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MAY 2013

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HH+H General Release

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For Hospice Providers

**Hospice Provider Contact Center Phone Number Change**

Effective May 1, 2013, CGS discontinued the hospice phone number, 1-866-539-5592. Both home health and hospice providers will call 1-877-299-4500, and choose Option 1, to contact a customer service representative (CSR) for assistance. The same CSRs that you are accustomed to will be available to take your call. If you call the discontinued hospice phone number on or after May 1, 2013, you will be directed to call 1-877-299-4500.

For Hospice Providers

**Reminder: Appropriate Attestations When Hospice Face-To-Face Performed by Nurse Practitioner**

The CGS Medical Review department has identified an issue with some hospice face-to-face (FTF) documentation when the FTF encounter was performed by the nurse practitioner (NP). In these cases, the hospice physician attested that the nurse practitioner performed the FTF encounter and provided the clinical findings used in the certification narrative.

However, the Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch. 9 section 20.1 states “A hospice physician or nurse practitioner who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter.” This means that if the NP performed the FTF encounter, he/she must complete their own attestation statement. It is not permissible for the hospice physician to complete the attestation when the FTF encounter was performed by the NP.


For Hospice Providers

**Reminder: Hospice Monthly Billing Requirements Effective July 1, 2013**

On July 1, 2013, new edits will be implemented in the Fiscal Intermediary Standard System (FISS) to ensure hospices are submitting only one claim per month per beneficiary, and that hospice claims do not span more than one calendar month. Claims that do not comply with these new system requirements will be returned to the provider (RTP) for correction, which will delay prompt payment of your Medicare claims.

Hospice providers must take steps now to prepare for this new edit, and ensure that your billers are compliant with the Medicare monthly billing requirements. We encourage hospices to also contact their software vendors, billing services and clearinghouse to ensure they meet the monthly billing requirements. Regardless of the different levels of care provided, all services provided to the beneficiary within the month must be submitted on one claim.

To prevent claims from being returned, the following rules must be followed:

- Submit only one claim per month, per beneficiary (unless the beneficiary has been discharged/revoked, and re-elects hospice in the same month);
- When a patient status code ‘30’ (still a patient) is reported on the claim, the “To” date of the claim must be the last calendar day of the month;
The claim cannot span two calendar months (e.g. June 27 – July 4).

For additional information, refer to:


For Hospice Providers

SE1306—Update on the Medicare Hospice Quality Reporting Program (HQRPs)

The Centers for Medicare & Medicaid Services (CMS) has provided the following Special Edition (SE) 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/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals.html

MLN Matters® Number: SE1306
Related Change Request (CR) #: Not applicable (N/A)
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Provider Types Affected
This MLN Matters® Special Edition article is intended for hospices submitting data under the Medicare Hospice Quality Reporting Program and claims to Medicare contractors (regional home health intermediaries (RHHIs) and A/B Medicare administrative contractors (MACs)) for services to Medicare beneficiaries.

Provider Action Needed
STOP – Impact to You
The Affordable Care Act, Section 3004, requires each hospice to collect data on quality measures specified by the Secretary, Department of Health and Human Services (DHHS), and submit the data timely, beginning in January 2013, to CMS.

CAUTION – What You Need to Know
This article informs hospices about:

- What they should be doing now with regard to data submission of the National Quality Forum (NQF) #0209 measure that is due on April 1, 2013, for the Fiscal Year (FY) 2014 Annual Payment Update (APU) determination;

- What they should be doing with regard to data collection for the second year of reporting (FY 2015 APU determination); and

- Where to get resources on the CMS HQRP webpage to help them with the above activities.

GO – What You Need to Do
Make sure that your staff is aware of these data collection and reporting requirements.
Background

Requirements for the First Year of Reporting
For the first year of reporting (affecting the FY 2014 payment determination), hospices will submit two measures:

- The Structural/Quality Assurance and Performance Improvement (QAPI) measure; and
- The NQF #0209 measure.

The data collection period was October 1, 2012, through December 31, 2012.

Note: To avoid a reduction in your APU, the structural measure must have been reported by January 31, 2013, and the NQF #0209 measure by April 1, 2013.

Requirements for the Second Year of Reporting
For the second year of reporting (affecting APU determination for FY 2015), hospices will:

- Collect data on these measures from January 1, 2013, through December 31, 2013, for the FY 2015 payment determination; and
- Submit data for both measures by April 1, 2014.

The Hospice Wage Index Final Rule, published in the Federal Register in August 2011, finalized that after the first year of reporting, all subsequent years of reporting would be based on a calendar year. Therefore, the data collection cycle is for duration of 12 months.

The Home Health Final Rule (November 2012) finalized that, for the second year of reporting (affecting the FY 2015 payment determination), the data submission periods for the two measures are consolidated (both measures will be submitted by April 1, 2014).

Key Points to Remember
You should now prepare for the second year of required reporting by:

- Collecting data for the Structural/QAPI measure and the NQF #0209 measure, as of January 1, 2013; and
- Preparing to submit the data on these measures by April 1, 2014, for the APU, FY 2015 determination.

For FY 2014, and each subsequent year, failure to submit required quality data will result in a 2 percentage point reduction to the market basket update for that fiscal year.

The following chart summarizes the dates you need to remember:

<table>
<thead>
<tr>
<th></th>
<th>Data Collection Period</th>
<th>Submission Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2 Reporting</td>
<td>Jan. 1, 2013 - Dec. 31, 2013</td>
<td>April 1, 2014, both Measures</td>
</tr>
</tbody>
</table>

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.
Note from CGS: For additional information, the “Hospice Quality Reporting Fact Sheet” can be viewed at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/HospiceQRFactSheet.zip on the CMS website.


The Home Health Final Rule, published in November 2012, which contains information on the hospice quality reporting requirements for CY 2013, is available at https://federalregister.gov/a/2012-26904 on the Internet.


This article contains updated information from MLN Matters® Special Edition Article #SE1301, titled “Hospice Quality Data Reporting Reminders,” which was published on January 17, 2013, and is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1301.pdf on the CMS website.

### HOME HEALTH PROVIDERS

**For Home Health Providers**

**ATTENTION Home Health Providers: New Ordering/Referring Edits Will Deny Medicare Payment**

Home health billing transactions for services provided on or after May 1, 2013, that fail the ordering/referring physician edits will be **fully denied and no Medicare payment** will be made to the billing home health agency.

Billing transactions and adjustments will deny when the “FROM” date is on or after May 1, 2013, AND:

- The attending physician National Provider Identifier (NPI) on the claim **is not found** in the eligible attending physician file from PECOS; or
- The attending physician NPI on the claim **is found** in the eligible attending physician file from PECOS but the name on the claim does not match the name in the PECOS file; or
- The specialty code is not a valid eligible code. (Additional information below.)

The Fiscal Intermediary Standard System (FISS) will verify that the attending physician is on the national PECOS file and is a type/specialty that is eligible to order and refer. If a match is found, FISS will compare the NPI, first letter of the first name, and the first four letters of the last name. **The attending physician name submitted on the billing transaction must exactly match the name in the PECOS file.**

If the attending physician name submitted on the Request for Anticipated Payment (RAP) does not exactly match the name in the PECOS file, no RAP payment will be made.

**Specialty Codes**

When the attending physician’s NPI and name edit against the PECOS file, the Fiscal Intermediary Standard System (FISS) applies the physician’s specialty code in the SC field on FISS Claim Page 03 (example below).

- If the attending NPI on the claim in not present in the PECOS record, FISS will place a ‘99’ in the ‘SC’ field.
- If the attending NPI on the claim is present in the PECOS record, but the name on the claim does not match the name in the PECOS record, the ‘SC’ field will be left blank.
- If the attending NPI on the claim is present in the physician/non-physician file and the name on the claim matches the name in the PECOS record, the specialty code of the first matching record will be placed in the ‘SC’ field.

**Medicare Ordering and Referring File**

It is extremely important for providers to check the “Medicare Ordering and Referring File” to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records, and are of a type/specialty that is eligible to order or refer in the Medicare program. The “Medicare Ordering and Referring File” is replaced weekly to ensure it is current. This file is available at [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html) on the Centers for Medicare & Medicaid Services (CMS) website, and under the “Quick Links” on the CGS Home Health & Hospice webpage at [https://www.cgsmedicare.com/hhh/index.html](https://www.cgsmedicare.com/hhh/index.html).

**Analysis of N272 Remark Code**

Phase I of the ordering/referring edits displayed Remark code N272 in the **REM** field of the remittance advice (RA) as an alert that the identification of the ordering/referring physician was missing, incomplete, or invalid, or that the ordering/referring physician was not eligible to order or refer.

Analysis of claims receiving Remark code N272 from September 2012 through February 2013, show approximately 4% of the billing transactions submitted to CGS would have been fully denied if the ordering/referring edits were in effect. Approximately 3 out of every 4 home health agencies (HHAs) had at least one claim, which would have been denied.

Based on data analysis, the following common errors were found.

