claim submitted on or after July 1, 2014. This instruction will enforce the current policy that limits payment of respite care to no more than 5 consecutive days. Make sure your billing staffs are aware of this update.

Background

The Code of Federal Regulations (CFR) 42, Part 418.302, states that payment for inpatient respite care is subject to the requirement that it may not be provided consecutively for more than 5 days at a time. Payment for the sixth and any subsequent day of respite care is made at the appropriate home care rate. In an effort to prevent potential overpayments in the Medicare Hospice benefit, CR 8569 implements new edits

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to prevent payment of respite care for more than 5 days at a time for any hospice claim submitted on or after July 1, 2014.

Since respite care is payable only for periods of respite up to 5 consecutive days, claims reporting respite periods greater than 5 consecutive days will be Returned to the Provider (RTP). Days of respite care beyond 5 days must be billed at the appropriate home care rate for payment consideration. When a MAC RTPs a claim, it will include an external narrative on the RTP reason code stating that respite care exceeding 5 consecutive days must be billed as routine home care and are not to be included in the M2 occurrence span code.

For example: If the patient enters a respite period on July 1 and is returned to routine home care on July 6, the units of respite reported on the line item would be 5 representing July 1 through July 5, July 6 is reported as a day of routine home care regardless of the time of day entering respite or returning to routine home care.

When there is more than one respite period in the billing period, the provider must include the M2 occurrence span code for all periods of respite. The individual respite periods reported shall not exceed 5 days, including consecutive respite periods.

For example: If the patient enters a respite period on July 1 and is returned to routine home care on July 6 and later returns to respite care from July 15 to July 18, and completes the month on routine home care, the provider must report two separate line items for the respite periods and two occurrence span code M2, as follows:

Revenue Line items:

- Revenue code 0655 with line item date of service 07/01/XX (for respite period July 1 through July 5) and line item units reported as 5
- Revenue code 0651 with line item date of service 07/06/XX (for routine home care July 6 through July 14) and line item units reported as 9
- Revenue code 0655 with line item date of service 07/15/XX (for respite period July 15 through 17th) and line item units reported as 3
- Revenue code 0651 with line item date of service 07/18/XX (for routine home care on date of discharge from respite through July 31 and line item units reported as 14.

Occurrence Span Codes:

- M2 0701XX – 0705XX
- M2 0715XX – 0717XX

Additional Information

The official instruction, CR 8569, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2867CP.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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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:

- **Hospice Medicare Billing Codes Sheet Quick Resource Tool** – This quick resource tool, available at http://www.cgsmedicare.com/hhh/education/materials/pdf/Hospice_Medicare_Billing_Codes_Sheet.pdf has been updated to include the most recent coding information for billing hospice claims. Updates were made to include billing information provided in Change Request 8358, which is required for dates of service April 1, 2014 (optional beginning January 1, 2014).
- The **"Beneficiary Eligibility Information FAQs"** Web page at http://www.cgsmedicare.com/hhh/education/faqs/Beneficiary_Eligibility_Info_FAQs.html and the "Checking Beneficiary Eligibility" Web page at http://www.cgsmedicare.com/hhh/claims/checking_bene_eligibility.html have been updated to include information about the revised SE1249 Medicare Learning Network (MLN) Matters ® article indicating that provider access to ELGA/ELGH, which was originally scheduled to be terminated April 7, 2014, has been delayed. CMS will provide at least 90 days advanced notice of the new termination date.
- The questions and answers from the February 4, 2014, "myCGS – Introduction to a World of Information Using a Web Portal" Ask-the-Contractor Teleconference (ACT) are available at: http://www.cgsmedicare.com/hhh/education/faqs/act/act_qa020414.html
- Based on the Medicare Learning Network (MLN) Matters ® article MM8620 "CWF Editing for Vaccines Furnished to Hospice – Correction," (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8620.pdf), the following Web pages have been updated to remove the information indicating that a beneficiary who is receiving hospice care must receive preventive vaccines from their hospice provider.
  - **Election of the Medicare Hospice Benefit While Receiving Home Health Services During an MA Plan Enrollment Period** - http://www.cgsmedicare.com/hhh/education/materials/Election_Med_Hospice_Benefit.html
  - **Top Claim Submission Errors for Home Health Providers: Error C7010** - http://www.cgsmedicare.com/hhh/education/materials/C7010.html
- The **"Adjustments/Cancels"** Web page at http://www.cgsmedicare.com/hhh/education/materials/Adjustments_Cancels.html has been updated to include information about the Document Control Number (DCN) being required in Form Locator (FL) 64 of the UB-04, or in the DCN field on FISS Page 01.
- The **"Reopenings"** Web page at http://www.cgsmedicare.com/hhh/appeals/Reopenings.html has been updated to specify that adjustments require the necessary adjustment coding (condition code, Document Control Number (DCN), and remarks), as required documentation for Clerical and Ordering/Referring Denial Reopenings.

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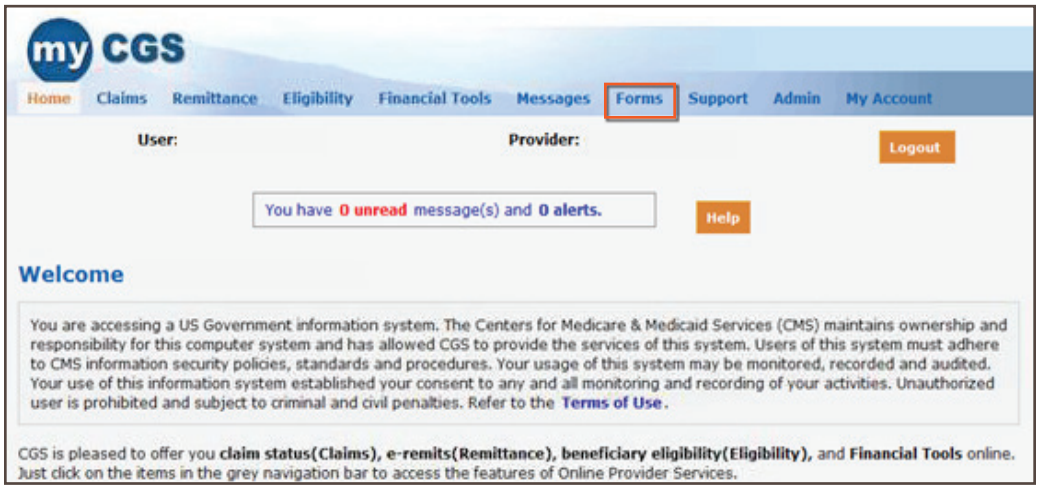
For Home Health and Hospice Providers

Introducing the myCGS Web Portal: Submitting Redeterminations through Forms Tab

This article is the third in a series of articles previously published in the CGS Medicare Bulletin to introduce the myCGS Web portal to all providers that submit claims to CGS.

The information below provides a general overview of the "Forms" tab in myCGS, which allows CGS providers to submit redetermination requests, the first appeal level, and monitor the status of these requests, using the myCGS Web portal.



What is the "Forms" tab in myCGS?

The "Forms" tab in myCGS allows users the ability to submit a redetermination request (1st appeal level) using the myCGS portal. Additional features via the Forms tab will be available in the near future.

What do I need to know about using the "Forms" tab?

Only those myCGS users who have been assigned rights by their Provider Administrator will have access to the "Forms" tab. If you do not have access to the "Forms" tab, but believe you should, talk with the myCGS Provider Administrator for your agency/organization, and they can update your security.

How do I use the "Forms" tab to submit a redetermination request?

To submit a redetermination request, click on the "Forms" tab to access the Secure Forms page. In the "Go To page" field, select the "Secure Forms" option.

