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Home Health and Hospice Medicare Bulletin

August 2013

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**HOME HEALTH PROVIDERS**

*For Home Health Providers*

**CMS Proposes Payment Changes for Medicare Home Health Agencies for 2014**

On June 27, the Centers for Medicare & Medicaid Services (CMS) announced proposed changes to the Medicare home health prospective payment system (HH PPS) for CY 2014 that would foster greater efficiency, flexibility, payment accuracy, and improved quality. Based on the most recent data available, CMS estimates that approximately 3.5 million beneficiaries received home health services from nearly 12,000 home health agencies, costing Medicare approximately $18.2 billion in 2012.

In the rule, CMS projects that Medicare payments to home health agencies in calendar year CY 2014 will be reduced by 1.5 percent, or $290 million based on the proposed policies. The proposed decrease reflects the effects of the 2.4 percent home health payment update percentage ($460 million increase), the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor ($650 million decrease), and the effects of ICD-9-CM coding adjustments ($100 million decrease).

In addition, the rule proposes routine updates to the HH PPS payment rates such as updating the payment rates by the HH PPS payment update percentage and updating the home health wage index for 2014. The proposed rule includes:

- HH PPS grouper refinements and ICD-10-CM conversion
- Rebasing the 60-day episode rate
- Rebasing per-visit amounts
- Rebasing and updating other components of the HH PPS Quality reporting
- Cost allocations for Home Health Agency surveys

CMS will accept comments on the proposed rule until August 26, 2013. For additional information about the HH PPS proposed rule, refer to the following resources:

- Home Health PPS website - [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html)

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**For Home Health Providers**

**MM8338—July 2013 Update of the Hospital Outpatient Prospective Payment System (OPPS)**


**MLN Matters® Number:** MM8338  
**Related Change Request (CR) #:** CR 8338  
**Related CR Release Date:** June 7, 2013  
**Effective Date:** July 1, 2013  
**Related CR Transmittal #:** R2718CP  
**Implementation Date:** July 1, 2013  

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

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*This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters are available at no cost from our website at www.cgsmedicare.com.*
Provider Action Needed
This article is based on CR 8338 which describes changes and billing instructions for various payment policies implemented in the July 2013 Outpatient Prospective Payment System (OPPS) update. The July 2013 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), Status Indicator (SI), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR 8338. CR 8338 also updates the “Medicare Claims Processing Manual,” Chapter 4, Sections 61.4.1 (Billing for Brachytherapy Sources) and 61.4.5 (Payment for New Brachytherapy Sources) which is included as an attachment.

The July 2013 revisions to I/OCE data files, instructions, and specifications are provided in CR 8317. A related MLN Matters® article is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8317.pdf on the CMS website. Be sure that your billing staff is aware of these changes.

Background
The key changes in the July 2013 OPPS update are as follows:

Changes to Device Edits for July 2013
The most current list of device edits can be found under “Device, Radiolabeled Product, and Procedure Edits” at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/ on the CMS website. Failure to pass these edits will result in the claim being returned to the provider.

New Service
The new service, listed in Table 1 below, is assigned for payment under the OPPS, effective July 1, 2013.

Table 1 – New Service Payable Under OPPS Effective July 1, 2013

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Effective Date</th>
<th>SI</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>Payment</th>
<th>Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9736</td>
<td>7/1/2013</td>
<td>T</td>
<td>0131</td>
<td>Lap ablate uteri fibroid rf</td>
<td>Laparoscopy, surgical, radiofrequency ablation of uterine fibroid(s), including intraoperative guidance and monitoring, when performed</td>
<td>$3,487.15</td>
<td>$1,001.89</td>
</tr>
</tbody>
</table>

New Long Descriptor for C9734
Table 2, shown below, reflects a new long descriptor for HCPCS code C9734, effective July 1, 2013. HCPCS code C9734 must be performed with Magnetic Resonance (MR) guidance.
Table 2 – New Long Descriptor for C9734 Effective July 1, 2013

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Effective Date</th>
<th>SI</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>Payment</th>
<th>Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9734</td>
<td>4/01/2013</td>
<td>S</td>
<td>0067</td>
<td>U/S trtmnt, not leiomyomata</td>
<td>Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance</td>
<td>$3,300.64</td>
<td>$660.13</td>
</tr>
</tbody>
</table>

Deletion of HCPCS Code C1879 and Use of A4648
Consistent with the CMS general policy of using permanent HCPCS codes rather than using temporary HCPCS codes under the OPPS in order to streamline coding, CMS is deleting HCPCS code C1879 (Tissue marker, implantable) on June 30, 2013, because it is described by HCPCS code A4648 (Tissue marker, implantable, any type). Therefore, effective July 1, 2013, when using implantable tissue markers with any services provided in the OPPS, providers should report the use and cost of the implantable tissue marker with HCPCS code A4648 only.

Category III CPT Codes
The American Medical Association (AMA) releases Category III CPT codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January. For the July 2013 update, CMS is implementing in the OPPS six Category III CPT codes that the AMA released in January 2013 for implementation on July 1, 2013. Of the six, four Category III CPT codes are separately payable under the hospital OPPS. The status indicators and APCs for these codes are shown in Table 3, below. Payment rates for these services can be found in Addendum B of the “July 2013 OPPS Update” that is posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html on the CMS website.

Table 3 -- Category III CPT Codes Implemented as of July 1, 2013

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0329T</td>
<td>Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report</td>
<td>E</td>
<td>N/A</td>
</tr>
<tr>
<td>0330T</td>
<td>Tear film imaging, unilateral or bilateral, with interpretation and report</td>
<td>S</td>
<td>0230</td>
</tr>
<tr>
<td>0331T</td>
<td>Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;</td>
<td>S</td>
<td>0398</td>
</tr>
<tr>
<td>0332T</td>
<td>Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT</td>
<td>S</td>
<td>0398</td>
</tr>
<tr>
<td>0333T</td>
<td>Visual evoked potential, screening of visual acuity, automated</td>
<td>E</td>
<td>N/A</td>
</tr>
<tr>
<td>0334T</td>
<td>Sacroiliac joint stabilization for arthrodesis, percutaneous or minimally invasive (indirect visualization), includes obtaining and applying autograft or allograft (structural or morselized), when performed, includes image guidance when performed (e.g., CT or fluoroscopic)</td>
<td>T</td>
<td>0208</td>
</tr>
</tbody>
</table>
Billing for Drugs, Biologicals, and Radiopharmaceuticals

1. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2013

In the Calendar Year (CY) 2013 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2013 release of the OPPS Pricer. The updated payment rates, effective July 1, 2013, will be included in the July 2013 update of the OPPS Addendum A and Addendum B, which will be posted at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html on the CMS website.

2. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2013

Two drugs and biologicals have been granted OPPS pass-through status effective July 1, 2013. These items, along with their descriptors and APC assignments, are identified in Table 4, below.

Table 4 – Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2013

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator Effective 7/1/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9131*</td>
<td>Injection, ado-trastuzumab emtansine, 1 mg</td>
<td>9131</td>
<td>G</td>
</tr>
<tr>
<td>Q4122</td>
<td>Dermacell, per square centimeter</td>
<td>1419</td>
<td>G</td>
</tr>
</tbody>
</table>

Note: The HCPCS codes identified with an “*” indicate that these are new codes effective July 1, 2013.

3. Flublok (Influenza virus vaccine)

Flublok (influenza virus vaccine) was approved by the FDA on January 16, 2013. For the July 2013 update, the HCPCS Workgroup established HCPCS code Q2033 to describe Flublok. CMS is assigning the OPPS status indicator “L” (Influenza Vaccine; Pneumococcal Pneumonia Vaccine) to HCPCS code Q2033 effective July 1, 2013. Prior to July 1, 2013, the appropriate code to report for Flublok would be an unlisted CPT/HCPCS vaccine code. Table 5, below, provides the descriptors and OPPS status indicator for HCPCS code Q2033.

Table 5– Flublok Influenza Vaccine OPPS Status Indicator

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator Effective 07/01/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2033</td>
<td>Influenza Vaccine, (Flublok)</td>
<td>Influenza Vaccine, Recombinant Himagglutinin Antigens, for Intramuscular Use (Flublok)</td>
<td>N/A</td>
<td>L</td>
</tr>
</tbody>
</table>

4. Fluarix Quadrivalent (Influenza Virus Vaccine)

Fluarix Quadrivalent (Influenza virus vaccine) was approved by the FDA on December 14, 2012, and is described by CPT code 90686. Because of the timing of the FDA approval, CMS was unable to assign CPT code 90686 to a separately payable status. For the July 2013 update, CMS is revising the OPPS status indicator for CPT code 90686 from “E” (Not Covered by Medicare) to “L” (Influenza Vaccine; Pneumococcal Pneumonia Vaccine) effective January 1, 2013. Prior to January 1, 2013, the appropriate code to report for Fluarix Quadrivalent would be an unlisted CPT/HCPCS vaccine code. Table 6, below, provides the descriptors and OPPS status indicator for CPT code 90686.
Table 6– Fluarix Quadrivalent (Influenza Virus Vaccine) Effective January 1, 2013

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator Effective 01/01/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>90686</td>
<td>Flu vac no prsv 4 val 3 yrs+</td>
<td>Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use</td>
<td>N/A</td>
<td>L</td>
</tr>
</tbody>
</table>

5. New HCPCS Codes Effective July 1, 2013 for Certain Drugs and Biologicals
Two new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biological listed in Table 4 above) in the hospital outpatient setting for July 1, 2013. These codes are listed in Table 7, below, and are effective for services furnished on or after July 1, 2013.

Table 7 – New HCPCS Codes for Certain Drugs and Biologicals Effective July 1, 2013

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator Effective 7/1/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2050*</td>
<td>Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10 mg</td>
<td>7046</td>
<td>K</td>
</tr>
<tr>
<td>Q2051**</td>
<td>Injection, Zoledronic Acid, Not Otherwise Specified, 1 mg</td>
<td>1356</td>
<td>K</td>
</tr>
</tbody>
</table>

*HCPCS code J9002 (Injection, Doxorubicin Hydrochloride, Liposomal, Doxil, 10 mg) will be replaced with HCPCS code Q2050 effective July 1, 2013. The status indicator for HCPCS code J9002 will change to E, “Not Payable by Medicare,” effective July 1, 2013.

** HCPCS code J3487 (Injection, Zoledronic Acid (Zometa), 1 mg) and HCPCS code J3488 (Injection, Zoledronic Acid (Reclast), 1 mg) will be replaced with HCPCS code Q2051 effective July 1, 2013. The status indicators for HCPCS codes J3487 and J3488 will change to E, “Not Payable by Medicare,” effective July 1, 2013.

6. Revised Status Indicator for HCPCS Codes Q4126 and Q4134 Effective July 1, 2013
Effective July 1, 2013, the status indicators for HCPCS code Q4126 (Memoderm, dermaspan, tranzgraft or integuply, per square centimeter) and HCPCS code Q4134 (Hmatrix, per square centimeter) will change from SI=E (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=K (paid under OPPS; separate APC payment). For the remainder of CY 2013, HCPCS code Q4126 and HCPCS code Q4134 will be separately paid and the prices for these codes will be updated on a quarterly basis. These codes are listed in Table 8, below, and are effective for services furnished on or after July 1, 2013.

Table 8 – Drugs and Biologicals with Revised Status Indicators Effective July 1, 2013

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator Effective 7/1/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4126</td>
<td>Memoderm, dermaspan, tranzgraft or integuply, per square centimeter</td>
<td>1452</td>
<td>K</td>
</tr>
<tr>
<td>Q4134</td>
<td>Hmatrix, per square centimeter</td>
<td>1453</td>
<td>K</td>
</tr>
</tbody>
</table>
7. **Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2013, Through June 30, 2013**

The payment rates for two HCPCS codes were incorrect in the April 2013 OPPS Pricer. The corrected payment rates are listed in Table 9, below, and have been installed in the July 2013 OPPS Pricer, effective for services furnished on April 1, 2013, through June 30, 2013.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Corrected Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9297</td>
<td>G</td>
<td>9297</td>
<td>Omacetaxine mepesuccinate</td>
<td>$2.53</td>
<td>$0.51</td>
</tr>
<tr>
<td>C9298</td>
<td>G</td>
<td>9298</td>
<td>Injection, ocriplasmin</td>
<td>$1,046.75</td>
<td>$209.35</td>
</tr>
</tbody>
</table>

8. **Updated Guidance: Billing and Payment for New Drugs, Biologicals, or Radiopharmaceuticals Approved by the FDA But Before Assignment of a Product-Specific HCPCS Code**

Hospital outpatient departments are allowed to bill for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which pass-through status has not been approved and a C-code and APC payment have not been assigned using the “unclassified” drug/biological HCPCS code C9399 (Unclassified drugs or biological). Drugs that are assigned to HCPCS code C9399 are contractor priced at 95 percent of AWP.