- An incorrect ordering/referring physician name was entered for the NPI submitted.  
  **Example:** NPI 1234567890 was entered on the claim along with the name “Mark Smith”. NPI 1234567890 belongs to “Robert-Mark Smith” not “Mark Smith”.

- Spaces were submitted for the physician’s name, but were not present in the PECOS file.  
  **Example:** the HHA entered the physician’s last name as “Van Nostrand”; however, it appears as “VanNostrand” in the PECOS file.

**Note:** To avoid being denied Medicare payment, it is important for you to check the “Medicare Ordering and Referring File” (mentioned above) to ensure the information submitted, exactly matches the information in PECOS. Do not use nicknames, or enter credentials (e.g., “Dr.”) or suffixes (e.g., Jr., M.D.). FISS will compare the NPI, first letter of the first name, and the first four letters of the last name.

If you use a billing software to submit billing transactions to CGS, we suggest contacting your vendor or clearinghouse to make them aware of these edits.

Lastly, because billing transaction are denied when they fail the ordering/referring physician edits, you are unable to submit an adjustment, or resubmit the billing transaction to correct the error. In order to receive Medicare payment for a denied claim, **you must file an appeal** through the usual Medicare Appeals process and provide a corrected NPI and attending physician name. Refer to the Appeals Overview webpage at [https://www.cgsmedicare.com/hhh/appeals/overview.html](https://www.cgsmedicare.com/hhh/appeals/overview.html) for information about submitting a Redetermination.
For Home Health Providers

**Manual Medical Review of Outpatient Therapy Claims Beginning April 1, 2013**

On January 2, 2013, President Barack Obama signed the American Taxpayer Relief Act of 2012. Section 603 of this Act, contains a number of Medicare provisions which directly impacts claims submitted for outpatient therapy services. Revisions of the Financial Limitation for Outpatient Therapy Services – Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 requires Original Medicare to temporarily apply therapy caps (and related provisions) to therapy services furnished in outpatient hospital settings between the dates of January 1 through December 31, 2013.

**What You Need to Know**

Effective April 1, 2013, Recovery Auditors began the process of reviewing all therapy claims, which have exceeded the $3,700 threshold cap for the year. Importantly, there are two separate thresholds triggering manual medical reviews (MMRs) and build upon the separate therapy caps as follows: one for occupational therapy (OT) services, and; one for physical therapy (PT) and speech language pathology (SLP) services combined. Although PT and SLP services are combined for triggering the threshold, the medical review will be conducted separately by discipline. Additional conditions include the requirement that all suppliers and providers who report on the beneficiary’s claims for therapy services provide the National Provider Identifier (NPI) of the physician (or non-physician practitioner where applicable) who is responsible for reviewing the therapy plan of care.

Recovery Auditors will complete two types of review:

- **Prepayment Review:**
  - Eleven states will be participating in the Recovery Audit Prepayment Review Demonstration. All therapy claims that have exceeded the $3,700 therapy cap threshold for the year will be reviewed and compared to the medical record before the claim is processed for payment. The demonstration will occur in the following 11 states (FL, CA, MI, TX, NY, LA, IL, PA, OH, NC, and MO).

  - If the Recovery Auditors determine an improper claim has been submitted, a review results letter will be sent to the provider, which clearly documents the rationale for the determination. The letter provides vital information to the provider regarding the Recovery Auditor’s findings and detailed description of the Medicare policy or rule that was violated.

  - Typical Additional Documentation Requests (ADR) limits will not apply. All therapy claims at or above the $3,700 threshold cap will trigger the MMR process and will need to be reviewed by the Recovery Auditors.

  - The Recovery Auditors will conduct prepayment review within 10 business days of receiving the medical record.

  - The ADR will be sent to the provider by the Medicare Administrative Contractor (MAC) with instructions to send the records to the Recovery Auditor.

- **Post Payment Review:**
  - In the remaining states, the Recovery Auditors shall conduct immediate post-pay reviews.

  - All therapy claims that have exceeded the $3,700 therapy cap threshold for the year will be reviewed and compared to the medical record after the claim has been processed for payment.

  - If the Recovery Auditors determine an improper payment has resulted, a demand letter will be sent to the provider, which clearly documents the rationale for the determination. The letter provides vital information to the provider regarding the Recovery Auditors findings and detailed description of the Medicare policy or rule that was violated.
Typical ADR limits will not apply. All therapy claims at or above the $3,700 threshold cap will trigger the manual medical review process and will need to be reviewed by the Recovery Auditors.

The ADR will be sent to the provider immediately after the claim is paid. The ADR will be sent by the MAC to the provider with instructions to send the records to the Recovery Auditor.

The threshold cap will accrue for claims with dates of service from January 1 through December 31, 2013. The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Private Practices
- Part B Skilled Nursing Facilities
- **Home Health Agencies (TOB 34X)**
- Outpatient Rehabilitation Facilities (ORFs)
- Rehabilitation Agencies (Comprehensive Outpatient Rehabilitation Facilities)
- Outpatient Hospitals

**Note from CGS:** Providers may also refer to the Medicare Learning Network (MLN) booklet, “Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program” at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf) for information about the different Centers for Medicare & Medicaid Services (CMS) claim review programs. Please note that the therapy caps do not apply to therapy services paid under the Home Health Prospective Payment System (HHPPS) and submitted on a 32X or 33X type of bill. Instead, only therapy services billed on a 34X type of bill are impacted by the outpatient therapy caps.

**Questions**
Additional guidance on the MMR process for therapy claims above the $3,700 threshold, as well as helpful medical review guidelines can be found on the Therapy Cap webpage at [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/TherapyCap.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/TherapyCap.html) on the Centers for Medicare & Medicaid Services (CMS) website. For all additional questions, please contact the appropriate Recovery Audit Contractor (RAC) in your region at their toll-free number, which may be found on the Provider Compliance Group Interactive Map at: [http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Provider-Compliance-Interactive-Map/index.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Provider-Compliance-Interactive-Map/index.html) or 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**

**MM7704 (Revised)—International Classification of Diseases - 10th Edition (ICD-10), Inclusion of Type of Bill 33X**


**MLN Matters® Number:** MM7704 Revised  
**Related Change Request (CR) #:** 7704  
**Related CR Release Date:** February 3, 2012  
**Effective Date:** October 1, 2013  
**Related CR Transmittal #:** R1039OTN  
**Implementation Date:** July 2, 2012

**Note** This article was revised on March 22, 2013, to add a reference to article SE1239 at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf) on the CMS website. SE1239 announces the revised ICD-10 implementation date of October 1, 2014. All other information remains unchanged.
Note from CGS: Providers should be aware that although the ICD-10 implementation date within this revised article appears as October 1, 2013, the ICD-10 implementation date is October 1, 2014.

Provider Types Affected
This MLN Matters® article is intended for Home Health Agencies (HHAs) who submit claims to Medicare fiscal intermediaries (FIs), Medicare administrative contractors (MACs), or regional home health intermediaries (RHHIs) for services provided to Medicare beneficiaries.

Provider Action Needed
STOP — Impact to You
You must include International Classification of Diseases, 10th Edition (ICD-10) codes on 33x Type of Bills (TOB) that you submit with Dates of Service / Discharge on or after October 1, 2013, and ICD-9 codes on those that you submit with Dates of Service / Discharge before that date. Do not submit such bills with both types of codes included.

CAUTION — What You Need to Know
CR 7704, from which this article is taken, provides guidance on reporting claims submissions and date span requirements for 33X TOBs containing ICD-10 codes with dates of service on and after October 1, 2013.

GO — What You Need to Do
You should make sure that your billing staffs are aware of these 33X TOB coding requirements.

Background
On October 1, 2013, all Medicare claims submissions of diagnosis and hospital inpatient procedure coding will require a change from the ICD-9 to the 10th Edition (ICD-10). All entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, necessitating systems changes throughout the entire health care industry.


CR 7492, however, did not include TOB 33X as a bill type for the requirements provided. CR 7704, from which this article is taken, adds TOB 33X to all requirements identified in CR 7492.

You should note that your FI, A/B MAC or RHHI will Return to Provider (RTP) 33X bill types they receive that include ICD-9 codes, and which have dates of service or dates of discharge / through dates on or after October 1, 2013. When they do RTP these claims, they will use the following message:

“For dates of service on or after October 1, 2013, claims may not contain ICD-9 codes. Please re-submit claim with the appropriate ICD-10 code”.

Further, they will RTP any 33X TOB with through dates prior to October 1, 2013, which are billed with ICD-10 diagnosis codes, using the following message:

“For dates of service prior to October 1, 2013, claims may not contain ICD-10 codes. Please re-submit claim with the appropriate ICD-9 code”.

Finally, they will RTP all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim; using the following message:

“Claims may not be submitted with both ICD-9 and ICD-10 diagnosis codes. Please correct. For dates of service prior to October 1, 2013, resubmit with the appropriate ICD-9 diagnosis code. For dates of service after October 1, 2013, resubmit with the appropriate ICD-10 diagnosis code”.
Note: Medicare will allow HHAs to use the payment group code derived from ICD-9 codes on claims, which span October 1, 2013, but will require those claims to be submitted using ICD-10 codes.

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.