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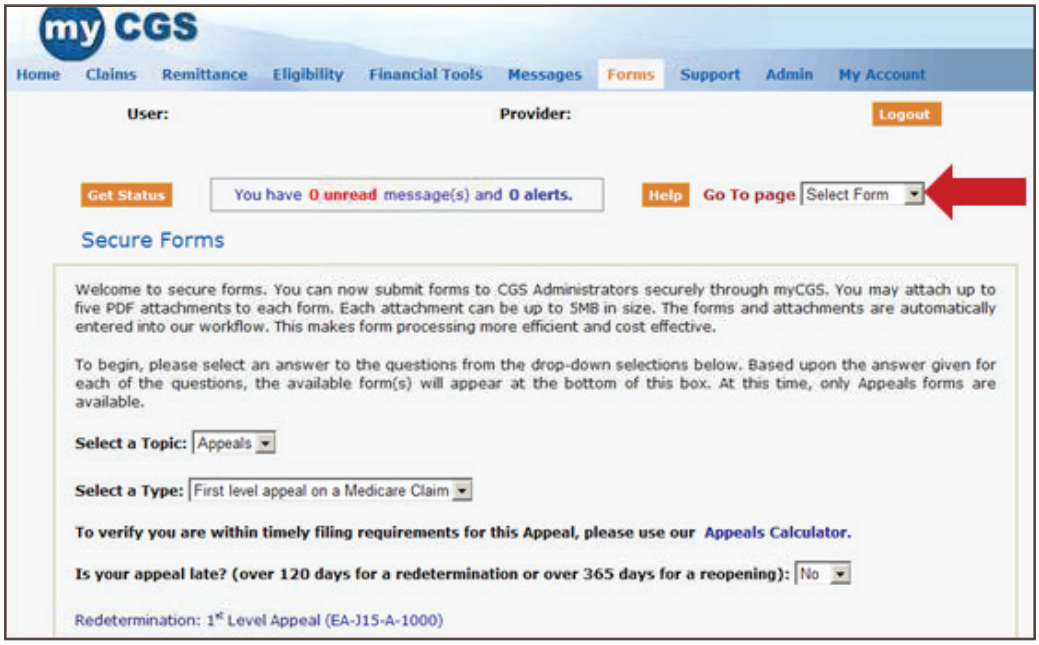

Currently, the only level of appeal that can be submitted via the myCGS portal is the first level of appeal, the redetermination. To determine if your appeal request is still timely, click on the "Appeals Calculator" link. If your appeal is untimely, you cannot submit your redetermination request via the myCGS portal.

Click on the "Redetermination: 1st Level Appeal" link to access the online Redetermination Form.

What information do I need to submit a redetermination request using myCGS?

The *myCGS Redetermination Form* is separated into sections: Beneficiary Information, Provider Information, and Attachments. Basic information, such as the beneficiary's claim number (HICN), dates of service being appealed, the Document Control Number (DCN) of the claim being appealed, and an explanation about why you are appealing the claim. It is also important to indicate whether your appeal request is related to an overpayment, such as the Comprehensive Error Rate Testing (CERT) program, a recovery audit (RA) findings, or a Zone Program Integrity Contractor (ZPIC) review. Fields that contain a red asterisk indicate that information is required.

myCGS also allows documentation supporting the appeal request to be attached directly to the redetermination request. This eliminates the need to copy and mail documentation with your appeal request. myCGS will accommodate up to 5 attachments, of 5 MB each, which should accommodate all medical documentation required for a patient's claim. Attachments must be in a PDF format, and at least one attachment is required.

How do I know if my Redetermination request was successfully received?

Once all required information is entered, simply click the "Submit" button to submit your redetermination request 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.

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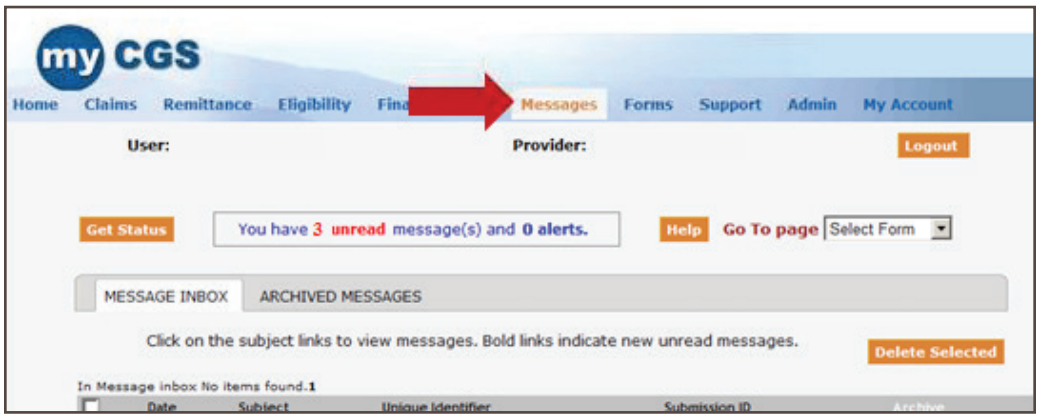

myCGS will confirm receipt of your redetermination request by indicating "Secure Form Received." Once a tracking number has been assigned to your redetermination request, myCGS will show "Secure Form Confirmation" along with the Submission ID number so you can continue to monitor your redetermination request.

For more information about the "Forms" tab, and submitting redeterminations using myCGS, go to Chapter 6: Messaging/Forms Tab of the *myCGS User Manual*, http://www.cgsmedicare.com/mycgs/manual.html, and select the appropriate link for your line of business (Part B or Home Health & Hospice).

For Home Health and Hospice Providers

Medicare Credit Balance Quarterly Reminder

This is to remind you to submit the Quarterly Medicare Credit Balance Report. The next report is due in our office postmarked by **April 30, 2014**, for the quarter ending **March 31, 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.

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

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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
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
  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**.

For Home Health and Hospice Providers

MLN Connects™ Provider e-News

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

- **February 20, 2014** - http://go.usa.gov/Bfxh
- **February 27, 2014** - http://go.usa.gov/BJwz
- **March 6, 2014** - http://go.usa.gov/KgZY
- **March 13, 2014** - http://go.usa.gov/K83W

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For Home Health and Hospice Providers

MM8456 (Revised): 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 issued the following ***Medicare Learning Network® (MLN) Matters*** article on February 11, 2014. A revision to this article was then issued on March 7, 2014. The following reflects the revised 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 *Revised*
Related CR Release Date: March 6, 2014
Related CR Transmittal #: R1356OTN
Related Change Request (CR) #: CR 8456
Effective Date: October 1, 2014
Implementation Date: October 6, 2014

Note: This article was revised on March 7, 2014, to reflect a revised Change Request (CR). The revise CR changes the effective and implementation dates. 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), including home health & hospice (HH&H) MACs and durable medical equipment Medicare administrative contractors (DME MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8456, which informs Medicare contractors about changes to the 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 HETS 271 response transaction will include as much Medicare Secondary Payer (MSP) information as possible to assist providers, physicians, and suppliers to identify which diagnosis codes are relevant to given MSP no-fault, liability, and workers' compensation cases. The diagnosis codes that the provider community will access via the HETS 270/271 process will assist providers, physicians, and other suppliers to better determine when Medicare is the secondary payer in association with their patients' current liability, no fault, or workers' compensation incidents that may prompt beneficiaries to seek medical services. Please ensure that your billing staffs are aware of these changes.

Background

The HETS 270/271 process is used by providers, physicians, and other suppliers to receive individual beneficiary eligibility information under the Medicare program, including information found on the CWF MSP auxiliary file. Although most MSP information from the MSP record is currently included on the HETS 271 response transaction, International Classification of Diseases (ICD), Clinical Modification (CM), diagnosis codes are not included. CMS believes it would be beneficial for CWF to

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include ICD-CM diagnosis codes, as derived from MSP no-fault, liability, and workers' compensation MSP auxiliary records, on the interface file that it sends to MBD. Through a separate Medicare Advantage Prescription Drug CR, CMS will ensure that the MBD table information that is exchanged with HETS will be modified to include ICD diagnosis codes. Thereafter, the diagnosis codes will be included in the HETS 271 response transaction that CMS makes available to providers, physicians, and suppliers.

Since the HETS 271 response transaction can only accommodate up to 8 diagnosis codes, CR 8456 instructs CWF to send up to 25 iterations of diagnosis codes associated with MSP no-fault, liability, and workers' compensation records for inclusion on the HETS 271 response transaction.

Additional Information

The official instruction, CR 8456 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1356OTN.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

MM8465 (Revised): International Classification of Diseases, 10th Revision (ICD-10) Testing with Providers through the Common Edits and Enhancements Module (CEM) and Common Electronic Data Interchange (CEDI)

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to 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: MM8465
Related CR Release Date: February 26, 2014
Related CR Transmittal #: R1353OTN
Related Change Request (CR) #: CR 8465
Effective Date: December 3, 2013
Implementation Date: March 3, 2014

Note: This article was revised on February 27, 2014, to reflect a revised CR that provides additional information to providers, suppliers, and clearinghouses about how claims will be submitted for testing **(page 2 in bold)**. The transmittal number, CR release date and link to the CR were also changed. All other information remains the same.

Provider Types Affected

This MLN Matters® article is intended for Medicare providers and suppliers submitting claims to Medicare contractors (A/B Medicare administrative contractors (A/B MACs), home health and hospice MACs (HHH MACs) and the durable medical equipment MACs (DME MACs) for services to Medicare beneficiaries.

What Providers Need to Know

This article is based on CR 8465, which announces plans for front-end ICD-10 testing between MACs and their trading partners.