Diagnostic radiopharmaceuticals and contrast agents are policy packaged under the OPPS unless they have been granted pass-through status. Therefore, new diagnostic radiopharmaceuticals and contrast agents are an exception to the above policy and should not be billed with C9399 prior to the approval of pass-through status but, instead, should be billed with the appropriate “A” NOC code as follows:

a. **Diagnostic Radiopharmaceuticals** – All new diagnostic radiopharmaceuticals are assigned HCPCS code A4641 (Radiopharmaceutical, diagnostic, not otherwise classified). HCPCS code A4641 should be used to bill a new diagnostic radiopharmaceutical until the new diagnostic radiopharmaceutical has been granted pass-through status and a C-code has been assigned. HCPCS code A4641 is assigned status indicator “N” and, therefore, the payment for a diagnostic radiopharmaceutical assigned to HCPCS code A4641 is packaged into the payment for the associated service.

b. **Contrast Agents** – All new contrast agents are assigned HCPCS code A9698 (Non-radioactive contrast imaging material, not otherwise classified, per study) or A9700 (Supply of injectable contrast material for use in echocardiography, per study). HCPCS code A9698 or A9700 should be used to bill a new contrast agent until the new contrast agent has been granted pass-through status and a C-code has been assigned. HCPCS code A9698 is assigned status indicator “N” and, therefore, the payment for a drug assigned to HCPCS code A9698 is packaged into the payment for the associated service. The status indicator for A9700 will change from SI=B (Not paid under OPPS) to SI=N (Payment is packaged into payment for other services) and, therefore, the payment for a drug assigned to HCPCS code A9700 is packaged into the payment for the associated service.

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

**Revisions to the “Medicare Claims Processing Manual,” Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS))**

CR 8338 updates the “Medicare Claims Processing Manual” (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)) by revising the Table of Contents and Section 61; 4.1 (Billing for Brachytherapy Sources), and by adding new Section 61.4.5 (Payment for New Brachytherapy Sources). The updated Chapter 4 is included as an attachment to CR 8338, and the new Section 61.4.5 (Payment for New Brachytherapy Sources) is as follows:
61.4.5-Payment for New Brachytherapy Sources

“Not otherwise specified (NOS) Brachytherapy source codes are available for payment of new Brachytherapy sources for which source codes have not yet been established: C2698 (Brachytherapy source, stranded, not otherwise specified, per source), and C2699 (Brachytherapy source, non-stranded, not otherwise specified, per source). The payment rates for these NOS codes are based on a rate equal to the lowest stranded or non-stranded payment rate for such sources, respectively, on a per source basis (as opposed, for example, to per mCi). Once CMS establishes a new HCPCS code for a new source, the new code will be assigned to its own APC, with the payment rate set based on consideration of external data and other relevant information, until claims data are available for the standard OPPS rate making methodology.”

Additional Information
The official instruction, CR 8338 issued to your FIs, RHHIs, and A/B MACs regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2718CP.pdf on the CMS website.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1-877-299-4500 and choose Option 1.

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HOME HEALTH & HOSPICE PROVIDERS

For Home Health and Hospice Providers

2014 ICD-10-CM Code Updates Now Available

The Centers for Medicare & Medicaid Services (CMS) has posted the 2014 ICD-10-CM code updates on the 2014 ICD-10-CM and GEMs web page at http://cms.gov/Medicare/Coding/ICD10/2014-ICD-10-CM-and-GEMs-.html, including the tabular and index sections, which comprise the complete ICD-10-CM code book in electronic format. Also included in this update:

- The 2014 ICD-10-CM code descriptions (code titles) have been posted in the correct tabular order.

- The 2014 ICD-10-CM Addendum document at http://www.cdc.gov/nchs/icd/icd10cm.htm in the “Related Links” section contains strikeout text to depict what is being deleted in the files.
  - If you are visually impaired and are unable to detect the strikeout text, please contact NCHSED at nchsed@cdc.gov or by calling 301-458-4688.


For Home Health and Hospice Providers

Availability of FISS, ELGA/ELGH During the Labor Day Holiday

While we celebrate the Labor Day holiday with our families, our offices will be closed on Monday, September 2, 2013. Our data center has informed us that the Fiscal Intermediary Standard System (FISS) and access to the Common Working File (CFW) eligibility screens, ELGA/ELGH will be available on September 2, 2013; however, no technical support will be available. In addition, FISS will not cycle that night, which means that claims will not be sent to CWF on September 2, 2013. Medicare Remittance Advices, Electronic Remittance Advices, (ERAs), Medicare paper checks, and Electronic Funds Transfers (EFTs) will not be produced September 2, 2013.

Refer to the Holiday/Training Closure Schedule at https://www.cgsmedicare.com/hhh/help/pdf/Holiday_Schedule.pdf for additional dates when CGS Medicare offices are closed.
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:

- **Home Health Face-to-Face (FTF) Encounters**—This new web page, available at [https://www.cgsmedicare.com/hhh/coverage/HH_Coverage_Guidelines/HH_FTF_encounter.html](https://www.cgsmedicare.com/hhh/coverage/HH_Coverage_Guidelines/HH_FTF_encounter.html) provides information about the time frame in which the FTF encounter must occur, who can perform and sign the FTF encounter, FTF documentation, billing responsibilities, and links to additional resources offered from the Centers for Medicare & Medicaid Services (CMS) and CGS. This page can be accessed from the Home Health Coverage Guidelines page at [https://www.cgsmedicare.com/hhh/coverage/Home_Health_Coverage_Guidelines.html](https://www.cgsmedicare.com/hhh/coverage/Home_Health_Coverage_Guidelines.html) which is located under the “LCDs & Coverage” tab. In addition, links to the new web page are available on the following web pages:

  
  

- **Provider Enrollment Frequently Asked Questions (FAQs)**—Questions number eighteen was added to address capitalization amounts. Review the answer at: [https://www.cgsmedicare.com/hhh/education/faqs/PE_FAQs.html](https://www.cgsmedicare.com/hhh/education/faqs/PE_FAQs.html)

- **myCGS User Manual updated**—This manual has been updated to provide detailed information about accessing and obtaining information from the myCGS web portal. The manual includes seven chapters; each associated with the various tabs available in myCGS. Go to [https://www.cgsmedicare.com/hhh/myCGS/Manual.html](https://www.cgsmedicare.com/hhh/myCGS/Manual.html) to review the updated User Manual.