For Home Health Providers

**MM8136 (Revised)—Data Reporting on Home Health Prospective Payment System (HH PPS) Claims**

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the MM8136 Medicare Learning Network® (MLN) Matters article “Data Reporting on Home Health Prospective Payment System (HH PPS) Claims,” which was first published in the March 2013 HH+H Medicare Bulletin. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals.html

MLN Matters® Number: MM8136 Revised  
Related Change Request (CR) #: CR 8136  
Related CR Release Date: April 2, 2013  
Effective Date: Home Health Episodes beginning on or after July 1, 2013  
Related CR Transmittal #: R2680CP  
Implementation Date: July 1, 2013

Note: This article was revised on April 3, 2013, to reflect the revised CR 8136 issued on April 2. The article was revised to delete references to a new modifier and to revise/add policy language regarding the use of the Q codes. Also, the transmittal number, CR release date, and the Web address for accessing the CR were revised. All other information remains the same.

Provider Types Affected  
This MLN Matters® article is intended for home health agencies (HHAs) that bill regional home health intermediaries (RHHIs) or Medicare administrative contractors (A/B MACs) for home health services provided to Medicare beneficiaries.

Provider Action Needed  
This article is based on CR 8136 which adds new data reporting requirements for Home Health Prospective Payment System (HH PPS) claims. HHAs must report new codes indicating the location of where services were provided and indicating whether services were added to the HH plan of care by a physician who did not certify the plan of care. Make sure that your billing staff are aware of these changes.
Background
Generally, Original Medicare makes payment under the HH PPS on the basis of a national standardized 60-day episode payment rate that is adjusted for the applicable case-mix and wage index. The national standardized 60-day episode rate pays for the delivery of home health services, which includes the six home health disciplines (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services). Claims must report all home health services provided to the beneficiary within the episode.

Healthcare Common Procedure Coding System (HCPCS) codes Q5001 through Q5009 currently describe where hospice services were provided (in the patient’s home, assisted living facility, etc). These codes have been reported on hospice claims since 2007.

Medicare is planning to capture data to show where home health services were provided by requiring HHAs to report the location on the claim.

Effective for HH episodes beginning on or after July 1, 2013, HHAs are to use the HCPCS codes Q5001, Q5002, and Q5009 on home health claims to report where home health services were provided. The following table lists the definitions of the Q codes Q5001, Q5002, and Q5009, which were revised effective April 1, 2013:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5001</td>
<td>Hospice or home health care provided in patient’s home/residence</td>
</tr>
<tr>
<td>Q5002</td>
<td>Hospice or home health care provided in assisted living facility</td>
</tr>
<tr>
<td>Q5009</td>
<td>Hospice or home health care provided in place not otherwise specified (NO)</td>
</tr>
</tbody>
</table>

The patient’s residence is wherever he or she makes his or her home. This may be his or her own dwelling, an apartment, a relative’s home, a home for the aged, or some other type of institution. Q code Q5002 should be used to indicate that home health services were provided at an assisted living facility (as defined by the state in which the beneficiary is located). Conversely, Q code Q5001 should be used to indicate that home health services provided at a patient’s residence except in the cases where the services are provided at an assisted living facility. Finally, Q code Q5009 may be reported in the rare instance an HHA believes the definitions of Q5001 and Q5002 do not accurately describe the location where services are provided.

The location where services were provided should be reported along with the first billable visit in a HH PPS episode. In addition to reporting a service line according to current instructions, HHAs must report an additional line item with the same revenue code and date of service, reporting one of the three Q codes (Q5001, Q5002, and Q5009), one unit, and a nominal charge (e.g., a penny).

CGS Screen print Example of FISS Claim Page 02

<table>
<thead>
<tr>
<th>CL</th>
<th>REV</th>
<th>HCPCS MODIFS</th>
<th>RATE</th>
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<th>UNIT</th>
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<td>0701YY</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the location where services were provided changes during the episode, the new location should be reported with an additional line corresponding to the first visit provided in the new location.
Note: Revisions to the definitions of the Q codes above (Q5001, Q5002, and Q5009) will be published in the HCPCS update on March 31, 2013.

Billing Information
Note the following billing requirements:

- HCPCS codes Q5001, Q5002, or Q5009 must be reported on HH PPS claims containing revenue code 042X, 043X, 044X, 055X, 056X, or 057X or the claim will be returned to the provider.

- The line item date of service of the line reporting Q5001, Q5002, or Q5009 must match the earliest dated HH visit line (revenue codes 042X, 043X, 044X, 055X, 056X, or 057X) on the claim or the claim will be returned to the provider.

- When more than one line on an HH PPS claim reports Q5001, Q5002, or Q5009, then the same HCPCS code must not be reported on consecutive dates or the claim will be returned to the provider.

- Claim lines reporting Q5001, Q5002, or Q5009 are not included in the visit counts passed to the HH Pricer, nor are they counted in medical policy parameters that count number of visits.

Additional Information
The official instruction, CR 8136 issued to your A/B MACs and RHHIs regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2680CP.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.
MM8246—Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

For Home Health Providers

The Centers for Medicare & Medicaid Services (CMS) has provided 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/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals.html

MLN Matters® Number: MM8246
Related Change Request (CR) #: CR 8246
Related CR Release Date: March 15, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2672CP
Implementation Date: July 1, 2013

Provider Types Affected
This MLN Matters® article is intended for providers and suppliers who submit claims to Medicare contractors (durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

What You Need to Know
This article is based on CR 8246 which provides the annual update to Home Health (HH) consolidated billing effective July 1, 2013. CR 8246 adds the following HCPCS codes to the HH consolidated billing therapy code list:

**G0456** (Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters) and **G0457** (Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 sq cm).

Background
The Social Security Act (Section 1842(b)(6); see http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the Internet) requires that payment for home health services provided under a home health plan of care is made to the home health agency (HHA). This requirement is found in Medicare regulations at 42 CFR 409.100 (see http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=e49c86165ce00a5c3e044053adf4c2d0&rgn=div5&view=text&node=42:2.0.1.2.9&dscno=42 on the Internet) and in the Medicare Claims Processing Manual (Chapter 10, Section 20; see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf on the CMS website).

CMS periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

Services appearing on this list (that are submitted on claims to Medicare contractors) will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA), with the exception of the following:

- Therapies performed by physicians;
- Supplies incidental to physician services; and
- Supplies used in institutional settings.

Medicare will only directly reimburse the primary HHAs that have opened such episodes during the episode periods.
The following are not subject to HH consolidated billing:

- Therapies performed by physicians,
- Supplies incidental to physician services, and
- Supplies used in institutional settings.

The HH consolidated billing code lists are updated annually to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., ‘K’ codes) throughout the calendar year.

These new codes were effective January 1, 2013, but were overlooked in the annual HH consolidated billing update published in CR 8043 (see the related article at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8043.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8043.pdf) on the CMS website).

The following HCPCS codes are added to the HH consolidated billing therapy code list effective for claims with dates of service on or after July 1, 2013:

- **G0456** - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters.

- **G0457** - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 sq cm.

**Note from CGS:** For a listing of revenue and HCPCS codes submitted on claims paid under the Home Health Prospective Payment System (HH PPS), please see the “Home Health Revenue Codes” listing on the CGS website at: [http://www.cgsmedicare.com/hhh/education/materials/HHE_Claim_Page_2.html#Revenue](http://www.cgsmedicare.com/hhh/education/materials/HHE_Claim_Page_2.html#Revenue)

**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.
For Home Health Providers

SE1305—Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)

The Centers for Medicare & Medicaid Services (CMS) has provided the following Special Edition (SE) 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/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals.html

MLN Matters® Number: SE1305
Related Change Request (CR) #: 6421, 6417, 6696, 6856
Related CR Release Date: N/A
Effective Date: May 1, 2013
Related CR Transmittal #: R642OTN, R643OTN, R328PI, and R7810TN
Implementation Date: May 1, 2013

Note: This Special Edition MLN Matters® article is a consolidation and update of prior articles SE1011, SE1201, SE1208, and SE1221. Effective May 1, 2013, CMS will turn on the Phase 2 denial edits. This means that Medicare will deny claims for services or supplies that require an ordering/referring provider to be identified and that provider is not identified, is not in Medicare’s enrollment records, or is not of a specialty type that may order/refer the service/item being billed.

Provider Types Affected
This MLN Matters® Special Edition Article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA), the Department of Defense (DoD), or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries,

- Part B providers and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare administrative contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and

- Part A home health agency (HHA) services who submit claims to regional home health intermediaries (RHHIs), fiscal intermediaries (FIs, who still maintain an HHA workload), and Part A/B MACs.

- Optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.

Provider Action Needed
If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) or by completing the paper enrollment application (CMS-855O). Review the background and additional information below and make sure that your billing staff is aware of these updates.

What Providers Need to Know
Phase 1: Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication. Phase 2: Effective May 1, 2013, CMS will turn on the edits to deny Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer.
All enrollment applications, including those submitted over the Internet, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application.

Waiting too long to begin this process could mean that your enrollment application may not be processed prior to the May 1, 2013, implementation date of the ordering/referring Phase 2 provider edits.