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For dates of service of October 1, 2014, (and after) providers are required to submit ICD-10 codes on their claims. MACs must provide the opportunity for providers and suppliers to submit test claims through the CEM or the CEDI on the designated testing days.

- **Test claims with ICD-10 codes must be submitted with current dates of service (i.e. October 1, 2013, through March 3, 2014), since testing does not support future dated claims.**
- **Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected in the system.**
- **Testing will not confirm claim payment or produce remittance advice.**
- **MACs and CEDI will be staffed to handle increased call volume during this week.**

Make sure that your billing staff is aware of these upcoming ICD-10 testing periods.

Background

CMS is in the process of implementing ICD-10. All covered entities have to be fully compliant on October 1, 2014.

CR 8465 instructs all Medicare MACs and the DME MACs CEDI contractor to implement an ICD-10 testing week with trading partners. 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 HIPAA 5010 implementation. The ICD-10 testing week has 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.

This testing week will give trading partners access to the MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on each MAC and the CEDI website as well as the CMS website.

The testing week will be March 3 through March 7, 2014.

Testing Week Information:

- Your MAC will announce and actively promote the testing week via ListServ messages and will post the testing week announcement on their website.
- Your MAC will host a registration site for the testing week, or provide an e-mail address for the trading partners to provide registration information. The registration site or e-mail address information will be available and publicized to trading partners at least four weeks prior to the testing week.
- During the testing week, EDI help desk support will be available, at a minimum, from 9:00 a.m. to 4:00 p.m. local contractor time, with enough support to handle any increased call volume.
- Providers and suppliers participating during the testing week will receive electronic acknowledgement confirming that the submitted test claims were accepted or rejected.
- On or before March 18, 2014, your contractor will report the following to CMS:
  - Number of trading partners conducting testing during the testing week.
  - Percent of trading partners that conducted testing during the testing week (versus number of trading partners supported) by contract.
  - Percent of test claims accepted versus rejected.
  - Report of any significant issues found during testing.

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Additional Information

The official instruction, CR 8465, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1353OTN.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

MM8485: Reporting Principal and Interest Amounts When Refunding Previously Recouped Money on the Remittance Advice (RA)

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: MM8485
Related CR Release Date: February 6, 2014
Related CR Transmittal #: R1342OTN
Related Change Request (CR) #: CR 8485
Effective Date: July 1, 2014
Implementation Date: July 7, 2014

Provider Types Affected

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

Provider Action Needed

This article is based on CR 8485 which informs MACs about changes necessary to create a new process that insures refunded principal and associated interest amounts can be reported separately on remittance advices and that claim identifiers are used to identify the appropriate claim for which those amounts apply. Make sure that your billing staffs are aware of these changes.

Background

CMS was advised that the current practice of reporting principal and interest amounts for all related claims on the Remittance Advice (RA) as one lump sum amount was creating problems for the provider community since it was not conducive to the proper posting of payments. CR 8485 instructs the MACs on how to report refunded principal and interest amounts separately and how to use claim identifiers to indicate the appropriate claim for those amounts. Providers should see these changes appear on RAs created after CR 8485 is implemented on July 7, 2014.

Step-by-step instructions on how refunds with interest on previously recouped money are handled (including step(s) required by providers), as well as an example of reporting for the new Refund PLB Codes, are found in Attachment 1 to this CR.

Additional Information

The official instruction, CR 8485 issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1342OTN.pdf on the CMS website.

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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

MM8506: Pub 100-03, Chapter 1, Language-only 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: MM8506
Related CR Release Date: February 5, 2014
Related CR Transmittal #: R159NCD
Related Change Request (CR) #: CR 8506
Effective Date: October 1, 2014
Implementation Date: October 1, 2014

Provider Types Affected

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

Provider Action Needed

CMS issued CR 8506 as an informational alert to providers that language-only changes—updates to the Medicare National Coverage Determinations (NCD) Manual, Pub 100-03—were made.

The changes were made to comply with:

1. Conversion from ICD-9 to ICD-10;
2. Conversion from ASC X12 Version 4010 to Version 5010;
3. Conversion of former contractor types to MACs; and,
4. Other miscellaneous editorial and formatting updates provided for better clarity, correctness, and consistency.

Note: The edits made to the NCD Manual are technical/editorial only and in no way alter existing NCD policies.

Background

These edits to Pub. 100-03 are part of a CMS-wide initiative to update its manuals and bring them in line with recently released instructions regarding the above-noted subject matter.

Additional Information

The official instruction, CR 8506, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R159NCD.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

MM8531 (Revised): Calendar Year (CY) 2014 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to 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/2013-MLN-Matters-Articles.html

MLN Matters® Number: MM8531 *Revised*
Related CR Release Date: December 13, 2013
Related CR Transmittal #: R2836CP
Related Change Request (CR) #: CR 8531
Effective Date: January 1, 2014
Implementation Date: January 6, 2014

Note: This article was revised on March 6, 2014, to provide updates regarding HCPCS codes changes that were effective January 1, 2014. The changes are on page 2 (bold). All other information remains unchanged.

Provider Types Affected

This MLN Matters® article is intended for providers and suppliers submitting claims to Medicare administrative contractors (MACs) for DMEPOS items or services paid under the DMEPOS fee schedule.

What You Need to Know

The CMS issued CR 8531 to advise providers of the Calendar Year (CY) 2014 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. Make sure your staffs are aware of these updates.

Background and Key Points of CR 8531

The DMEPOS fee schedules are updated on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual, Chapter 23, Section 60, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website. Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section1834 (a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for Parenteral and Enteral Nutrition (PEN) and splints, casts, and certain intraocular lenses.

Fee Schedule Files

The DMEPOS fee schedule file will also be available for providers and suppliers, as well as State Medicaid Agencies, managed care organizations, and other interested parties at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/ on the CMS website.

Healthcare Common Procedure Coding System (HCPCS) Codes Added/ Deleted

The following new codes are effective January 1, 2014:

- A7047 in the inexpensive/routinely purchased (IN) payment category;

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- E0766 in the frequently serviced (FS) payment category; and E1352.

The following new codes are in the prosthetics and orthotics (PO) payment category: L5969, L8679, L0455, L0457, L0467, L0469, L0641-L0643, L0648-L0651, L1812, L1833, L1848, L3678, L3809, L3916, L3918, L3924, L3930, L4361, L4387, and L4397.

The following code is deleted from the HCPCS effective January 1, 2014, and therefore, is removed from the DMEPOS fee schedule files: L0430

The following codes are deleted from the DMEPOS fee schedule files as of January 1, 2014: A4611, A4612, A4613, E0457, E0459, L8685, L8686, L8687, and L8688.

For gap-filling purposes, the 2013 deflation factors by payment category are listed in the following table:

Factor	Category
0.469	Oxygen
0.472	Capped Rental
0.473	Prosthetics and Orthotics
0.600	Surgical Dressings
0.653	Parental and Enteral Nutrition

Specific Coding and Pricing Issues

As part of this update, fee schedules for the following codes will be added to the DMEPOS fee schedule file effective January 1, 2014:

- A4387 Ostomy Pouch, Closed, With Barrier Attached, With Built-In Convexity, (I Piece), Each; and
- L3031 Foot, Insert/Plate, Removable, Addition to Lower Extremity Orthotic, High Strength, Lightweight Material, All Hybrid Lamination/Prepreg Composite, Each.

CMS is adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes, A5512 or A5513. To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of CY2004. For 2014, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the Calendar Year 2012. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2014.

Off-the-Shelf Orthotics

Section 1847(a)(2)(C) of the Act mandates implementation of competitive bidding programs throughout the United States for awarding contracts for furnishing Off-The-Shelf (OTS) orthotics which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual. Regulations at 42 CFR 414.402 define the term “minimal self-adjustment” to mean an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist,

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an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc, or by the Board for Orthotist/Prosthetist Certificationor an individual who has specialized training.

As shown in the following table, 22 new codes are added to the HCPCS for OTS orthotics. In addition, as part of the review to determine which HCPCS codes for prefabricated orthotics describe OTS orthotics, it was determined that HCPCS codes for prefabricated orthotics describe items that are furnished OTS and items that require expertise in customizing the orthotic to fit the individual patient. Therefore, it was necessary to explode these codes into two sets of codes. One set is the existing codes revised, effective January 1, 2014, to only describe devices customized to fit a specific patient by an individual with expertise and a second set of new codes describing the OTS items.

Also, as shown in the table that follows for CY 2014, the fee schedule amounts for existing codes will be applied to the corresponding new codes added for the items furnished OTS. The cross walking of fee schedule amounts for a single code that is exploded into two codes for distinct complete items is in accordance with the instructions found in the Medicare Claims Processing Manual, Chapter 23,

Section 60.3.1, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website.