- **Comprehensive Error Rate Testing (CERT) Program**—The CERT web page is available at [https://www.cgsmedicare.com/hhh/education/materials/CERT.html](https://www.cgsmedicare.com/hhh/education/materials/CERT.html) under the Educational Materials web page at [https://www.cgsmedicare.com/hhh/education/materials/index.html](https://www.cgsmedicare.com/hhh/education/materials/index.html). This page has been revised to include additional information about claim selection, CERT requests, and responding to CERT requests. In addition, a link to this page has also been added to the Medical Review tab on the CGS website.

Make sure that your appropriate staff is 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 with 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

**MM7903 (Revised)—Expeditied Determinations for Provider Service Terminations**


**MLN Matters® Number:** MM7903 Revised  
**Related Change Request (CR) #:** CR 7903  
**Related CR Release Date:** May 24, 2013  
**Effective Date:** August 26, 2013  
**Related CR Transmittal #:** R2711CP  
**Implementation Date:** August 26, 2013

**Note:** This article was revised on July 1, 2013, to correct a reference in the first sentence of the “NOMNC Preparation and Delivery” section to state Medicare patient number, instead of Medicare provider number. All other information remains the same.

**Provider Types Affected**
This MLN Matters® article is intended for home health agencies (HHAs), comprehensive outpatient rehabilitation facilities (CORFs), hospices, and skilled nursing facilities (SNFs) providing services to Medicare beneficiaries.

**What You Need to Know**
Medicare beneficiaries, or a representative acting for a beneficiary, can appeal their provider service terminations to a Quality Improvement Organization (QIO) through the Expedited Determinations process. You have provider responsibilities in this process which, if not completed correctly, could impact your reimbursement. **CR 7903, from which this article is taken, provides new information to the Medicare Claims Processing Manual; in accordance with the 42 Code of Federal Regulations (CFR), Part 405 Medicare Program, Expedited Determination Procedures for Provider Service Terminations: Final Rule (Final Rule), published November 26, 2004. The manual addition ensures consistency with provisions of the final rule and clarifies operating instructions.**

**Background**
Excerpts from these manual changes are summarized below.

**Health Care Settings in Which the Expedited Determination Process is Available to Beneficiaries**
This expedited determination process is available to beneficiaries in Original Medicare whose Medicare covered services are being terminated in the following settings:
- Home Health Agencies (HHA)
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Hospice

Skilled nursing facilities (SNFs), including services covered under a Part A stay, as well as Part B services provided under consolidated billing (i.e. physical therapy, occupational therapy, and speech therapy). For example, a beneficiary exhausts their SNF Part A 100 day benefit, but remains in the facility under a private pay stay and receives covered physical and occupational therapy under Medicare Part B. A Notice of Medicare Non-Coverage (NOMNC) must be delivered by the SNF at the end of a Part A stay or when all of the Part B therapies are ending.

**Note:** Skilled Nursing Facilities includes beneficiaries receiving Part A and B Services in Swing Beds.

**Care Settings in which NOMNC Delivery Does Not Apply**
The following care settings do not qualify for NOMNC delivery for termination of services:
- When beneficiary never received Medicare covered care in one of the covered settings (for example, an admission to a SNF will not be covered due to the lack of a qualifying hospital stay, or a face-to-face visit was not conducted for the initial episode of home health care);
When services are being reduced (for example, an HHA providing physical therapy and occupational therapy discontinues the occupational therapy);

When beneficiaries are moving to a higher level of care (for example, home health care ends because a beneficiary is admitted to a SNF);

When beneficiaries exhaust their benefits (for example, a beneficiary reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit);

When beneficiaries end care on their own initiative (for example, a beneficiary decides to revoke their Hospice benefit and return to standard Medicare coverage);

When a beneficiary transfers to another provider at the same level of care (for example, a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay); or

When a provider discontinues care for business reasons (for example, an HHA refuses to continue care at a home with a dangerous animal or because the beneficiary was receiving physical therapy and the provider’s physical therapist leaves the HHA for another job).

**Notice of Medicare Non-Coverage (NOMNC)**

Medicare providers are responsible for the delivery of the NOMNC. You must deliver a NOMNC to all beneficiaries eligible for the expedited determination process, even if they agree with the termination of services.

The NOMNC is a two page document, subject to the Paperwork Reduction Act Process and approval by the Office of Management and Budget (OMB). As such, it can only be modified according to its accompanying instructions, as unapproved modifications may invalidate it.

Further, while you may include your business logo and contact information at the top of the notice, this cannot cause a shift in text – the NOMNC must remain two pages. You can also include information in the optional “Additional Information” section relevant to the beneficiary’s situation. Please note that including information in this section that would normally be found in the Detailed Explanation of Non-Coverage (DENC), does not satisfy your responsibility to deliver the DENC, if otherwise required. You can find the notices and accompanying instructions online at [http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html) on the CMS website.

**NOMNC Preparation and Delivery**

When you prepare the NOMNC, you must use the OMB approved form (CMS-10123), and type or write in the appropriate fields: 1) The patient’s name; 2) the Medicare patient number; 3) The type of coverage (SNF, home health, CORF, or hospice); and 4) The effective date (last day of coverage), which is always the last day beneficiaries will receive coverage for their services.

While you may formally delegate the delivery of the notices to a designated agent such as a courier service, you should remember that all of the requirements of valid notice delivery apply to designated agents. It should be delivered to the beneficiary at least two days before Medicare covered services end, or the second to last day of service if care is not being provided daily, or no later than the next to last visit before Medicare covered services end for home health services that are being provided less frequently than daily.

**Note:** Beneficiaries have no liability for services received on this date, but may face charges for services received the day following the effective date of the NOMNC for home health, hospice, and CORF services. Because SNFs cannot bill the beneficiary for services furnished on the day of (but before the actual moment of) discharge, beneficiaries may leave a SNF the day after the effective date and not face liability for such services.

There are some exceptions to these required delivery timeframes:

1. You may deliver the NOMNC earlier than two days preceding the end of covered services; however, its delivery should be closely tied to the impending end of coverage;
2. You should not routinely give the notice at the time services begin, unless the services are expected to last fewer than two days; and

3. You should deliver the NOMNC sooner than two days or the next to last visit before coverage ends when a beneficiary receiving home health services is unexpectedly found to no longer be homebound, and thus ineligible for covered home health care.