**Background**

The Affordable Care Act, Section 6405, “Physicians Who Order Items or Services are Required to be Medicare Enrolled Physicians or Eligible Professionals,” requires physicians or other eligible professionals to be enrolled in the Medicare Program to order or refer items or services for Medicare beneficiaries. Some physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program. Also, effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the National Provider Identifier (NPI). CMS has implemented edits on ordering and referring providers when they are required to be identified in Part B, DME, and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

Below are examples of some of these types of claims:

- Claims from laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures; and
- Claims from suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for ordered DMEPOS.

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

- Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.);
- Physician Assistants;
- Clinical Nurse Specialists;
- Nurse Practitioners;
- Clinical Psychologists;
- Interns, Residents, and Fellows;
- Certified Nurse Midwives; and
- Clinical Social Workers.

CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.
CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.

- HHA services may only be ordered or referred by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Doctor of Podiatric Medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.

- Optometrists may only order and refer DMEPOS products/services, and laboratory and X-Ray services payable under Medicare Part B.

Questions and Answers Relating to the Edits

1. **What are the ordering and referring edits?**

The edits will determine if the Ordering/Referring Provider (when required to be identified in Part B, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and contains a valid National Provider Identifier (NPI) (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. **Why did Medicare implement these edits?**

These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. **How and when will these edits be implemented?**

These edits were implemented in two phases:

**Phase 1 - Informational messaging:** Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication. The informational messages used are identified below:

For Part B providers and suppliers who submit claims to carriers:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N264</td>
<td>Missing/incomplete/invalid ordering provider name</td>
</tr>
<tr>
<td>N265</td>
<td>Missing/incomplete/invalid ordering provider primary identifier</td>
</tr>
</tbody>
</table>

For adjusted claims, the Claims Adjustment Reason Code (CARC) code 16 (Claim/service lacks information which is needed for adjudication.) is used.

DME suppliers who submit claims to carriers (applicable to 5010 edits):

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N544</td>
<td>Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future</td>
</tr>
</tbody>
</table>

For Part A HHA providers who order and refer, the claims system initially processed the claim and added the following remark message:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N272</td>
<td>Missing/incomplete/invalid other payer attending provider identifier</td>
</tr>
</tbody>
</table>

For adjusted claims the CARC code 16 and/or the RARC code N272 was used.
CMS has taken actions to reduce the number of informational messages.
In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.1

On January 28, 2010, CMS made available to the public, via the Downloads section of the “Ordering Referring Report” page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the Report on a weekly basis. At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report and to download it, go to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html; click on “Ordering & Referring Information” (on the left). Information about the Report will be displayed.

Phase 2: Effective May 1, 2013, CMS will turn on the Phase 2 edits. In Phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral. Below are the denial edits for Part B providers and suppliers who submit claims to carriers and/or MACs, including DME MACs:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>254D</td>
<td>Referring/Ordering Provider Not Allowed To Refer</td>
</tr>
<tr>
<td>255D</td>
<td>Referring/Ordering Provider Mismatch</td>
</tr>
<tr>
<td>289D</td>
<td>Referring/Ordering Provider NPI Required</td>
</tr>
</tbody>
</table>

CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims.

Below are the denial edits for Part A HHA providers who submit claims:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>37236</td>
<td>This reason code will assign when:</td>
</tr>
<tr>
<td></td>
<td>• The statement “From” date on the claim is on or after the date the phase 2 edits are turned on</td>
</tr>
<tr>
<td></td>
<td>• The type of bill is ‘32’ or ‘33’</td>
</tr>
<tr>
<td></td>
<td>• Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code</td>
</tr>
<tr>
<td>37237</td>
<td>This reason code will assign when:</td>
</tr>
<tr>
<td></td>
<td>• The statement “From” date on the claim is on or after the date the phase 2 edits are turned on</td>
</tr>
<tr>
<td></td>
<td>• The type of bill is ‘32’ or ‘33’</td>
</tr>
<tr>
<td></td>
<td>• The type of bill frequency code is ‘7’ or ‘F-P’</td>
</tr>
<tr>
<td></td>
<td>• Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code</td>
</tr>
</tbody>
</table>
Effect of Edits on Providers

I order and refer. How will I know if I need to take any sort of action with respect to these two edits?
In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, you, the ordering/referring provider, need to ensure that:

a. You have a current Medicare enrollment record.

   • If you are not sure you are enrolled in Medicare, you may:
     i. Check the Ordering Referring Report and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI;
     ii. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or
     iii. Use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare).
     iv. If you choose iii, please read the information on the Medicare provider/supplier enrollment webpage about Internet-based PECOS before you begin.

b. If you do not have an enrollment record in Medicare.

   • You need to submit either an electronic application through the use of internet-based PECOS or a paper enrollment application to Medicare.
     i. For paper applications - fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor.
     ii. For electronic applications – complete the online submittal process and either e-sign or mail a printed, signed, and dated Certification Statement and digitally submit any required supporting paper documentation to your designated Medicare enrollment contractor.
     iii. In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement.
     iv. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment webpage to learn more about the web-based system before you attempt to use it. Go to [link], click on “Internet-based PECOS” on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that webpage.
     v. If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via internet-based PECOS or .pdf for downloading from the CMS forms page [link].

c. You are an opt-out physician and would like to order and refer services. What should you do?

   If you are a physician who has opted out of Medicare, you may order items or services for Medicare beneficiaries by submitting an opt-out affidavit to a Medicare contractor within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit).

d. You are of a type/specialty that can order or refer items or services for Medicare beneficiaries.

   When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty (Chiropractors are excluded) and only the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.
e. I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the Ordering/Referring Provider edits?

- You need to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the Ordering Referring Report described earlier in this article.

- Ensure you are correctly spelling the Ordering/Referring Provider’s name.

- If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the Ordering/Referring Provider edits.

- The Ordering Referring Report will be replaced weekly to ensure it is current. It is possible that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next Report.

f. Make sure your claims are properly completed.

- Do not use “nicknames” on the claim, as their use could cause the claim to fail the edits.

- Do not enter a credential (e.g., “Dr.”) in a name field.

- On paper claims (CMS-1500), in item 17, you should enter the Ordering/Referring Provider’s first name first, and last name second (e.g., John Smith).

- Ensure that the name and the NPI you enter for the Ordering/Referring Provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral.

- Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer.

If there are additional questions about the informational messages, billing providers should contact their local carrier, A/B MAC, or DME MAC.

Billing providers should be aware that claims that are denied because they failed the Ordering/Referring Provider would not expose the Medicare beneficiary to liability. Therefore, an Advance Beneficiary Notice is not appropriate.

g. What if my claim is denied inappropriately?

If your claim did not initially pass the Ordering/Referring provider edits, you may file an appeal through the standard claims appeals process.

Additional Guidance

1. Terminology: Part B claims use the term “ordering/referring provider” to denote the person who ordered, referred, or certified an item or service reported in that claim. The final rule uses technically correct terms: 1) a provider “orders” non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider “certifies” home health services to a beneficiary. The terms “ordered” “referred” and “certified” are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term “ordered/referred” in materials directed to a broad provider audience.
2. **Orders or referrals by interns or residents**: The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that State-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from unlicensed interns and residents must still specify the name and NPI of the teaching physician. However, if states provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with State law.

3. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense (DoD)/Tricare**: These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

4. **Orders or referrals by dentists**: Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

**Additional Information**

For more information about the Medicare enrollment process, visit [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html) or contact the designated Medicare contractor for your state. Medicare provider enrollment contact information for each state can be found at [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.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.

Note from CGS: Please also see the article, “ATTENTION Home Health Providers: New Ordering/Referring Edits Will Deny Medicare Payment” included in this Medicare HH+H Bulletin.

HOME HEALTH & HOSPICE PROVIDERS

For Home Health and Hospice Providers

CGS Website Updates

CGS has recently made updates to their website, giving providers additional resources to provide and bill Medicare-covered services appropriately.

Please review the following updates:

- **Sequestration Qs & As**—The Centers for Medicare & Medicaid Services (CMS) provided questions and answers related to the mandatory 2% payment reduction for Medicare Fee-for-Service (FFS) claims. CGS has made those Q&As available on the “Frequently Asked Questions (FAQs)” webpage at https://www.cmsmedicare.com/hhh/education/faqs/index.html. Simply scroll down and click on “Sequestration”.

- **Provider Enrollment Frequently Asked Questions (FAQs)**—See the answer to question #17 at https://www.cmsmedicare.com/hhh/education/faqs/PE_FAQs.html for information about how to terminate your Medicare provider number.

- **Hot Topics**—CGS has added a “Hot Topics” listing on the Home Health & Hospice home page at https://www.cmsmedicare.com/hhh/index.html, directing under the Quick Links. Topics that are important to home health and hospice providers will be added in this area, allowing you a quick look and access to the hot topics. Current issues include the following:
  - Hospice phone number will be discontinued - https://www.cmsmedicare.com/hhh/pubs/news/2013/0313/cope21659.html


- **Home Health & Hospice Contact Information**—Instead of having two separate webpages for telephone numbers and addresses, all contact information has been combined into one page, the “Home Health & Hospice Contact Information” webpage at https://www.cmsmedicare.com/hhh/help/telephone_numbers.html. Access this page by selecting “Contact Information”, which is available from the “Customer Service” tab.