Prefabricated Orthotic Codes Split into Two Codes—Effective January 1, 2014			
Fee from Existing Code	Crosswalk to New Off-The-Shelf and Revised Custom Fitted Orthotic Codes	Fee from Existing Code	Crosswalk to New Off-The-Shelf and Revised Custom Fitted Orthotic Codes
L0454	L0455 and L0454	L1810	L1812 and L1810
L0456	L0457 and L0456	L1832	L1833 and L1832
L0466	L0467 and L0466	L1847	L1848 and L1847
L0468	L0469 and L0468	L3807	L3809 and L3807
L0626	L0641 and L0626	L3915	L3916 and L3915
L0627	L0642 and L0627	L3917	L3918 and L3917
L0630	L0643 and L0630	L3923	L3924 and L3923
L0631	L0648 and L0631	L3929	L3930 and L3929
L0633	L0649 and L0633	L4360	L4361 and L4360
L0637	L0650 and L0637	L4386	L4387 and L4386
L0639	L0651 and L0639	L4396	L4397 and L4396

Further information on the development of new OTS orthotic codes can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html on the CMS website.

Neurostimulator Devices

HCPCS codes, L8685, L8686, L8687, and L8688 are not included on the 2014 DMEPOS fee schedule file. They were removed from the file to reflect the change in the coverage indicators for these codes to invalid for Medicare ("I") effective January 1, 2014. However, code L8679 (Implantable Neurostimulator, Pulse Generator, Any Type) is added to the HCPCS and DMEPOS fee schedule file, effective January 1, 2014, for billing Medicare claims previously submitted under L8685, L8686, L8687 and L8688. The fee schedule amounts for code L8679 are based on the established Medicare fee schedule amounts for all types of pulse generators under the previous HCPCS code E0756 Implantable Neurostimulator Pulse Generator which was discontinued effective 12/31/2005. The payment amount is based on the explosion of code E0756 into four codes for different types of neurostimulator pulse generator systems which were not materially utilized in the

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Medicare program. As such, payment for code L8679 will revert back to the fee schedule amounts previously established for code E0756.

Diabetic Testing Supplies

The fee schedule amounts for non-mail order diabetic testing supplies, without KL modifier, for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for CY 2014. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the single payment amounts for mail order Diabetic Testing Supplies (DTS) established in implementing the national mail order Competitive Bidding Program (CBP) under Section 1847 of the Act. The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years as CBP contracts are recompeted. The national CBP for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016. The program instructions reviewing these changes are Transmittal 2709, Change Request (CR) 8325, dated May 17, 2013, and Transmittal 2661, Change Request (CR) 8204, dated February 22, 2013. You may review the MLN Matters® Articles for these CRs at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf and http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf on the CMS website.

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for Multi-Factor Productivity (MFP), which results in update of 1.0 percent for CY 2014. The single payment amount public use file for the national mail order competitive bidding program is available at http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts on the Internet.

CY2014 Fee Schedule Update Factor

For CY 2014, the update factor of 1.0 percent is applied to the applicable CY 2013 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2014 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2013, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP).

The MFP adjustment is 0.8 percent and the CPI-U percentage increase is 1.8 percent. Thus, the 1.8 percentage increase in the CPI-U is reduced by the 0.8 percentage increase in the MFP resulting in a net increase of 1.0 percent for the update factor.

2014 Update to the Labor Payment Rates

The 2014 fees for HCPCS labor payment codes K0739, L4205, and L7520 are increased 1.8 percent effective for claims with dates of service from January 1, 2014, through December 31, 2014, and those rates are as follows:

STATE	K0739	L4205	L7520
AK	$27.40	$31.22	$36.73
AL	14.55	21.68	29.43

STATE	K0739	L4205	L7520
NC	14.55	21.68	29.43
ND	18.13	31.16	36.73

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STATE	K0739	L4205	L7520
AR	14.55	21.68	29.43
AZ	17.99	21.66	36.21
CA	22.32	35.59	41.48
CO	14.55	21.68	29.43
CT	24.30	22.16	29.43
DC	14.55	21.66	29.43
DE	26.79	21.66	29.43
FL	14.55	21.68	29.43
GA	14.55	21.68	29.43
HI	17.99	31.22	36.73
IA	14.55	21.66	35.23
ID	14.55	21.66	29.43
IL	14.55	21.66	29.43
IN	14.55	21.66	29.43
KS	14.55	21.66	36.73
KY	14.55	27.76	37.64
LA	14.55	21.68	29.43
MA	24.30	21.66	29.43
MD	14.55	21.66	29.43
ME	24.30	21.66	29.43
MI	14.55	21.66	29.43
MN	14.55	21.66	29.43
MO	14.55	21.66	29.43
MS	14.55	21.68	29.43
MT	14.55	21.66	36.73

STATE	K0739	L4205	L7520
NE	14.55	21.66	41.04
NH	15.62	21.66	29.43
NJ	19.63	21.66	29.43
NM	14.55	21.68	29.43
NV	23.18	21.66	40.12
NY	26.79	21.68	29.43
OH	14.55	21.66	29.43
OK	14.55	21.68	29.43
OR	14.55	21.66	42.32
PA	15.62	22.30	29.43
PR	14.55	21.68	29.43
RI	17.34	22.32	29.43
SC	$14.55	21.68	29.43
SD	16.26	21.66	39.35
TN	14.55	21.68	29.43
TX	14.55	21.68	29.43
UT	14.59	21.66	45.83
VA	14.55	21.66	29.43
VI	14.55	21.68	29.43
VT	15.62	21.66	29.43
WA	23.18	31.77	37.74
WI	14.55	21.66	29.43
WV	14.55	21.66	29.43
WY	20.28	28.89	41.04

2014 National Monthly Payment Amounts for Stationary Oxygen Equipment

CR8531 implements the 2014 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service on or after January 1, 2014. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for Oxygen Generating Portable Equipment (OGPE). The updated 2014 monthly payment amount of $178.24 includes the 1 percent update factor for the 2014 DMEPOS fee schedule.

Please note that when updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2014 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

CR 8531 also updates the 2014 payment amount for maintenance and servicing for certain oxygen equipment. You can read more about payment for claims for maintenance and servicing for oxygen equipment in MLN Matters® Articles, MM6792 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf and MM6990 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf on the CMS website.

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To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section1834(a)(14) of the Act. Thus, the 2013 maintenance and servicing fee is adjusted by the 1 percent MFP-adjusted covered item update factor to yield a CY 2014 maintenance and servicing fee of $68.73 for oxygen concentrators and transfilling equipment.

Additional Information

The official instruction, CR 8531 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2836CP.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

MM8582 (Revised): Claim Status Category and Claim Status Codes Update

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to 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: MM8582 *Revised*
Related CR Release Date: February 24, 2014
Related CR Transmittal #: R2884CP
Related Change Request (CR) #: CR 8582
Effective Date: April 1, 2014
Implementation Date: April 7, 2014

Note: This article was revised on February 27, 2014, to reflect an updated Change Request (CR). The CR corrects the date when the Claim Status Category Codes and Claim Status Codes will be posted, which is March 1, 2014. 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 durable medical equipment Medicare administrative contractors (DME MACs) and home health & hospice MACs, for services to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 8582 which informs Medicare contractors about the changes to Claim Status Category Codes and Claim Status Codes. Make sure that your billing personnel are aware of these changes.

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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). 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 January 2014 committee meeting shall be posted on these sites on or about March 1, 2014. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

These code changes are to 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 8582.

Additional Information

The official instruction, CR 8582 issued to your MAC regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2884CP.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

MM8602: International Classification of Diseases, Tenth Revision (ICD-10) Limited End to End Testing with Submitters

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: MM8602
Related CR Release Date: February 21, 2014
Related CR Transmittal #: R1352OTN
Related Change Request (CR) #: CR 8602
Effective Date: July 7, 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 claims administration contractors (durable medical equipment Medicare administrative contractors (DME MACs), A/B Medicare administrative contractors (A/B MACs), and/or home health and hospices (HH & H MACs) for services provided to Medicare beneficiaries.

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What You Need to Know

This article is based on CR 8602 which instructs providers and clearinghouses on how to volunteer to be chosen for ICD-10 End to End testing with Medicare in July 2014. Potential testers must complete the volunteer form on the MAC website by March 24, 2014.

Background

The International Classification of Disease, Tenth Revision, (ICD-10) must be implemented by October 1, 2014. While system changes to implement this project have been completed and tested in previous releases, the industry has requested the opportunity to test with CMS.