Finally, you must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that they received the notice and understand that the termination decision can be disputed. If the beneficiary refuses to sign the NOMNC, you should annotate the notice to that effect, and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. Please note that beneficiaries who refuse to sign the NOMNC still remain entitled to an expedited determination.

You may deliver NOMNC to representatives whom the beneficiary has authorized and appointed to act on their behalf during the appeal process. A beneficiary may designate an appointed representative via the “Appointment of Representative” form, the CMS-1696 which can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf on the CMS website. You should inform the representative of the beneficiary’s right to appeal a coverage termination decision, and include the following information:

- The beneficiary’s last day of covered services, and the date when the beneficiary's liability is expected to begin;
- The beneficiary’s right to appeal a coverage termination decision;
- A description of how to request an appeal by a QIO;
- The deadline to request a review as well as what to do if the deadline is missed; and
- The telephone number of the QIO to request the appeal.

If you choose to contact the representative by telephone, the date you communicate the information is considered the NOMNC’s receipt date. You should annotate the NOMNC to document the telephone contact with the beneficiary on the day that you make telephone contact, reflecting that all of the information indicated above was included in the communication. The annotated NOMNC should also include the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called. You must place a dated copy of the annotated NOMNC in the beneficiary’s medical file, and mail a NOMNC to the representative the day the telephone contact is made.

If you choose to communicate the information in writing, a hard copy of the NOMNC must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (e.g. FedEx, UPS). You should keep in mind that the burden is on you to demonstrate that timely contact was attempted with the representative and that the notice was delivered. The date that someone at the representative’s address signs (or refuses to sign) the receipt is considered the date received. Place a copy of the annotated NOMNC in the beneficiary’s medical file.

As an alternative to both telephone or hardcopy contact, if both you and the representative agree, you may send the notice by fax or e-mail; however your fax and e-mail systems must meet the HIPAA privacy and security requirements.

As an alternative to both telephone or hardcopy contact, if both you and the representative agree, you may send the notice by fax or e-mail; however your fax and e-mail systems must meet the HIPAA privacy and security requirements.

Finally, in all cases of delivering the NOMNC, you must retain the original signed document in the beneficiary’s file; and send the beneficiary copies of all notices that include all of the required information such as the effective date and covered service at issue.

**Amending the NOMNC Date**

If you have already delivered the initial NOMNC to a beneficiary and the effective date has changed, you should amend the notice to reflect the new date; and verbally notify the beneficiary, and deliver the amended NOMNC to the beneficiary (retaining a copy in their file). Further, if an expedited determination is already in progress, you must immediately notify the QIO of the change and also provide them an amended notice.
**Beneficiary Responsibilities**
A beneficiary who receives a NOMNC, and disagrees with the termination of services, may request an expedited determination by the appropriate QIO for the state where the services were provided. The beneficiary must contact the QIO (either by telephone or in writing) by noon of the day before the NOMNC's effective date. (If the QIO is unable to accept the request, the beneficiary must submit the request by noon of the next day the QIO is available).

The beneficiary: 1) Must be available to answer questions or supply information requested by the QIO; 2) May (but is not required to) supply additional information to the QIO that he or she believes is pertinent to the case; and 3) Must obtain a physician certification stating that failure to continue (home health or CORF services only) is likely to place his or her health at significant risk.

Without such a certification statement a QIO may not make a determination for service terminations in these settings, although the beneficiary may request an expedited determination from a QIO before obtaining this certification of risk. Once the QIO is aware of a review request, it will instruct the beneficiary on how to obtain the necessary certification from a physician.

**Note: You may not bill a beneficiary who has timely filed an expedited determination for disputed services until the review process (including a reconsideration by a QIO, if applicable) is complete.**

If the beneficiary makes an untimely request (by not meeting the timeliness requirements described above), the QIO will accept the request for review, but is not required to complete the review within its usual 72-hour deadline. Beneficiaries have up to 60 days from the effective date of the NOMNC to make an untimely request to a QIO. When the beneficiary is still receiving services, the QIO must make a determination and notify the parties within 7 days of receipt of the request. When the beneficiary is no longer receiving services, the QIO will make a determination within 30 days of the request.

You should also be aware that the coverage protections discussed above will not apply to a beneficiary who makes an untimely request to the QIO.

**Provider Responsibilities**
When a QIO notifies you of a beneficiary request for an expedited determination, you must deliver the beneficiary a DENC by close of business the day they are notified, supply the QIO with copies of the NOMNC and DENCs by close of business of the day of the QIO notification, and also supply (by telephone, in writing, or electronically) all information, including medical records, that the QIO requests. If you do this by telephone, you must place a written record of the information you that you provided into the patient record.

In addition, you must (at their request) furnish the beneficiary with access to, or copies of, any documentation you provide to the QIO. You may charge the beneficiary a reasonable amount to cover the costs of duplicating and delivering the documentation, which must be provided to the beneficiary by close of business of the first day after the material is requested.

The DENC is subject to the Paperwork Reduction Act Process and approval by the Office of Management and Budget. OMB-approved notices may only be modified as per their accompanying instructions. Unapproved modifications may invalidate the DENC. The DENC must contain the following information:

- A specific and detailed explanation of why services are either no longer reasonable and necessary or no longer covered;

- A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review; and

- The facts specific to the beneficiary’s discharge and provider’s determination that coverage should end.

You should make insertions on the notice in Spanish, if necessary. If this is impossible, additional steps should be taken to ensure that the beneficiary comprehends the content of the notice. Providers may resource CMS multilingual services provided through the 1-800-MEDICARE help line if needed.
The delivery must occur in person by close of business of the day the QIO notifies you that the beneficiary has requested an expedited determination. You may also choose to deliver the DENC with the NOMNC. It does not require a signature, but should be annotated in the event of a beneficiary’s refusal to sign upon delivery.

Please note that an HHA is not required to make a separate trip to the beneficiary’s residence solely to deliver a DENC. Upon notification from the QIO of a beneficiary’s request for an expedited determination, an HHA may telephone the beneficiary to provide the information contained on the DENC, annotate the DENC with the date and time of telephone contact, and file it in the beneficiary’s records. A hard copy of the DENC should be sent to the beneficiary via tracked mail or other personal courier method by close of business of the day the QIO notifies the provider that the beneficiary has requested an expedited determination. The burden is on the provider to demonstrate that timely contact was attempted with the beneficiary and that the notice was delivered.