- **IVR Beneficiary Name to Number Converter**—CGS has added a new tool that will assist your staff when using the CGS interactive voice response (IVR) system. To access claim or beneficiary information from the IVR, it requires that you enter the beneficiary’s first initial of their first name, and the first six letters of their last name.
This tool will quickly convert the patient’s name to the corresponding numbers on your telephone keypad. To access, look for the “IVR Beneficiary Name to Number Converter” link on the “Home Health & Hospice Contact Information” webpage at https://www.cgsmedicare.com/hhh/help/telephone_numbers.html, or for easy and quick access, bookmark the webpage at https://www.cgsmedicare.com/medicare_dynamic/J15/converter.asp.

- Chapter One: FISS Overview of the FISS Guide at https://www.cgsmedicare.com/hhh/education/materials/pdf/Chapter%201-FISS_Overview.pdf was revised to update the telephone number used to contact the Electronic Data Interchange (EDI) department. Additional revisions were made to enhance the information about the FISS menu options.

- Recovery Audit Program—The “Recovery Audit Program” webpage at https://www.cgsmedicare.com/hhh/medreview/recovery_audit_program.html provides an overview of the Recovery Audit program and identifies the four recovery auditor jurisdictions and corresponding states. It also provides a link to the “Program Comparison: Medical Review, CERT and Recovery Audit” webpage at https://www.cgsmedicare.com/hhh/medreview/program_comparison.html that summarized the similarities and differences between CGS’s Medical Review program, the Comprehensive Error Rate Testing (CERT) Program, and the Recovery Audit Program.

Make sure that your appropriate staffs are aware of this information.

In addition, tell us what you think! Please take a few moments to complete the website pop-up survey, and provide us your valuable feedback. 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 CGS website.

For Home Health and Hospice Providers

Change Request (CR) 8226—Implementation of the Award for Jurisdiction E Part A/Part B Medicare Administrative Contractor (JE A/B MAC)

The Centers for Medicare & Medicaid Services (CMS) has provided Change Request (CR) 8223 with the following information.

Effective Date: July 1, 2013
Implementation Date: July 1, 2013

1. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) has awarded the JE A/B MAC contract for the administration of the Part A and Part B Medicare fee-for-service claims in the states and territories of California, Hawaii, Nevada, American Samoa, Guam and the Northern Marianas to Noridian Administrative Services, LLC (NAS). NAS’ address is 900 42nd Street South Fargo, North Dakota 58103.

Palmetto Government Benefit Authorizers (PGBA) is the OGC for the current Jurisdiction1 (J1) A/B MAC workloads. (The A/B MAC was renamed for the current award.) Its address is 17 Technology Circle, Columbia, South Carolina 29203.

CMS has determined that the JE workloads currently processed by the J1 A/B MAC will require new workload numbers when they are transitioned. This change is being made because CMS needs to differentiate between the workload processed by the outgoing and the incoming A/B MAC. The workload numbers shall be changed and the workloads shall be transitioned to the JE A/B MAC as follows:

PART A
1. Part A California JE A/B MAC Workload Number- 01111; Effective Date - 08/26/2013; Current Workload Number - 01101; OGC- PGBA.
2. Part A Hawaii, American Somoa, Guam, and the Northern Marianas JE A/B MAC Workload Number - 01211; Effective Date - 08/26/2013; Current Workload Number- 01201; OGC- PGBA.

3. Part A Nevada JE A/B MAC Workload Number- 01311; Effective Date - 08/26/2013; Current Workload Number - 01301; OGC- PGBA.

4. Part A J1 WPS Legacy JE A/B MAC Workload Number - 01911; Effective Date - 08/26/2013; Current Workload Number - 01901; OGC- PGBA.

**PART B**

1. Part B Northern California JE A/B MAC Workload Number - 01112; Effective Date - 09/16/2013; Current Workload Number - 01102; OGC- PGBA.

2. Part B Southern California JE A/B MAC Workload Number - 01182; Effective Date - 09/16/2013; Current Workload Number - 01192; OGC- PGBA.

3. Part B Hawaii, American Somoa, Guam, and the Northern Marianas JE A/B MAC Workload Number - 01212; Effective Date - 09/16/2013; Current Workload Number- 01202; OGC- PGBA.

4. Part B Nevada JE MAC Workload Number - 01312; Effective Date - 09/16/2013; Current Workload Number- 01302; OGC- PGBA,

The following applications or business owners shall accept the new JE A/B workload number once the above cited workload is transitioned to the JE A/B MAC.

1. Administrative Qualified Independent Contractor (AdQIC);
2. CMS Analysis, Reporting and Tracking System (CMS ARTS);
3. Contractor Administrative, Budget and Cost Reporting System (CAFM);
4. Comprehensive Error Rate Testing System (CERT);
5. Contractor Management Information System (CMIS);
6. CMS Baltimore Data Center (BDC);
7. Coordination of Benefits Agreement program (COBA);
8. Coordination of Benefits Contractor (COBC);
9. Contractor Reporting of Operational Workload Data System (CROWD);
10. Common Working File (CWF);
11. CWF Part B Eligibility and Security Maintenance (CWF ELGE);
12. Customer Service Assessment and Management System (CSAMS);
13. Debt Collection System (DCS);
14. Electronic Correspondence Referral System (ECRS);
15. Electronic Health Records Incentive Program (EHR);
16. Electronic Prescription File (eRx);
17. Enterprise Data Centers (EDCs);
18. Expert Claims Processing System (ECPS);
19. Fiscal Intermediary Shared System (FISS);
20. Fraud Prevention System (FPS);
21. Health Care Information System (HCIS);
22. Health Care Integrated General Ledger Accounting System (HIGLAS);
23. Health Insurance Master Record (HIMR);
24. Integrated Data Repository (IDR);
25. Intern and Resident Information System (IRIS);
26. Local Coverage Determination Database (LCD);
27. Medicare Appeals System (MAS);
28. Medicare Coverage Data Base (MCD);

For Home Health and Hospice Providers

**MM7260 (Revised)—Modification to CWF, FISS, MCS and VMS to Return Submitted Information When There is a CWF Name and HIC Number Mismatch**

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the MM7260 Medicare Learning Network® (MLN) Matters article “Modification to CWF, FISS, MCS and VMS to Return Submitted Information When There is a CWF Name and HIC Number Mismatch,” which was first published in the June 2012 HH+H Medicare Bulletin. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals.html

**MLN Matters® Number:** MM7260
**Related Change Request (CR) #:** CR 7260
**Related CR Release Date:** March 14, 2013
**Effective Date:** October 1, 2012
**Related CR Transmittal #:** R2670CP
**Implementation Date:** April 1, 2013

**Note:** This article was revised on March 15, 2013, to reflect a revised Change Request (CR). The revised CR restores the Common Working File (CWF) entitlement validation criterion (in bold below) used prior to the implementation of CR 7260 (October 1, 2012). The implementation date for CR 7260 was changed to April 1, 2013. The Transmittal Number, CR release date, and web address of the CR also changed. All other information remains the same.
Provider Types Affected
This MLN Matters® article is intended all physicians, providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, A/B Medicare administrative contractors (MACs) and durable medical equipment MACs or DME MACs) for Medicare beneficiaries.

Provider Action Needed
If Medicare systems reject a claim when there is a mismatch of the Health Insurance Claim Number (HICN) with the beneficiary’s personal characteristics (such as name, sex or date of birth), your Medicare contractor will return the claim to you as unprocessable with the identifying beneficiary information from the submitted claim as follows:

- Your contractor will return to provider (RTP) Part A claims.
- Your contractor will return as unprocessable Part B claims. Your contractor will use Reason Code 140 (Patient/Insured health identification number and name do not match).

When returning these claims as unprocessable, your contractor will utilize remittance advice codes MA130 and MA61. Also, based on CR 7260, you will receive the beneficiary name information you originally submitted when the claim is returned rather than the beneficiary data associated with the potentially incorrectly entered HICN. Previously, Medicare returned the name of the beneficiary that is associated with that HICN within its files.

If an adjustment claim is received where the beneficiary’s name does not match the submitted HICN, your contractor will suspend the claim and, upon their review, either correct, develop, or delete the adjustment, as appropriate.

All providers should ensure that their billing staffs are aware of these changes.

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.

For Home Health and Hospice Providers
MM7492 (Revised)—Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10)

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the MM7704 Medicare Learning Network® (MLN) Matters article “Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10),” which was first published in the October 2011 HH+H Medicare Bulletin. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals.html

MLN Matters® Number: MM7492 Revised
Related Change Request (CR) #: 7492
Related CR Release Date: August 19, 2011
Effective Date: October 1, 2013
Related CR Transmittal #: R950OTN
Implementation Date: January 1, 2012

Note This article was revised on March 21, 2013, to add a reference to article SE1239 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf on the CMS website. SE1239 announces the revised ICD-10 implementation date of October 1, 2014. All other information remains unchanged.
Note from CGS: Providers should be aware that although the ICD-10 implementation date within this revised article appears as October 1, 2013, the ICD-10 implementation date is October 1, 2014.