CR 8602 will allow for a small subset of Medicare claims submitters to test with MACs and the Common Electronic Data Interchange (CEDI) contractor to demonstrate that CMS systems are ready for the ICD-10 implementation. This additional testing effort will further ensure a successful transition to ICD-10.

To facilitate this testing, CR 8602 requires MACs to do the following:

- Conduct a limited end to end testing with submitters in July 2014. Test claims will be submitted July 21-25, 2014.
- Each MAC (and CEDI with assistance from DME MACs) will select 32 submitters to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will select 16 submitters. Testers will be selected randomly from a list of volunteers. At least five, but not more than ten of the testers will be a clearinghouse, and submitters should be a mix of provider types.
- By March 7, 2014, the MACs and CEDI will post a volunteer form to their website to collect volunteer information with which to select volunteers. The form will provide information to verify that volunteers are ready to test, meet the requirements to test, and collect needed data about the tester (how they submit claims, what type of claims will be tested, etc.). Volunteers must submit the completed forms to the MACs and CEDI by March 24, 2014.
- By April 14, 2014, the MACs and CEDI (for the DME MACs) will notify the volunteers that they have been selected to test and provide them with the information needed for the testing, such as:
  - How to submit test claims (for example, what test indicators should be set);
  - What dates of service may be used for testing;
  - How many claims may be submitted for testing (Test claims volume is limited to a total of 50 claims for the entire testing week, submitted in no more than three files);
  - Request for National Provider Identifiers (NPIs) and Health Insurance Claim Numbers (HICNs) that will be used in testing (no more than 5 NPIs and 10 HICNs per submitter);
  - Notice that if more than 50 claims are submitted, they may not be processed;
  - Notice that claims submitted with NPIs or HICNs not previously submitted for testing, likely will not be completed; and
  - Notice of potential Protected Health Information (PHI) on test remittances not submitted (and instructions to report PHI found to the MAC).
- MACs and CEDI (for the DME MACs) will collect information from the selected test volunteers to request the HICNs, NPIs, and Provider Transaction Access Numbers (PTANs) the testers will use during the testing. The forms for this information must

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be completed and returned to the MAC/CEDI by May 2, 2014. If these forms are not returned by May 2, the tester may lose the opportunity to test.

- CEDI will instruct suppliers to submit claims with ICD-10 codes with Dates of Service (DOS) 10/1/2014 through 10/15/2014. They may also submit claims with ICD-9 codes with DOS before 10/1/2014.
- MACs will instruct testers to submit test claims with ICD-10 codes with DOS on or after 10/1/2014. They may also submit test claims with ICD-9 codes with DOS before 10/1/2014.
- MACs and CEDI will be prepared to support increased call volume from testers during the testing window, and up to 2 weeks following the receipt of the Electronic Remittance Advices (ERAs) from testing. MACs and CEDI will provide information to the testers on who to contact for testing questions. There may be separate contacts for front end questions and remittance questions.
- MACs will post an announcement about the testing to their websites.

Additional Information

The official instruction, CR 8602, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1352OTN.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

MM8611: Healthcare Provider Taxonomy Codes (HPTC) Update, April 2014

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: MM8611
Related CR Release Date: February 28, 2014
Related CR Transmittal #: R2888CP

Related Change Request (CR) #: CR 8611
Effective Date: April 1, 2014
Implementation Date: July 7, 2014 (Contractors with the capability to do so will implement April 1, 2014)

Provider Types Affected

This MLN Matters® article is intended for physicians, other providers, and suppliers submitting claims to Medicare claims administration contractors (fiscal intermediaries (FIs), carriers, A/B Medicare administrative contractors (A/B MACs), regional home health intermediaries (RHHIs), home health and hospices MACs (HHH MACs), and durable medical equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

CR 8611, from which this article is taken, instructs Medicare contractors to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

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Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used.

Both the current Accredited Standards Committee (ASC) X-12 837 institutional and professional Technical Report Type 3 (TR3s) require that the National Uniform Claim Committee (NUCC) HPTC set be used to identify provider specialty information on a health care claim. However, the standards do not mandate the reporting of provider specialty information via a HPTC be on every claim, nor for every provider to be identified by specialty. The standard implementation guides state that this information is:

- "Required when the payer's adjudication is known to be impacted by the provider taxonomy code;" and
- "If not required by this implementation guide, do not send."

Note: Medicare does not use HPTCs to adjudicate its claims and would not expect to see these codes on a Medicare claim. However, currently, it validates any HPTC that a provider happens to supply against the NUCC HPTC set.

The Transactions and Code Sets Final Rule, published on August 17, 2000, establishes that the maintainer of the code set determines its effective date. See http://aspe.hhs.gov/admnsimp/final/txfin00.htm on the Internet. This rule also mandates that covered entities must use the nonmedical data code set specified in the standard implementation guide that is valid at the time the transaction is initiated. For implementation purposes, Medicare generally uses the date the transaction is received for validating a particular nonmedical data code set required in a standard transaction.

The HTPC set is maintained by the NUCC for standardized classification of health care providers, and the NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at http://www.wpc-edi.com/codes on the Internet

CR 8611 implements the NUCC HPTC code set that is effective on April 1, 2014, and instructs Medicare contractors to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files.

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

- New items are green;
- Modified items are orange; and
- Inactive items are red.

Additional Information

The official instruction, CR 8611 issued to your carriers, FIs, A/B MACs, RHHIs, HHH MACs, and DME MACs, regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2888CP.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

MM8619: Implementation of Health Insurance Portability & Accountability Act (HIPAA) Standards and Operating Rules for Health Care Electronic Funds Transfers

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: MM8619
Related CR Release Date: February 21, 2014
Related CR Transmittal #: R1351OTN
Related Change Request (CR) #: CR 8619
Effective Date: July 1, 2014
Implementation Date: July 7, 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 and hospice (HH&H) MACs, for services to Medicare beneficiaries.

What You Need to Know

This article is based on CR 8619, which informs Medicare contractors that Section 1104 of the Affordable Care Act mandates the adoption of a standard for the Health Care Electronic Funds Transfers (EFT) HIPAA transaction and operating rules for the Health Care EFT and Remittance Advice Transaction.

The main intent of these standards and operating rules is to assure health plans transmit a trace number that allows providers to re-associate the EFT health care payment with its associate electronic remittance advice. Make sure that your billing staffs are aware of these changes.

Note that CR 8619 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the ACH (EFT) Network with electronic health care payments.

Physicians, other providers, and suppliers should be aware that, consequently, the payment information that a provider receives or that is transmitted from a provider's financial institution regarding the health care EFT payment may change as per these requirements. Specifically, the Company Entry Description and the TRN Segment that is reported or transmitted to a provider from its financial institution may change in terms of content or length.

Providers are urged to contact their financial institutions directly in order to understand the form in which payment information will be transmitted or reported on a per payment basis as a result of CR 8619. We suggest that providers should subsequently take steps to assure that the payment information that is changed as a result of related CR 8629 (see the related article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8629.pdf can be accommodated by your accounting processes and systems.

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Background

The regulation adopting the Health Care EFT standards is available at https://www.federalregister.gov/articles/2012/01/10/2012-132/administrative-simplification-adoption-of-standards-for-health-care-electronic-funds-transfers-efts on the Internet.

The regulation adopting the EFT & ERA Operating Rules can be found at https://www.federalregister.gov/articles/2012/08/10/2012-19557/administrative-simplification-adoption-of-operating-rules-for-health-care-electronic-funds-transfers#h-4 on the Internet.

A new National Automated Clearinghouse Association (NACHA) standard for electronic healthcare claim payments went into effect on September 20, 2013, impacting all originators and receivers of electronic funds transfers (EFT) used to pay healthcare claims. This Healthcare EFT standard stems from the Affordable Care Act, which requires that healthcare payers must pay healthcare claim payments electronically using HIPAA standards if requested by the healthcare provider.

The standard designated for these claim payments is the Healthcare EFT Standard, which is a NACHA CCD+ transaction that includes the ASC X12 835 TRN data segment in the addenda record. The Healthcare EFT Standard requires the following:

- Company Entry Description of "HCCLAIMPMT" to identify the payment as healthcare;
- Company Name should be the health plan or third party administrator paying the claim;
- An addenda record must be included with a Record Type Code of "7" and an Addenda Type Code equal to "05"; and
- Payment Related Information in the addenda record must contain the ASC X12 835 TRN (Re-association Trace Number) data segment that is included on the electronic remittance advice.

Healthcare providers will use the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result, specific addenda formatting requirements must be followed for healthcare EFT payments. The TRN data segment must contain the following data elements, separated by an asterisk "*."