**Effect of QIO Determination on Continuation of Care**

If the QIO decision extends coverage beyond a point covered by the physician’s orders (either because of the duration of the expedited determination process, or because the physician has already concurred with the termination of care) providers cannot deliver care. In the event of a QIO decision favorable to a beneficiary without physician orders, the ordering physician should be made aware the QIO has ruled coverage should continue, and be given the opportunity to reinstate orders. The beneficiary may also seek other personal physicians to write orders for care as well as find another service provider. The expedited determination process does not override regulatory or State requirements that physician orders are required for a provider to deliver care.

If a QIO decision is favorable to the beneficiary and the beneficiary resumes covered services, a new NOMNC should be delivered for the new course of care per the usual requirements described above. If the beneficiary again disagrees with the termination of care, a new request to the QIO must be made.

The QIO decision will also affect the necessity of subsequent Advance Beneficiary Notice (ABN) deliveries.

**Example 1:** If covered home health care continues following a favorable QIO decision for the beneficiary, the HHA would resume issuance of Home Health Advance Beneficiary Notices (HHABN) as warranted for the remainder of this home health episode. If the QIO decides that Medicare covered care should end and the patient wishes to continue receiving care from the HHA even though Medicare will not pay, an HHABN with Option Box 1 (use when item(s) and/or service(s) may be provided that will not be paid for by Medicare) must be issued to the beneficiary since this would be an initiation of non-covered care.

**Example 2:** If covered SNF care continues, following a favorable QIO decision for the beneficiary, but later ends due to the end of Medicare coverage; and the patient wishes to continue receiving uncovered care at the SNF, a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) must be issued to the beneficiary.

Please keep in mind that delivery of the NOMNC does not replace the required delivery of other mandatory notices, including ABNs. Notice of delivery must be determined by the individual NOMNC requirements (per cite) and ABN delivery requirements per Section 1879 of the Social Security Act and guidance found in the Medicare Claims Processing Manual, Chapter 30 (Financial Liability Protections). In certain instances, both the NOMNC and an ABN may be required, whereas in others, one, two, or even no notices may be required.

**Example When One Notice is Required:** The following is an example of an instance in which only one notice may be required when Medicare covered care is ending: A beneficiary is receiving comprehensive outpatient rehabilitation facility (CORF) services, and all covered CORF care is ending. A NOMNC must be delivered at least two days, or two visits, prior to the end of coverage. If the beneficiary does not wish to continue the CORF services, an ABN should not be given.

**Example When Two Notices are Required:** The following is an example of an instance in which two notices may be required when Medicare covered care is ending: A beneficiary’s Part A stay is ending because a skilled level of care is no longer medically necessary and the beneficiary wishes to remain in the SNF receiving custodial-level care. The beneficiary must receive the NOMNC two days prior to the end of coverage, and a SNFABN must also be delivered before custodial level care begins.
Example When No Notice is Required: As mentioned above, it is also possible that no notice is required when Medicare coverage is ending. The following is an example of such an instance: A beneficiary exhausts the 100 day benefit in a SNF. In this instance, neither the NOMNC nor the SNFABN should be delivered, although the latter can be issued voluntarily, as a courtesy to the beneficiary.

Finally, please keep in mind that a beneficiary for whom coverage is denied, continues to receive services of the type at issue in the expedited determination after the coverage end date, may appeal the denial within the standard claims appeal process (See the Medicare Claims Processing Manual, Chapter 29 Appeals of Claims Decisions), which you can find at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html on the CMS website.

Additional Information
You can find more information about Expedited Determinations for Provider Service Terminations by going to CR 7903, located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2711CP.pdf on the CMS website. You will find the updated Medicare Claims Processing Manual, Chapter 30, as an attachment to that CR.

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

MM8232 (Revised)—Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - July 2013

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the MM8232 Medicare Learning Network® (MLN) Matters article “Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - July 2013,” which was published in the June 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: MM8232 Revised
Related Change Request (CR) #: CR 8232
Related CR Release Date: April 5, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2682CP
Implementation Date: July 1, 2013

Note: This article was revised on June 20, 2013, to list 15 new ZIP codes, instead of the previous 10 new ZIP codes. All other information remains the same.

Provider Types Affected
This MLN Matters® article is intended for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) providers and suppliers submitting claims to Medicare durable medical equipment Medicare administrative contractors (DME MACs) or Medicare regional home health intermediaries (RHHIs) for DMEPOS provided to Medicare beneficiaries.

What You Need to Know
CMS issued CR 8232 to provide the DMEPOS July 2013 quarterly update. CR 8232 provides specific instructions for implementing updates to the DMEPOS Competitive Bidding Program (CBP) Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Background
Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new competitive bidding program for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare
contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and CMS determines payment amounts resulting from the competition to replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards.

Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 areas in 2007. As required by law, CMS conducted the Round One competition in 10 areas and for 10 DMEPOS product categories, and successfully implemented the program on July 1, 2008, for two weeks before the contracts were terminated by subsequent law.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008, terminated the Round One contracts that were in effect, and made other limited changes. As required by MIPPA, CMS conducted the supplier competition again in 2009, referring to it as the Round One Rebid.

The Round One Rebid Competitive Bidding Program was implemented on January 1, 2011, in Competitive Bidding Areas (CBA) defined by ZIP codes within nine of the largest Metropolitan Statistical Areas (MSAs). The CBAs in the Round One Rebid include: Charlotte-Gastonia-Concord, NC-SC; Cincinnati-Middletown, OH-KY-IN; Cleveland-Elyria-Mentor, OH; Dallas-Fort Worth-Arlington, TX; Kansas City, MO-KS; Miami-Fort Lauderdale-Pompano Beach, FL; Orlando- Kissimmee, FL; Pittsburgh, PA; and Riverside-San Bernardino- Ontario, CA.

The Round One Rebid competitive bidding product categories are: Oxygen Supplies and Equipment; Standard Power Wheelchairs, Scooters, and Related Accessories; Group 2 Complex Rehabilitative Power Wheelchairs and Related Accessories; Mail-Order Diabetic Supplies; Enteral Nutrients, Equipment and Supplies; Continuous Positive Airway Pressure (CPAP) Devices, Respiratory Assist Devices, and Related Supplies and Accessories; Hospital Beds and Related Accessories; Walkers and Related Accessories; and, in the Miami-Fort Lauderdale-Pompano Beach CBA only, Support Surfaces (Group 2 Mattresses and Overlays). A list of the HCPCS codes that are included in each of the Round One Rebid product categories can be accessed by visiting the Competitive Bidding Implementation Contractor's (CBIC) website at http://www.dmecompetitivebid.com/palmetto/cbic.nsf on the Internet.