Provider Types Affected
This article is for all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs) and/or Part A/B Medicare administrative contractors (MACs), regional home health intermediaries (RHHIs), 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, 2013, 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, 2013. Make sure your billing and coding staffs are aware of these changes.

Key Points of CR 7492

• **General Reporting of ICD-10**

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to [http://www.cms.gov/Medicare/Coding/ICD10/index.html](http://www.cms.gov/Medicare/Coding/ICD10/index.html) for more information on the format of ICD-10 codes. In addition, ICD-10 Procedure Codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

• **General Claims Submissions Information**

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2013. Institutional claims containing ICD-9 codes for services on or after October 1, 2013, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2013, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP/return as unprocessable all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2013, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2013, submit with the appropriate ICD-10 diagnosis code. For claims with dates of service on or after October 1, 2013, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2013. Institutional claims containing ICD-10 codes for services prior to October 1, 2013, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2013, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

• **Claims that Span the ICD-10 Implementation Date**

CMS has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2013, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2013, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2013. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.
### Table A – Institutional Providers

<table>
<thead>
<tr>
<th>Bill Type(s)</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>11X</td>
<td>Inpatient Hospitals (incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)</td>
<td>If the hospital claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>12X</td>
<td>Inpatient Part B Hospital Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>13X</td>
<td>Outpatient Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>14X</td>
<td>Non-patient Laboratory Services</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>18X</td>
<td>Swing Beds</td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>21X</td>
<td>Skilled Nursing (Inpatient Part A)</td>
<td>If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>22X</td>
<td>Skilled Nursing Facilities (Inpatient Part B)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>23X</td>
<td>Skilled Nursing Facilities (Outpatient)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>Bill Type(s)</td>
<td>Facility Type/Services</td>
<td>Claims Processing Requirement</td>
<td>Use FROM or THROUGH Date</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------------</td>
<td>------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>32X</td>
<td>Home Health (Inpatient Part B)</td>
<td>Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2013, but require those claims to be submitted using ICD-10 codes.</td>
<td>THROUGH</td>
</tr>
<tr>
<td>3X2</td>
<td>Home Health – Request for Anticipated Payment (RAPs)*</td>
<td>*NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2013.</td>
<td>*See Note</td>
</tr>
<tr>
<td>34X</td>
<td>Home Health – (Outpatient)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>71X</td>
<td>Rural Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>72X</td>
<td>End Stage Renal Disease (ESRD)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>73X</td>
<td>Federally Qualified Health Clinics (prior to 4/1/10)</td>
<td>N/A – Always ICD-9 code set.</td>
<td>N/A</td>
</tr>
<tr>
<td>74X</td>
<td>Outpatient Therapy</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>75X</td>
<td>Comprehensive Outpatient Rehab facilities</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>Bill Type(s)</td>
<td>Facility Type/Services</td>
<td>Claims Processing Requirement</td>
<td>Use FROM or THROUGH Date</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>76X</td>
<td>Community Mental Health Clinics</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>77X</td>
<td>Federally Qualified Health Clinics (effective 4/4/10)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>81X</td>
<td>Hospice - Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>82X</td>
<td>Hospice – Non hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>83X</td>
<td>Hospice – Hospital Based</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>85X</td>
<td>Critical Access Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.</td>
<td>FROM</td>
</tr>
</tbody>
</table>

**Table B - Special Outpatient Claims Processing Circumstances**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-day /1-day Payment Window</td>
<td>Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2013, the claim must be billed with ICD-10 for those bundled outpatient services.</td>
<td>THROUGH</td>
</tr>
</tbody>
</table>

**Table C – Professional Claims**

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>All anesthesia claims</td>
<td>Anesthesia procedures that begin on 9/30/13 but end on 10/1/13 are to be billed with ICD-9 diagnosis codes and use 9/30/13 as both the FROM and THROUGH date.</td>
<td>FROM</td>
</tr>
</tbody>
</table>
Table D – Supplier Claims

<table>
<thead>
<tr>
<th>Supplier Type</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH/TO Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMEPOS</td>
<td>Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/13 (i.e., the FROM date of service occurs prior to 10/1/13 and the TO date of service occurs after 10/1/13).</td>
<td>FROM</td>
</tr>
</tbody>
</table>

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.


**For Home Health and Hospice Providers**

**MM8121—Clarification of Detection of Duplicate Claims Section of the CMS Internet Only Manual**


**MLN Matters® Number:** MM8121  
**Related Change Request (CR) #:** CR 8121  
**Related CR Release Date:** March 29, 2013  
**Effective Date:** April 29, 2013  
**Related CR Transmittal #:** R2678CP  
**Implementation Date:** April 29, 2013

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

**Provider Action Needed**

STOP — Impact to You  
The purpose of this CR is for clarification only and does not constitute any change in Medicare policy. CMS is alerting providers to the update of the Medicare Internet Only Manual (IOM), Chapter 1, Section 120: “Detection of Duplicate Claims.”

CAUTION — What You Need to Know  
CR 8121, from which this article is taken, alerts providers that the claims processing systems contain edits which identify duplicate claims and suspect duplicate claims. All exact duplicate claims or claim lines are auto-
denied or rejected (absent appropriate modifiers). Suspect duplicate claims and claim lines are suspended and reviewed by the Medicare contractors to make a determination to pay or deny the claim or claim line.

**GO – What You Need to Do**

Please be aware that Medicare contractors examine and compare to the prior bill any bill that is identified as a suspect duplicate. If the services (revenue or HCPCS codes) on a claim duplicate the services for the other, contractors will check the diagnosis. If the diagnosis codes are duplicates, contractors will request an explanation before making payment. The official instruction for CR 8121 spells out what your Medicare contractor looks for when analyzing the history of paid and pending claims, duplicate claims and the criteria for detecting suspect duplicate claims.

**Background**

Some claims that appear to be duplicates are actually claims or claim lines that contain an item or service, or multiple instances of an item or service, for which Medicare payment may be made. Correct coding rules applicable to all billers of health care claims encourage the appropriate use of condition codes or modifiers to identify claims that may appear to be duplicates, but are in fact, not.

For example, there are some Healthcare Common Procedure Coding System (HCPCS) modifiers that are appropriate to be appended to some services and can indicate that a claim line is not a duplicate of a previous line on the claim. Level I modifiers would typically be used by a biller to indicate that a potential duplicate claim or claim line is not, in fact, a duplicate. Level II modifiers may also be used. The Level II modifiers “RT” and “LT,” for example, indicate that a service was performed on the right and left side of the body, respectively.

However, not every HCPCS code has an appropriate modifier to indicate that a claim line is not a duplicate. In that case, the claims and claim lines are reviewed by Medicare Contactors’ local software modules for a determination, or they suspend for contractor review.

**Key Points of CR 8121**

**Exact Duplicates**

**A. Submission of Institutional Claims**

Claims or claim lines that have been determined an exact duplicate are rejected and do not have appeal rights. An exact duplicate for institutional claims is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- Health Insurance Claim (HIC) number;
- Type of Bill;
- Provider Identification Number;
- From Date of Service;
- Through Date of Service;
- Total Charges (on the line or on the bill); and
- HCPCS, CPT-4, or Procedure Code modifiers.

Whenever any of the following claim situations occur, your Medicare contractor develops procedures to prevent duplicate payment of claims. This includes, but is not limited to:

- Outpatient payment is claimed where the date of service is totally within inpatient dates of service at the same or another provider.
- Outpatient bill is submitted for services on the day of an inpatient admission or the day before the day of admission to the same hospital.
- Outpatient bill overlaps an inpatient admission period.
- Outpatient bill for services matches another outpatient bill with a service date for the same revenue code at the same provider or under a different provider number.
B. Claims Submitted by Physicians, Practitioners, and other Suppliers (except DMEPOS Suppliers)
Claims or claim lines that have been determined an exact duplicate are denied. Such denials may be appealed. An exact duplicate for physician and other supplier claims submitted to a MAC or carrier is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- HIC Number;
- Provider Number;
- From Date of Service;
- Through Date of Service;
- Type of Service;
- Procedure Code;
- Place of Service; and
- Billed Amount.

C. Claims Submitted by DMEPOS Suppliers
Claims or claim lines that have been determined an exact duplicate are denied. Such denials may not be appealed. An exact duplicate for DMEPOS supplier claims submitted to a DME MAC is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- HIC Number;
- From Date of Service;
- Through Date of Service;
- Place of service;
- HCPCS;
- Type of Service;
- Billed Amount; and
- Supplier.

Suspect Duplicates
Suspect duplicates are claims or claim lines that contain closely aligned elements and require that the claim be reviewed.

A. Criteria for Detecting Suspect Duplicates on Institutional Claims
A “suspect duplicate” claim is a claim being processed which, when compared to Medicare’s history or pending files, begins with these characteristics:

- Match on the beneficiary information;
- Match on provider identification; and
- Same date of service or overlapping dates of service.