Example: TRN*1*12345*1512345678*9999999~

TRN, TRN01, TRN02, TRN03, TRN04, Segment Terminator

* data element separator

Element	Element Name	Mandatory or Optional	Data Content
TRN	Re-association Trace Number	M	ASC X12 835 segment identifier. This is always "TRN."
TRN01	Trace Type Code	M	Trace Type Code is always a "1."
TRN02	Re-association Information	M	This data element must contain the EFT trace number.
TRN03	Origination Company ID	M	A unique identifier designating the company initiating the funds transfer. This must be a "1" followed by the payer's Tax Identification Number (TIN).
TRN04	Reference Identification	O	This data element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.
Segment Terminator	Segment Terminator	M	The TRN data segment in the addenda record must end with either a tilde "~" or a backslash "\."

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Additional Information

The official instruction, CR 8619, issued to your MAC regarding this change, is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1351OTN.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

MM8620: CWF Editing for Vaccines Furnished at Hospice - Correction

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: MM8620
Related CR Release Date: February 6, 2014
Related CR Transmittal #: R1339OTN
Related Change Request (CR) #: CR 8620
Effective Date: October 1, 2013
Implementation Date: April 7, 2014

Provider Types Affected

This MLN Matters® article is intended as an update for non-hospice providers furnishing vaccines to hospice beneficiaries and submitting claims to Medicare Administrative Contractors (MACs).

Provider Action Needed

CMS issued CR 8620 to alert providers that any provider may furnish vaccines to hospice beneficiaries. Be sure your billing staffs are aware of this change.

Background

When CR 8098, Transmittal 1298, was published, effective October 1, 2013, it denied claims for vaccines furnished to hospice patients that were provided by anyone other than the patient's hospice provider. This was to enforce the statement in the *Medicare Claims Processing Manual*, chapter 18, section 10.2.4 that vaccines "may be covered when furnished by the hospice." CMS has determined that this enforcement is too restrictive, since the manual does not say "*only* when furnished by the hospice." CR 8620 removes the changes made to Medicare systems in CR 8098, in order to allow any provider to furnish vaccines to hospice beneficiaries.

Key Points

- Your MAC will allow professional claims for vaccines (Influenza, PPV, and Hepatitis B) and vaccine administration containing modifier GW when the date of service falls within a hospice election.
- Your MAC will adjust vaccine claims with dates of service on or after October 1, 2013, which were previously rejected due to a hospice election, if you bring such claims to your MAC's attention.

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Note from CGS: Once this CR is implemented (April 7, 2014), providers may submit a reopening request to CGS to adjust and pay rejected claims with dates of service on or after October 1, 2013, which are processed through April 6, 2014. Providers must submit the HHH Reopening Adjustment Request Form (https://www.cgsmedicare.com/hhh/appeals/pdf/hhh_reopening_form.pdf) and include a hardcopy UB-04 adjustment claim (XX7). For information about submitting a reopening, refer to the Clerical Reopenings section of the Reopenings Web page at https://www.cgsmedicare.com/hhh/appeals/Reopenings.html

Additional Information

The official instruction, CR 8620, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1339OTN.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

MM8629: Implementation of National Automated Clearinghouse Association (NACHA) Operating Rules for Health Care Electronic Funds Transfers (EFT)

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: MM8629
Related CR Release Date: February 21, 2014
Related CR Transmittal #: R1349OTN
Related Change Request (CR) #: CR 8629
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 home health & hospice MACs (HH&H MACs) and durable medical equipment Medicare administrative contractors (DME MACs) for services to Medicare beneficiaries.

What You Need to Know

This article is based on CR 8629 which informs MACs that they must comply with NACHA Operating Rules that are applicable to initiators of health care payments. CR 8629 requires MACs to modify or change data elements currently inputted into payment information that is transmitted through the ACH (EFT) Network with electronic health care payments. The overarching goal of the requirements of CR 8629 are to assure that providers receiving health care payments via EFT will receive a “trace number” that facilitates automatic reassociation of the EFT health care payment with its associated remittance advice.

Physicians, other providers, and suppliers should be aware that, consequently, the payment information that a provider receives or that is transmitted from a provider’s financial institution regarding the health care EFT payment may change as per these requirements. Specifically, the Company Entry Description and the TRN Segment that is

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reported or transmitted to a provider from its financial institution may change in terms of content or length.

Providers are urged to contact their financial institutions directly in order to understand the form in which payment information will be transmitted or reported on a per payment basis as a result of CR 8629. We suggest that providers should subsequently take steps to assure that the payment information that is changed as a result of CR 8629 can be accommodated by your accounting processes and systems.

Background

In support of Health Insurance Portability & Accountability Act of 1996 (HIPAA) Operating Rules for health care EFT and remittance advice transactions adopted by HHS, NACHA – The Electronic Payments Association has adopted its own operating rules that apply to ACH transactions that are health care payments from health plans to providers. NACHA manages the development, administration and governance of the ACH Network used by all types of financial networks and represents more than 10,000 financial institutions.

A new NACHA standard for electronic healthcare claim payments went into effect on September 20, 2013, impacting all originators and receivers of EFT used to pay healthcare claims. This Healthcare EFT standard stems from the Affordable Care Act, which requires that healthcare payers must pay healthcare claim payments electronically using HIPAA standards if requested by the healthcare provider.

The standard designated for these claim payments is the Healthcare EFT Standard, which is a NACHA CCD+ transaction that includes the ASC X12 835 TRN data segment in the addenda record. The Healthcare EFT Standard requires the following:

- Company Entry Description of “HCCLAIMPMT” to identify the payment as healthcare;
- Company Name should be the health plan or third party administrator paying the claim;
- An addenda record must be included with a Record Type Code of “7” and an Addenda Type Code equal to “05”; and
- Payment Related Information in the addenda record must contain the ASC X12 835 TRN (Re-association Trace Number) data segment that is included on the electronic remittance advice.

Healthcare providers will utilize the data within the addenda record to match the payment to the electronic remittance advice, which is sent to the provider separate from the payment. As a result, specific addenda formatting requirements must be followed for healthcare EFT payments. See “Healthcare EFT Standard Format” in the Medicare IOM for more information.

Example:

TRN*1*12345*1512345678*9999999~

TRN, TRN01, TRN02, TRN03, TRN04, Segment Terminator

*** data element separator**

The following table explains this example:

Element	Element Name	Mandatory or Optional	Data Content
TRN	Reassociation Trace Number	M	ASC X12 835 segment identifier. This is always “TRN.”

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Element	Element Name	Mandatory or Optional	Data Content
TRN01	Trace Type Code	M	Trace Type Code is always a "1."
TRN02	Reassociation Information	M	This data element must contain the EFT trace number.
TRN03	Origination Company ID	M	A unique identifier designating the company initiating the funds transfer. This must be a "1" followed by the payer's Tax Identification Number (TIN).
TRN04	Reference Identification	O	This data element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment.
Segment Terminator	Segment Terminator	M	The TRN data segment in the addenda record must end with either a tilde "~" or a backslash "\."

Additional Information

For information on the NACHA Operating Rules that apply to health care payments, particularly with regard to requirements for originators, see https://healthcare.nacha.org/healthcarerules . The official instruction, CR 8629 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1349OTN.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)

- Looking for the latest new and revised MLN Matters® articles? Subscribe to the MLN Matters® electronic mailing list! For more information about MLN Matters® and how to register for this service, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/What_Is_MLNMatters.pdf and start receiving updates immediately!
- Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:
  - MLN Matters® Article #MM8433, "Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season" - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8433.pdf
  - MLN Matters® Article #SE1336, "2013-2014 Influenza (Flu) Resources for Health Care Professionals" - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1336.pdf
  - HealthMap Vaccine Finder (http://vaccine.healthmap.org/) - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community.

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  - Free Resources (http://www.cdc.gov/flu/freeresources/), can be downloaded from the CDC website including prescription-style tear-pads that allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu. On the CDC order form, under "Programs," select "Immunizations and Vaccines (Influenza/Flu)" for a list of flu related resources.