MIPPA required the competition for Round Two to occur in 2011 in 70 additional Metropolitan Statistical Areas (MSAs) and authorizes competition for national mail order items and services after 2010. The Affordable Care Act expands the number of Round Two MSAs from 70 to 91 areas and mandates that all areas of the country are subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. You can find additional information on the DMEPOS Competitive Bidding Program at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html on the CMS website.

More information on Round Two is also available at http://www.dmecompetitivebid.com/palmetto/cbic.nsf on the Internet. The information at this site includes Round Two and National Mail Order information, the latest product categories in the CBP, single payment amounts, and the ZIP codes of areas impacted by the CBP.

**Updates to the ZIP Code Files:**
Fifteen new ZIP codes have been added to the ZIP code file to conform with United States Postal Service ZIP code changes within CBAs:

<table>
<thead>
<tr>
<th>ZIP</th>
<th>CBA</th>
</tr>
</thead>
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<tr>
<td>22350</td>
<td>20530 - Washington-Arlington-Alexandria, DC-VA-MD-WV</td>
</tr>
<tr>
<td>31144</td>
<td>20075 - Atlanta-Sandy Springs-Marietta, GA</td>
</tr>
<tr>
<td>35270</td>
<td>20110 - Birmingham-Hoover, AL</td>
</tr>
<tr>
<td>40166</td>
<td>20290 - Louisville/Jefferson County, KY-IN</td>
</tr>
<tr>
<td>46197</td>
<td>20250 - Indianapolis-Carmel, IN</td>
</tr>
<tr>
<td>46213</td>
<td>20250 - Indianapolis-Carmel, IN</td>
</tr>
<tr>
<td>56935</td>
<td>20530 - Washington-Arlington-Alexandria, DC-VA-MD-WV</td>
</tr>
</tbody>
</table>
Additional Information
The official instruction, CR 8232, issued to your RHII or DME MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2682CP.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.

MLN Matters® article SE1244 is designed as a quick reference tool that provides referral agents with a list of important web links and phone numbers to find information on the Medicare DMEPOS Competitive Bidding Program at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1244.pdf on the CMS website.

You may review the fact sheet designed to outline the requirements related to providing mail order diabetic supplies to beneficiaries who reside in a CBA as well as information detailing options for purchasing diabetic supplies on a non-mail order basis at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Mail_Order_Factsheet_ICN900924.pdf on the CMS website.

For Home Health and Hospice Providers

MM8317 (Revised)—July 2013 Integrated Outpatient Code Editor (I/OCE) Specifications Version 14.2


MLN Matters® Number: MM8317 Revised
Related Change Request (CR) #: CR 8317
Related CR Release Date: June 12, 2013
Effective Date: July 1, 2013
Related CR Transmittal #: R2724CP
Implementation Date: July 1, 2013

Note: This article was revised on June 13, 2013, to reflect a revised CR 8317 issued on June 12. The article is revised to align the “Key Points” section with the revised Appendix M of CR 8317. Also, the CR release date, transmittal number, 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 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 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 8317, which describes changes to the I/OCE and OPPS to be implemented in the July 2013 OPPS and I/OCE updates. Be sure your billing staff is aware of these changes.

See the “Background” and “Additional Information” sections of this article for further details regarding 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 on the CMS website. There is a summary of the changes for July 2013 in Appendix M of Attachment A of CR 8317 and that summary is captured in the following key points.

Key Points of CR 8317
- Effective August 2, 2012, Medicare implemented mid-quarter NCD approval coverage for code G0460. Edit 68 is affected.
- Effective July 1, 2013, Medicare made HCPCS/APC/SI changes as specified by CMS (data change files).
- Effective July 1, 2013, Medicare updated the skin substitute product list.
- Effective July 1, 2013, Medicare implemented Version 19.2 of the NCCI (as modified for applicable institutional providers). Edits 20 and 40 are affected.
- Effective January 1, 2013, Medicare will update procedure/device edit requirement. Edit 71 is affected.
- Effective July 1, 2013, Medicare added new modifier JE (Administered Via Dialysate) to the list of valid modifiers. Edit 22 is affected.

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

MM8341—Update to Chapter 15 of the Program Integrity Manual (PIM)

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: MM8341
Related Change Request (CR) #: CR 8341
Related CR Release Date: July 5, 2013
Effective Date: October 8, 2013
Related CR Transmittal #: R474PI
Implementation Date: October 8, 2013

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

Provider Action Needed
This article is based on CR 8341, which incorporates certain provider enrollment policy and operational clarifications into chapter 15 of the “Program Integrity Manual” (PIM).

Background
The key clarifications/updates of interest to providers are as follows:

- If a contractor returns an enrollment revalidation application, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider’s Medicare billing privileges under 42 CFR 424.535(a)(1) if the applicable time period for submitting the revalidation application has expired.

- If a contractor returns a revalidation application and the applicable time period for submitting the revalidation application has not expired, the contractor shall deactivate the provider’s billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider resubmits the revalidation application and the contractor returns it again, rejects it, or denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – deactivate the provider’s billing privileges, assuming the applicable time period has expired.

- If the contractor rejects or denies a revalidation application, the contractor shall – unless an existing CMS instruction or directive dictates otherwise - deactivate the provider’s Medicare billing privileges under 42 CFR 424.535(a)(1) if the applicable time period for submitting the revalidation application has expired.

- If the contractor rejects or denies a revalidation application and the applicable time period for submitting the revalidation application has not expired, the contractor shall deactivate the provider’s billing privileges after the applicable time period expires unless the provider has resubmitted the revalidation application. If the provider resubmits the revalidation application and the contractor rejects it again, returns it, or denies it, the contractor shall - unless an existing CMS instruction or directive dictates otherwise – deactivate the provider’s billing privileges, assuming the applicable time period has expired.

- Absent a CMS instruction or directive to the contrary, the contractor shall send a denial letter to the provider or supplier (1) no later than 5 business days after the contractor concludes that the provider or supplier’s application should be denied, or (2) if the denial requires prior CMS authorization, no later than 5 business days after CMS notifies the contractor of such authorization.