B. Suspect Duplicate Claims Submitted by Physicians and other Suppliers (including DMEPOS Claims)
The criteria for identifying suspect duplicate claims submitted by physicians and other suppliers vary according to the type of billing entity, type of item or service being billed, and other relevant criteria. The denial of claim as a duplicate of another claim may be appealed when the denial is based on criteria other than those specified above for exact duplication.

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.
For Home Health and Hospice Providers

MM8169 (Revised)—April Update to the CY 2013 Medicare Physician Fee Schedule Database (MPFSDB)

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the MM8169 Medicare Learning Network (MLN) Matters article “April Update to the CY 2013 Medicare Physician Fee Schedule Database (MPFSDB),” which was first published in the April 2013 HH+H Medicare Bulletin. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals.html

MLN Matters® Number: MM8169 Revised  
Related Change Request (CR) #: CR 8169  
Related CR Release Date: March 26, 2013  
Effective Date: January 1, 2013  
Related CR Transmittal #: R2677CP  
Implementation Date: April 1, 2013

Note: This article was revised on March 26, 2013, to reflect a revised CR 8169 issued on March 26, 2013. In this article, the CR transmittal number, CR release date, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected
This MLN Matters® article is intended for physicians and other providers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FI), A/B Medicare administrative contractors (A/B MAC), and/or regional home health intermediaries (RHHI)) for services that are paid under the Medicare Physician Fee Schedule (MPFS).

What You Need To Know
This article is based on CR 8169 and instructs Medicare contractors to download and implement a new Medicare Physician Fee Schedule Data Base (MPFSDB), effective January 1, 2013.

Background
Section 1848 (c) (4) of the Social Security Act (see http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) authorizes the U.S. Secretary of Health and Human Services (HHS) to establish ancillary policies necessary to implement relative values for physicians’ services.

CR 8169, from which this article is taken announces that the Medicare Physician Fee Schedule Data Base (MPFSDB) has been updated effective January 1, 2013; and new payment files have been created in order to reflect appropriate payment policy in line with the CY 2013 Medicare Physician Fee Schedule (MPFS) Final Rule, published in the Federal Register on November 16, 2012, as modified by the Final Rule Correction Notice, published in the Federal Register on January 2, 2013, and relevant statutory changes applicable January 1, 2013.

The summary of changes in the April 2013 update consists of the following (all other indicators remain the same):

- 0309T Global Indicator is being corrected to “ZZZ” (add-on). This change is effective January 1, 2013.
- For 36222 – 36228, their Bilateral Indicators are being corrected to “1” = 150% payment adjustment applies if billed with modifier 50. This change is effective January 1, 2013.
- 90785 Global Indicator is being corrected to “ZZZ” (add-on). This change is effective January 1, 2013.
- The codes in the following table are having their short descriptors corrected or adjusted as shown below. These changes are effective January 1, 2013.
<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Old Short Description</th>
<th>Revised Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19301</td>
<td>Partial mastectomy</td>
<td>Partial mastectomy</td>
</tr>
<tr>
<td>31648</td>
<td>Bronchial valve addl insert</td>
<td>Bronchial valve remov init</td>
</tr>
<tr>
<td>31649</td>
<td>Bronchial valve remov init</td>
<td>Bronchial valve remov addl</td>
</tr>
<tr>
<td>31651</td>
<td>Bronchial valve remov addl</td>
<td>Bronchial valve addl insert</td>
</tr>
<tr>
<td>87631</td>
<td>Resp virus 3-11 targets</td>
<td>Resp virus 3-5 targets</td>
</tr>
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<td>95907</td>
<td>Motor&amp;sens 1-2 nrv cndj tst</td>
<td>Nrv cndj test 1-2 studies</td>
</tr>
<tr>
<td>95908</td>
<td>Motor&amp;sens 3-4 nrv cndj tst</td>
<td>Nrv cndj test 3-4 studies</td>
</tr>
<tr>
<td>95909</td>
<td>Motor&amp;sens 5-6 nrv cndj tst</td>
<td>Nrv cndj test 5-6 studies</td>
</tr>
<tr>
<td>95910</td>
<td>Motor&amp;sens 7-8 nrv cndj test</td>
<td>Nrv cndj test 7-8 studies</td>
</tr>
<tr>
<td>95911</td>
<td>Motor&amp;sen 9-10 nrv cndj test</td>
<td>Nrv cndj test 9-10 studies</td>
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<tr>
<td>95912</td>
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<td>Nrv cndj test 11-12 studies</td>
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<tr>
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<td>Motor&amp;sens 13/&gt; nrv cnd test</td>
<td>Nrv cndj test 13/&gt; studies</td>
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<td>Nrv cndj test 1-2 studies</td>
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<tr>
<td>95908-26</td>
<td>Motor&amp;sens 3-4 nrv cndj tst</td>
<td>Nrv cndj test 3-4 studies</td>
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<td>Nrv cndj test 5-6 studies</td>
</tr>
<tr>
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<td>Nrv cndj test 7-8 studies</td>
</tr>
<tr>
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<td>Motor&amp;sen 9-10 nrv cndj test</td>
<td>Nrv cndj test 9-10 studies</td>
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<td>Nrv cndj test 11-12 studies</td>
</tr>
<tr>
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<td>Motor&amp;sens 13/&gt; nrv cnd test</td>
<td>Nrv cndj test 13/&gt; studies</td>
</tr>
<tr>
<td>95907-TC</td>
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<tr>
<td>95908-TC</td>
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<td>Nrv cndj test 11-12 studies</td>
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<td>95913-TC</td>
<td>Motor&amp;sens 13/&gt; nrv cnd test</td>
<td>Nrv cndj test 13/&gt; studies</td>
</tr>
<tr>
<td>0195T</td>
<td>Arthrod presac interbody</td>
<td>Prescrl fuse w/o instr L5/S1</td>
</tr>
<tr>
<td>0196T</td>
<td>Arthrod presac interbody eac</td>
<td>Prescrl fuse w/o instr L4/L5</td>
</tr>
<tr>
<td>0206T</td>
<td>Pptr dbs alys car elec dta</td>
<td>Cptr dbs alys car elec dta</td>
</tr>
<tr>
<td>90700</td>
<td>Dtap vaccine &gt; 7 yrs im</td>
<td>Dtap vaccine &lt; 7 yrs im</td>
</tr>
<tr>
<td>90702</td>
<td>Dtap vaccine &gt; 7 yrs im</td>
<td>Dtap vaccine &lt; 7 yrs im</td>
</tr>
</tbody>
</table>

- G9157 will become an active code with a Procstat of “A” and a PC/TC indicator of “2” = Professional component only. Payment amounts are being included. All other indicators remain the same. This change is effective January 1, 2013.

- 33961 Global Indicator is being corrected to “XXX”. This change is effective January 1, 2013.

- The **TC components** of the following Nerve Conduction Test: 95907, 95908, 95909, 95910, 95911, 95912, and 95913, are having their Physician Supervision Of Diagnostic Procedures Indicators adjusted to “7A" = “Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may personally supervise another PT, but only the PT with ABPTS certification may bill.” (“77” = “Procedure must be performed by a PT with ABPTS certification (TC & PC) or by a PT without certification under general supervision of a physician (TC only; PC always physician)”). These changes are effective January 1, 2013.
- 81161 is being added to the fee schedule with a Procstat of “X” = Statutory exclusion. This change is effective January 1, 2013.

- Q0507, Q0508, Q0509 are being added to the fee schedule with Procstat indicators of “E” = Excluded from physician fee schedule by regulation. These codes are effective April 1, 2013.

- The Procstat indicator of 3750F, 4142F, 6150F, 3517F is changing to “M” effective April 1, 2013.

- The Procstat indicator of G8559, G8560, G8561, G8562, G8563, G8564, G8565, G8566, G8567, G8568, Q0505 is changing to “I” effective April 1, 2013.

- For 23000, 32997, 32998, their Bilateral Indicators are being corrected to “1” = 150% payment adjustment applies if billed with modifier 50. These changes are effective April 1, 2013.

**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.

**For Home Health and Hospice Providers**

**MM8242—April 2013 Integrated Outpatient Code Editor (I/OCE) Specifications Version 14.1**


**MLN Matters® Number:** MM8242  
**Related Change Request (CR) #:** CR 8242  
**Related CR Release Date:** March 8, 2013  
**Effective Date:** April 1, 2013  
**Related CR Transmittal #:** R2667CP  
**Implementation Date:** April 1, 2013

**Provider Types Affected**

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

**Provider Action Needed**

This article is based on CR 8242, which describes changes to the I/OCE and OPPS to be implemented in the April 2013 OPPS and Integrated Outpatient Code Editor (I/OCE) updates. Be sure your billing staff is aware of these changes.