- Products from the Medicare Learning Network® (MLN)
  - 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
  - NEW "Vaccine Payments Under Medicare Part D" Fact Sheet, ICN 908764, downloadable and hard copy at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Vaccines-Part-D-Factsheet-ICN908764.pdf
  - NEW "Hospice Related Services – Part B" Podcast, ICN 908995, downloadable only at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/ICN908995-podcast.html
  - REVISED "Contractor Entities At A Glance: Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities" Educational Tool, ICN 906983, downloadable at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ContractorEntityGuide_ICN906983.pdf
  - REVISED "Quick Reference Information: Medicare Immunization Billing" Educational Tool, ICN 006799, downloadable at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/qr_immun_bill.pdf
  - REVISED "Medical Privacy of Protected Health Information"¨ Fact Sheet, ICN 006942, downloadable at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SE0726FactSheet.pdf
  - REVISED "General Equivalence Mappings Frequently Asked Questions," Booklet, ICN 901743, hard copy only at http://www.cms.gov/Medicare/Coding/ICD10/Downloads/GEMs-CrosswalksBasicFAQ.pdf
  - REVISED "Medicare Enrollment and Claim Submission Guidelines," Booklet, ICN 906764, Downloadable and hard copy at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareClaimSubmissionGuidelines-ICN906764.pdf
- In September 2012, the Centers for Medicare & Medicaid Services (CMS) announced the availability of a new electronic mailing list for those who refer Medicare beneficiaries for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Referral agents play a critical role in providing information and services to Medicare beneficiaries. To ensure you give Medicare patients the most current DMEPOS Competitive Bidding Program information, CMS strongly encourages you to review the information sent from this new electronic mailing list. In addition, please share the information you receive from the mailing list and the link to the "mailing list for referral agents" (https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7814) subscriber Web page with others who refer Medicare beneficiaries for DMEPOS. Thank you for signing up!
- Are you ready to transition to ICD-10 on October 1, 2014? In this MLN Connects™ video at http://www.youtube.com/watch?v=kCV6aFIA-Sc&feature=youtu.be on ICD-

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10 Coding Basics, Sue Bowman from the American Health Information Management Association (AHIMA) provides a basic introduction to ICD-10 coding, including:

- Similarities and differences;
- ICD-10 code structure; and
- Coding process and examples.

To receive notification of upcoming MLN Connects videos and calls and the latest Medicare program information on ICD-10, subscribe to the weekly MLN Connects™ Provider eNews at https://public-dc2.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819 .

- **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.

For Home Health and Hospice Providers

Provide Your Feedback on the Home Health & Hospice Website Redesign

CGS launched the redesign of the Home Health & Hospice website on March 3, 2014. Tell us what you think by taking a few moments to complete the Foresee survey. This survey measures your satisfaction with the CGS website; therefore, your participation is important to us. The survey gives you the opportunity to tell us your likes and dislikes, and what improvements you would like to see to the redesigned HH&H section of the CGS website.

For Home Health and Hospice Providers

Provider Contact Center (PCC) Availability

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). Listed below are the dates and time the home health and hospice PCC at **1.877.299.4500**, (**Option 1**) will be closed for training.

CSR Training Date	Time
Tuesday, April 8, 2014	8:00 a.m. – 10:00 a.m. (Central Time)
Tuesday, April 22, 2014	

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,

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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.

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

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**.

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For Home Health and Hospice Providers

SE1249 (Revised): HIPAA Eligibility Transaction System (HETS) to Replace Common Working File (CWF) Medicare Beneficiary Health Insurance Eligibility Queries

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to 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/2012-MLN-Matters-Articles.html

MLN Matters® Number: SE1249 *Revised*
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: This article was revised on February 10, 2014, to update certain language to reflect the current **status of this change (see bolded language on page 2)**. Also, clarifications have been made to the last question in the Frequently Asked Questions section on page 3. All other information is unchanged.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for health care providers, suppliers and their billing agents, software vendors and clearinghouses that use Medicare's Common Working File (CWF) queries to obtain their patient's Medicare health insurance eligibility information from Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), durable medical equipment Medicare administrative contractors (DME MACs), and/or Part A/B Medicare administrative contractors (A/B MACs)).

Provider Action Needed

If you currently use CWF queries to obtain Medicare health insurance eligibility information for Medicare fee-for service patients, you should immediately begin transitioning to the Medicare Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS).

What You Need to Know

This article describes upcoming changes to Medicare beneficiary health insurance eligibility inquiry services that CMS will implement in the coming months. In April 2013, access to CWF eligibility query functions implemented in the Multi-Carrier System (MCS) and ViPS Medicare System (VMS), also referred to as PPTN and VPIQ, was terminated. CMS intends to terminate access to the other CWF eligibility queries implemented in the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE), often referred to the HIQA, HIQH, ELGA and ELGH screens and HUQA. **Change Request 8248 creates the ability for CMS to terminate these queries. While termination was originally scheduled for April 2014, CMS is delaying the date. CMS will provide at least 90 days advanced notice of the new termination date.** This **will not** affect the use of DDE to submit claims or to correct claims and will not impact access to beneficiary eligibility information from Medicare Contractor's Interactive Voice Response (IVR) units and/or Internet portals.

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Background

In 2005, CMS began offering HETS in a real-time environment to Medicare health care providers, suppliers and their billing agents, software vendors and clearinghouses. HETS is Medicare's Health Care Eligibility Benefit Inquiry and Response electronic transaction, ASCX12 270/271 Version 5010, adopted under HIPAA. HETS replaces the CWF queries, and is to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

Key Points

General Information

CMS plans to discontinue access to the CWF queries through the shared systems. Medicare providers and their agents that currently access the CWF queries through the shared system screens will need to modify their business processes to use HETS to access Medicare beneficiary eligibility information.

HETS

HETS allows Medicare providers and their agents to submit and receive X12N 270/271 eligibility request and response files over a secure connection. Many Medicare providers and their agents are already receiving eligibility information from HETS. For more information about HETS and how to obtain access to the system, refer to the CMS HETS Help Web page at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html on the CMS website.

Frequently Asked Questions

Are Medicare providers that currently use CWF to obtain beneficiary eligibility information required to switch to HETS?

No, but it is recommended. Providers may also choose to use a Medicare Contractor's IVR or Internet portal.

What are the minimum data elements required in order to complete an eligibility search in HETS?

HETS applies search logic that uses a combination of four data elements: Health Insurance Claim Number (HICN), Medicare Beneficiary's Date of Birth, Medicare Beneficiary's Full Last Name (including Suffix, if applicable), and Medicare Beneficiary's Full First Name. The Date of Birth and First Name are optional, but at least one must be present.

Does HETS return the same eligibility information that is currently provided by the CWF eligibility queries?

Changes are currently underway in HETS to return psychiatric information to authorized providers and to return Hospice period information in the same format as CWF. When these changes are made, HETS will return all of the information provided by the CWF eligibility queries that is needed to process Medicare claims. These changes will be in place before the termination date for the FISS DDE CWF query access.

HETS returns additional information that CWF does not return. For example, HETS returns:

- Part D plan number, address and enrollment dates; and
- Medicare Advantage Organization name, address, website and phone number.

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The HETS 270/271 Companion Guide provides specific details about the eligibility information that is returned in the HETS 271 response. The guide is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271CompanionGuide5010.pdf on the CMS website.

Additional Information

If you use a software vendor or clearinghouse to access Medicare beneficiary health insurance eligibility information, you should direct questions to your vendor or clearinghouse. If you have any questions about HETS, please contact the MCARE Help Desk at 1.866.324.7315.

For Home Health and Hospice Providers

SE1402: Updated Mobile Applications (Apps) for Open Payments

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/2014-MLN-Matters-Articles.html

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Provider Types Affected

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

What You Need to Know

CMS is issuing this article to alert the provider community of updates to the mobile applications (apps), *Open Payments Mobile for Industry* and *Open Payments Mobile for Physicians*, implemented as a result of user feedback to CMS. See the "Background" and "Key Points" sections of this article for details.

Also, a part of SE1402 is new technical documentation: "The Open Payments QR Code Reader How-To Guide." Included are the technical instructions for creating or importing contact information using a QR code reader and generating a QR code to transfer profile or payment information to other user devices.

Background

In July 2013, CMS released two mobile apps: *Open Payments Mobile for Industry* and *Open Payments Mobile for Physicians*. Below are enhancements to the original Open Payments mobile apps. The changes to the apps include the following:

- Streamlining the menu on the Welcome screen;
- Adding the ability to export **all** profile data associated with a payment into CSV format; and
- Developing a new function to view reports of payments in bar and pie charts.

The apps are intended to support reporting under the Open Payments program. For more details refer to: http://www.cms.gov/Regulations-and-Guidance/Legislation/

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National-Physician-Payment-Transparency-Program/index.html on the CMS website. For help with the apps contact the CMS helpdesk at OpenPayments@cms.hhs.gov.

Key Points of SE1402

If you already downloaded the apps, you will need to run an update to take advantage of the new app functionality. To do so, visit either the Google Play™ app store or iOSApple™ app store, look for your available updates, and select the Open Payments apps to download the updates. If you have not yet downloaded the apps, search for Open Payments in the applicable app store and you'll be prompted to download the newly updated versions.