Additional Information
For Home Health and Hospice Providers

New CMS FAQs for ICD-10 Billing


New FAQs for ICD-10 Billing

CMS has released three new FAQs about submitting ICD-10 claims around the October 1, 2014, deadline. These FAQs update previous information about submitting claims and explain how to split claims for services that span the October 1, 2014, transition date. The three new FAQs on ICD-10 billing discuss these topics:

- How do I report ICD-10 codes on claims when the dates of service span from prior to 10/1/2014 to on or after 10/1/2014? (#8246) - https://questions.cms.gov/faq.php?id=5005&faqId=8246

- If I submit or process a transaction with an ICD-9 code for a date of service after October 1, 2014, am I HIPAA compliant? (#8248) - https://questions.cms.gov/faq.php?id=5005&faqId=8248

- How long after the October 1, 2014 ICD-10 compliance date must I continue to report and/or process ICD-9 codes? (#8252) - https://questions.cms.gov/faq.php?id=5005&faqId=8252

You can find these questions and many other FAQs about ICD-10 at: https://questions.cms.gov/

Keep Up to Date on ICD-10

Visit the CMS ICD-10 website at http://www.cms.gov/Medicare/Coding/ICD10/index.html for the latest news and resources to help you prepare for the October 1, 2014, deadline. Sign up for CMS ICD-10 Industry Email Updates and follow us on Twitter.
For Home Health and Hospice Providers

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

- REVISED products from the Medicare Learning Network® (MLN)

- DMEPOS Competitive Bidding Program—On January 30, 2013, CMS announced the single payment amounts for the Round 2 and national mail-order competitions of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. For additional information, see the Press Release (http://www.cms.gov/apps/media/press/release.asp?Counter=4512&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date), a related Fact Sheet (http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4513&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date), and other information at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html on the CMS website.

For Home Health and Hospice Providers

Provider Contact Center (PCC) Availability

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our customer service representatives (CSRs). Listed below are the dates and time the home health and hospice PCC (1-877-299-4500, Option 1) will be closed for training.

<table>
<thead>
<tr>
<th>CSR Training Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday, August 13, 2013</td>
<td>8:00 a.m. – 10:00 a.m. (Central Time)</td>
</tr>
<tr>
<td>Tuesday, August 27, 2013</td>
<td></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

Timely Mailing of Additional Development Request (ADR) Documentation to CGS

The Medicare Program Integrity Manual (CMS Pub. 100-08) Ch. 3 §3.2.3.2 states that when a Medicare administrative contractor (MAC) requests documentation for a claim selected for medical review, the MAC shall notify the provider that “the requested documentation is to be submitted within 30 calendar days of the request.” CGS providers’ are notified of this 30-day timeline in the message that appears on the Fiscal Intermediary Standard System (FISS) Page 08 of a claim that has been ADRd. This usually appears on the first line of the narrative, as indicated in the example below.

**REASONS: 59964**

**REASON CODE NARRATIVES FOR HIC/DCN: XXXXXXXXXXX XXXXXXXXXXXXXXXXXXX**

**59964 MEDICARE NEEDS TO RECEIVE THE RETURNED ADR INFORMATION BY THE 30TH DAY.**

This allows for mail time and for us to move the claim into the medical review status/location SM50MR by Day 45 or it will be denied with reason code 56900 on the 46th day.

Please send the following information for the home health episode billed:

* All OASIS assessments used to determine the HIPPS code(s) billed for this episode
* The comprehensive assessment
* Evaluations, plans of care and notes for all services provided during the episode and 5 days prior to the episode.
* All signed and dated physician orders, including the signed physicians certification and plan of care.
* Hospital/SNF discharge summaries if applicable
The 30th day can be determined by reviewing FISS Page 07 (see example below). There are two fields to assist you in determining the 30th day.

The **ORIG REQ DT** field indicates day 1 of the ADR, so day 30 can be calculated from this date. In addition, because the **DUE DATE** field indicates day 45, you can also deduct 15 days from this date to determine the 30th day.

```
REPORT: 001       MEDICARE PART A 15004       PVDR NO : XXXXXXXXXXX
DATE : MM/DD/CCYY   ADDITIONAL DEVELOPMENT REQUEST   BILL TYPE: XXX
CASE ID: XXXXXXXXXXXXXXXXXXX

ABC PROVIDER
123 MAIN STREET
ANYTOWN       IA 50010 1234

WE HAVE REVIEWED THIS CLAIM RECORDS AND FOUND THAT ADDITIONAL DEVELOPMENT WILL BE NECESSARY BEFORE PROCESSING CAN BE FINALIZED. TO ASSIST YOU IN PROVIDING THE REQUIRED INFORMATION, WE HAVE ASSIGNED REASON CODES TO THE CLAIM RECORD FOR YOUR REVIEW. WE MUST RECEIVE THE REQUESTED INFORMATION BEFORE THE DUE DATE LISTED BELOW OR THE CLAIM WILL BE DENIED DUE TO NO RESPONSE. SEND YOUR RESPONE TO THE ATTENTION OF:

CGS J15 MAC
J15 - HHH CORRESPONDENCE
P O BOX 20014
NASHVILLE       TN 37202

PATIENT CNTRL NBR: [redacted]
MEDICAL REC NO: [redacted] DCN: [redacted]
HIC: XXXXXXXXX     PATIENT NAME: IMA     PATIENT
FROM DATE: MM/DD/CCYY  THRU DATE: MM/DD/CCYY  OPR/MED ANALYST:
TOTAL CHARGES: XXXX.XX

DUE DATE: 07/25/2013
ORIG REQ DT: 06/10/2013
CLM RCPT DT: 06/07/2013
```

The 30 day timeframe allows for mail time of the documentation, and time for CGS to receive and process the documentation. When the documentation is received by CGS, it is scanned into the Optical Character Recognition (OCR) software, and CGS staff must move the claim from the S B6001 status/location in to the S M50MR location. This process can take some additional time from when CGS receives the documentation.

Section 3.2.3.2 of the *Program Integrity Manual* also states that MACs “shall deny claims for which the requested documentation was not received by day 45.” When documentation is mailed after day 30, there may not be ample time to allow CGS staff to move the claim into S M50MR before it is set to auto-deny.

To avoid your claim from auto-deny unnecessarily, please ensure that you mail ADR documentation by day 30. In addition, providers should be aware that CGS will review all documentation received timely (by day 45), and there is no need to request a reopening or appeal as long as the documentation was received by the due date indicated on FISS Page 07.
August 2013 Webinar Schedule
There are no CGS webinars scheduled for August. 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 web page at https://www.cgsmedicare.com/hhh/education/Education.html and refer to the list of events under the “Replay Past Webinars and Teleconferences” heading. The replay of past webinars is only available for 30 days from the date of the live event.
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