**Background**

The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE, eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis. The full list of I/OCE specifications can now be found at [http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html](http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html) on the CMS website. There is a summary of the changes for April 2013 in Appendix M of Attachment A of CR 8242 and that summary is captured in the following key points.
Effective April 1, 2013, (except as noted below) Medicare will:

- Clarify the criteria for assignment of the electrophysiology/ablation composite Ambulatory Payment Classification (APC): If there is one or more codes from group C present with one or more codes from either group A or group B; assign the composite APC to the group C code and assign the standard APC and related SI to any separate group A or group B codes present. **Effective January 1, 2013.**

- Correct the logic to apply edit 84 to psychiatric add-on codes only on Partial Hospitalization Program (PHP) claims (Type of Bill (TOB) 13x w/CC41 or 76x): Ignore psychiatric add-on codes on non-PHP claims; do not apply edit 84; do not check for related primary codes. **Effective January 1, 2013.**

- Implement mid-quarter National Coverage Determination (NCD) non-coverage for code L0430. Edit 83 is affected. **Effective November 17, 2012.**

- Implement mid-quarter Food and Drug Administration (FDA) approval date for code 90661. Edit 67 is affected. **Effective November 20, 2012.**

- Make HCPCS/APC/Status Indicator (SI) changes as specified by CMS (data change files). **Effective January 1, 2013.**

- Implement version 19.1 of the National Correct Coding Initiative (NCCI) (as modified for applicable institutional providers). [All edits combined in a single file, in code1/code2 format; mutually exclusive pairs no longer differentiated]. Edits 20 and 40 are affected. **Effective January 1, 2013.**

- Update procedure/device & device/procedure edit requirements. Edits 71 and 77 are affected. **Effective January 1, 2013.**

- Delete all genetic testing modifiers from the valid modifier list, retroactive to January 1, 2013. Edit 22 is affected.

- Update the skin substitute list; delete C9367 retroactive to January 1, 2013.

- Correct table 4 to display the correct initial versions for deactivated edits 63 and 64 (v1.0 – v13.3).

- Update the skin substitute list to delete Q4129 and to add Q4127.

**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.
For Home Health and Hospice Providers

MM8247—July 2013 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

The Centers for Medicare & Medicaid Services (CMS) has provided 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/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals.html

MLN Matters® Number: MM8247
Related Change Request (CR) #: CR 8247
Related CR Release Date: March 15, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2676CP
Implementation Date: July 1, 2013

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

Provider Action Needed
STOP – Impact to You
Medicare will use the July 2013 quarterly Average Sales Price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 1, 2013, with dates of service July 1, 2013, through September 30, 2013.

CAUTION – What You Need to Know
Also, CR 8247, from which this article is taken, instructs your Medicare contractors to download and implement the July 2013 ASP Medicare Part B drug pricing file for Medicare Part B drugs and, if released by CMS, to also download and implement the revised April 2013, January 2013, October 2012, and July 2012 files.

GO – What You Need to Do
Make sure that your billing staffs are aware of the release of these July 2013 ASP Medicare Part B drug files.

Background
The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the Medicare Claims Processing Manual (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf on the CMS website.

The following table shows how the quarterly payment files will be applied:

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective for Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2013 ASP and ASP NOC</td>
<td>July 1, 2013, through September 30, 2013</td>
</tr>
<tr>
<td>April 2013 ASP and ASP NOC</td>
<td>April 1, 2013, through June 30, 2013</td>
</tr>
<tr>
<td>January 2013 ASP and ASP NOC</td>
<td>January 1, 2013, through March 31, 2013</td>
</tr>
<tr>
<td>October 2012 ASP and ASP NOC</td>
<td>October 1, 2012, through December 31, 2012</td>
</tr>
</tbody>
</table>
**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.

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**MM8265—Claim Status Category and Claim Status Codes Update**


**MLN Matters® Number:** MM8265  
**Related Change Request (CR) #:** CR 8265  
**Related CR Release Date:** April 5, 2013  
**Effective Date:** July 1, 2013  
**Related CR Transmittal #:** R2681CP  
**Implementation Date:** July 1, 2013

**Provider Types Affected**

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

**What You Need to Know**

CR 8265, from which this article is taken, requires Medicare contractors to use only national Code Maintenance Committee-approved Claim Status Category Codes and Claim Status Codes when sending Medicare healthcare status responses (277 transactions) to report the status of your submitted claim(s). **Proprietary codes may not be used in the X12 276/277 to report claim status.**

All code changes approved during the January 2013 Committee meeting will be posted on or about March 1, 2013, at [http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes](http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes) and [http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes](http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes) and are to be reflected in the X12 277 transactions issued on and after the date of implementation of CR 8265 (July 1, 2013).

**Background**

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national Code Maintenance Committee-approved Claim Status Category Codes and Claim Status Codes to explain the status of submitted claims. These codes, which have been adopted as the national standard to explain the status of submitted claim(s), are the only such codes permitted for use in the X12 276/277 Health Care Claim Status Request and Response format.

The national Code Maintenance Committee meets three times each year (February, June, and October) in conjunction with the Accredited Standards Committee (ASC) X12 trimester meeting, and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of the newly added or changed codes. Therefore, on and after the date of implementation of CR 8265 (July 1, 2013), your Medicare contractor must: 1) Complete the entry of all applicable code text changes and new codes; 2) Terminate the use of deactivated codes; 3) Use these new codes for editing all X12 276 transactions and reflect them in the X12 277 transactions that they issue.
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.

For Home Health and Hospice Providers
News Flash Messages from the Centers for Medicare & Medicaid Services (CMS)

- Medicare Learning Network® (MLN)

- Effective May 1, 2013, CMS will instruct contractors to turn on Phase 2 denial edits on the following claims to check for a valid individual National Provider Identifier (NPI) and to deny the claim when this information is missing:
  - Medicare Part B laboratory and imaging claims and Durable Medical Equipment, Orthotics, and Supplies (DMEPOS) claims that require an ordering or referring physician/non-physician provider; and
  - Part A Home Health Agency (HHA) claims that require an attending physician provider.


- Flu Activity Continues: Prompt Antiviral Treatment is Crucial for Seniors Sick with Flu
  This season, flu activity started early and has placed a significant burden on people 65 years of age and older. In fact, so far this season, CDC has reported nearly four times more hospitalizations among people 65 and older than occurred during the entire 2011-2012 season. The CDC recommends that vaccination efforts continue as long as influenza viruses are circulating. People 65 years of age and older, as well as their close contacts and caregivers, should be vaccinated; and should seek medical treatment with antiviral drugs as soon as symptoms appear in order to reduce serious complications from flu infection, including hospitalizations, intensive care unit (ICU) admissions and deaths.

Note: Influenza vaccine and its administration is a Medicare Part B covered benefit. Influenza vaccines are NOT Part D-covered drugs.

For More Information:
- 2012-2013 Seasonal Influenza Vaccines Pricing list (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html).
• HealthMap Vaccine Finder (http://flushot.healthmap.org/) is a free, online service where users can find locations offering flu vaccines as well as other vaccines for adults.

• CDC website (http://www.cdc.gov/flu/professionals/index.htm) offers a variety of provider resources for the 2012-2013 flu season.

• CDC article Seniors among Groups Hardest Hit by Flu this Season (http://www.cdc.gov/flu/pdf/matte/seniors-flu-advice.pdf).

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 is the date and time the home health and hospice PCC (1-877-299-4500) will be closed for training.

<table>
<thead>
<tr>
<th>CSR Training Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday, May 14, 2013</td>
<td>8:00 a.m. – 10:00 a.m. (Central Time)</td>
</tr>
</tbody>
</table>

The Interactive Voice Response (IVR) (877-220-6289) is available for assistance in obtaining patient eligibility information, claim and deductible information, and general information. For information about the IVR, access the IVR User Guide at http://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf on the CGS website. In addition, CGS’ Internet portal, myCGS, is offered 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 webpage.

For Home Health and Hospice Providers

System Availability During the Memorial Day Holiday

While we celebrate the Memorial Day holiday with our families, our offices will be closed on Monday, May 27, 2013. Our data center has informed us that the Fiscal Intermediary Standard System (FISS) and access to the ELGA and ELGH eligibility screens will not be available on May 27. In addition, the system will not cycle that night, which means that claims will not be sent to the Common Working File (CWF) on May 27, 2013. Medicare Remittance Advices, Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfers (EFTs) will not be produced Monday night.
CGS HOME HEALTH AND HOSPICE LEARNING CORNER

May 2013 Webinar Schedule

There are no CGS webinars scheduled for May 2013. However, please visit the “Calendar of Educational Events” webpage at https://www.cgsmedicare.com/hhh/education/webinars.html often for future educational events.

Replay Past Webinars

Home health and hospice provider staff who are unable to attend CGS live webinars can now register to replay the live presentation at your convenience. To access, go to the Home Health & Hospice Education webpage at https://www.cgsmedicare.com/hhh/education/Education.html and refer to the list of events under the “Replay Past Webinars and Teleconferences” heading.
Join the CGS ListServ

By joining the CGS electronic mailing list, you can get immediate updates on Medicare information, including:

- Medicare publications
- Important updates
- Workshops
- Medical Review information

To join the ListServ follow this link: https://www.cgsmedicare.com/medicare_dynamic/ls/001.asp