In response to user feedback, the table below describes the enhancements made to the apps since their initial launch in July 2013. All changes are intuitive and will add elements of ease expected by app users.

Enhancement Topic	Details – What It Does
Changes that Apply to Both Apps *(Open Payments Mobile for Industry and Open Payments Mobile for Physicians)*	
Streamlined "Welcome" screen options	• A number of infrequently used menu options (e.g., "Program Information" and "Change Password") moved from the "Welcome" screen and now appear in a hidden menu. • To access the menu, swipe to the right at the "Welcome" screen.
Reports/Statistics	• A new "Reports/Statistics" button, accessible on the "Welcome" screen, allows the user to create a chart (bar and pie), showing their transfer of value data sorted by physician (within Open Payments Mobile for Industry) or vendor (within Open Payments Mobile for Physicians). • This new chart creation capability will streamline data review.
CSV exporting	• When payment data is exported via CSV format, all profile data for the associated vendor/physician is included in the CSV file (including address, phone number, etc.). • The prior app version included only vendor/physician name in the CSV file. This enhancement will simplify the data review process.
Streamlined "Add Payment" process	• The steps to "Add Payment" are streamlined to allow the user to enter contact information for the vendor or physician, while staying within the "Add Payment" menu. • The prior app version required the user to first enter contact information for the vendor or physician separately, and then go to the "Add Payment" menu.
Easy payment duplication	• A new button available on the "View Payment" screen allows payment data to be easily duplicated, in case a physician or vendor has multiple occurrences of the same payment. • The only data field that needs to be re-entered is the date.
Vendors/Physicians sorted alphabetically	• In "Manage Vendors/Physicians," vendors or physicians are now listed alphabetically. • The prior app version listed vendors and physicians in the order in which they were entered.
Email/print QR code added	• A "Share" button is available to email or print a QR code that is generated within the app, for sharing at a later time.
Payment QR code warning added	• After a payment QR code is scanned, a red warning message appears to remind the user to manually add the vendor or physician name to the payment data conveyed in the QR code.
Additional data elements added in "Add Payment" > "Travel & Lodging"	• When nature of payment in "Add Payment" is "Travel & Lodging," the following additional data elements can be entered: city, state, and country of travel (note that these new data elements are required for reporting purposes; but remember, the apps are not used for reporting data, only for tracking it).
Tablet support	• Both apps are optimized for viewing on tablet devices.
Changes that Apply to Just One App *Open Payments Mobile for Physicians*	
"Manage Companies" added	• Within "Manage Vendors", a new data field allows users to assign vendors to companies when entering new vendor information. • Company information is needed for the "Reports/Statistics" functionality to illustrate all payments by company name.

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The updated Frequently Asked Questions at http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Downloads/Mobile-App-FAQs-%5bAugust-2013%5d.pdf about the mobile apps contain all the details about these enhancements (link to the document above, or visit the "Apps for Tracking Assistance" page on the Open Payments website).

QR Code Technical Guide Available for Apps: Also now available to support use of the Open Payments apps is a how-to-guide that explains the technical details associated with how to create Quick Response (QR) codes usable in the apps. "The Open Payments QR Code Reader How-To Guide" includes detailed, highly technical instructions for creating or importing contact information using a QR code reader, and generating a QR code to transfer profile or payment information to other user's devices.

Additional 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**.

To review "The Open Payments Mobile Application Quick Response (QR) Code Reader Documentation: A How-To Guide to Create Java Script Object Notation (JSON) QR Code" referenced in this SE1402, see http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Downloads/Open-Payments-QR-Code-Reader-How-To-Guide-%5bDecember-2013%5d.pdf on the CMS website.

To review the series of SE articles leading up to SE1402 see the following:

1. MLN Matters® SE1303 "Information on the National Physician Payment Transparency Program: Open Payments," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1303.pdf on the CMS website.
2. MLN Matters® SE1329 "Mobile Apps for the Open Payments program (Physician Payments Sunshine Act)" is available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1329.pdf on the CMS website.
3. MLN Matters® SE1330 "Open Payments: An Overview for Physicians and Teaching Hospitals" may be found at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1330.pdf on the CMS website.

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For Home Health and Hospice Provides

SE1409 (Revised): Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach

The Centers for Medicare & Medicaid Services (CMS) issued the following ***Special Edition Medicare Learning Network® (MLN) Matters*** article on February 19, 2014. A revision to this article was then issued on February 27, 2014. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2014-MLN-Matters-Articles.html

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Note: This article was revised on February 27, 2014, to add information about the second week of acknowledgement testing and to provide more details about end-to-end testing.

Provider Types Affected

This article is intended for all physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

For dates of service on and after October 1, 2014, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2014. Be sure you are ready. This MLN Matters® Special Edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

Background

The implementation of International Classification of Diseases, 10th Edition (ICD-10) represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2014, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing to ensure that CMS as well as the Medicare Fee-For-Service (FFS) provider community is ready.

When “you” is used in this publication, we are referring to the FFS provider community.

The four-pronged approach includes:

- CMS internal testing of its claims processing systems;
- Provider-initiated Beta testing tools;
- Acknowledgement testing; and
- End-to-end testing.

Each approach is discussed in more detail below

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CMS Internal Testing of Its Claims Processing Systems

CMS has a very mature and rigorous testing program for its Medicare FFS claims processing systems that supports the implementation of four quarterly releases per year. Each release is supported by a three-tiered and time-sensitive testing methodology:

- Alpha testing is performed by each FFS claims processing system maintainer for 4 weeks;
- Beta testing is performed by a separate Integration Contractor for 8 weeks; and
- Acceptance testing is performed by each MAC for 4 weeks to ensure that local coverage requirements are met and the systems are functioning as expected.

CMS began installing and testing system changes to support ICD-10 in 2011. As of October 1, 2013, all Medicare FFS claims processing systems were ready for ICD-10 implementation. CMS continues to test its ICD-10 software changes with each quarterly release.

Provider-Initiated Beta Testing Tools

To help you prepare for ICD-10, CMS recommends that you leverage the variety of Beta versions of its software that include ICD-10 codes as well as National Coverage Determination (NCD) code crosswalks to test the readiness of your own systems. The following testing tools are available for download:

- NCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html on the CMS website;
- The ICD-10 Medicare Severity-Diagnosis Related Groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the General Equivalence Mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html on the CMS website. On this web page, you can also find current versions of the ICD-10-CM MS-DRG Grouper, Medicare Code Editor (available from National Technical Information Service), and MS-DRG Definitions Manual that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and
- A pilot version of the October 2013 Integrated Outpatient Code Editor (IOCE) that utilizes ICD-10-CM located at http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/ICD-10-IOCE-Code-Lists.pdf on the CMS website. The final version of the IOCE that utilizes ICD-10-CM is scheduled for release in August 2014.

Crosswalks for Local Coverage Determinations (LCDs) will be available in April 2014.

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2014, you should investigate downloading the free billing software that CMS offers from their MACs. The software has been updated to support ICD-10 codes and requires an internet connection. This billing software only works for submitting fee-for-service claims to Medicare. Alternatively, many MACs offer provider internet portals, and some MACs offer a subset of these portals that you can register for to ensure that you have the flexibility to submit professional claims this way as a contingency.

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Acknowledgement Testing

Crosswalks for Local Coverage Determinations (LCDs) will be available in April 2014.

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2014, you should investigate downloading the free billing software that CMS offers from their MACs. The software has been updated to support ICD-10 codes and requires an internet connection. This billing software only works for submitting fee-for-service claims to Medicare. Alternatively, many MACs offer provider internet portals, and some MACs offer a subset of these portals that you can register for to ensure that you have the flexibility to submit professional claims this way as a contingency were accepted or rejected. For more information about acknowledgement testing, refer to the information on your MAC's website.

Note from CGS: For more information about the ICD-10 testing week, refer to the "ICD-10-CM/PCS" Web page at https://www.cgsmedicare.com/hhh/claims/5010.html on the CGS website.

CMS plans to offer a second week of acknowledgement testing in early May 2014.

End-to-End Testing

In late July 2014, CMS will offer end-to-end testing to a small sample group of providers.

End-to-end testing includes the submission of test claims to CMS with ICD-10 codes and the provider's receipt of a Remittance Advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

- Providers or submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems;
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims (based on the pricing data used for testing purposes); and
- Accurate RAs are produced.

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. Information about the volunteer registration will be available in March 2014. Over 500 volunteer submitters will be selected nationwide to participate in the end-to-end testing. The small sample group of participants will be selected to represent a broad cross-section of provider types, claims types, and submitter types.

Additional details about the end-to-end testing process will be disseminated at a later date in a separate MLN Matters® article.

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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