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For Home Health Providers

MM8403: Home Health Change of Care Notice (HHCCN), Form CMS-10280, Manual Instructions

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: MM8403  Related Change Request (CR) #: CR 8403
Related CR Release Date: September 6, 2013  Effective Date: December 9, 2013
Related CR Transmittal #: R2781CP  Implementation Date: December 9, 2013

Provider Types Affected
This MLN Matters® article is intended for home health agencies (HHAs) submitting claims to Medicare contractors (regional home health intermediaries (RHHIs)) for services to Medicare beneficiaries.

Provider Action Needed
This article is based on CR 8403 which introduces and implements the Home Health Change of Care Notice (HHCCN) and instructions. Make sure that your staff is aware of these changes. See the “Background” and “Additional Information” sections of this article for further details regarding these changes.

Background
Home Health Advance Beneficiary Notices (HHABNs) have been required since 2002 to inform beneficiaries in Original Medicare about possible noncovered charges when limitation of liability applies. In 2006, CMS revised the notice and its instructions in response to a Federal court decision so that the notice could encompass broader notification requirements codified under the Conditions of Participation (COPs) for HHAs. In an effort to streamline, reduce, and simplify notices issued to Medicare beneficiaries, the HHABN, Form CMS-R-296, will be discontinued. The newly-approved HHCCN will replace the HHABN Option Box 2 and the HHABN Option Box 3 for change of care notifications. The HHABN Option Box 1, issued for beneficiary liability notification, will be replaced with the Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, an existing CMS notice that has been used by other provider types. Triggering events for HHCCN issuance will remain the same as those previously used for HHABN Option Boxes 2 and 3. The revised manual chapter is attached to CR 8403.

The date for mandatory use of the HHCCN and ABN in place of the HHABN will be posted on the CMS Web link for home health notices at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html

Chapter 30, Section 60 and its subsections are being replaced in accordance with these notice changes. CR 8403 replaces previous information from CR 7323, transmittal 2362, dated December 1, 2011.

Note: The HHCCN fulfills the requirement that HHAs provide beneficiaries with written notification of changes in care as contained in the COPs for HHAs in Section1891 of the Social Security Act.
Key revisions in Chapter 30, Section 60:

- Discontinuation of HHABN
- HHCCN replaces the HHABN Option Box 2 (for reduction or termination of items and/or services for HHA administrative reasons)
- HHCCN replaces the HHABN Option Box 3 (for reduction or termination of items and/or services based on physician’s orders)
- ABN replaces HHABN Option Box 1 (see CR 8404)
- The HHCCN and the general instructions for preparing the HHCCN are available for download on the home health notice link at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html on the CMS website.
- The Notice of Medicare Provider Non-Coverage (NOMNC), CMS-10123, must be issued to the beneficiary when all Medicare covered services are ending based on the physician’s orders. Since the NOMNC provides written notification of the forthcoming termination of all home health care, it satisfies the regulatory requirement for change of care advisement (HHCCN issuance). Thus, when the NOMNC is issued as required, a separate HHCCN does not need to be issued.
- When home health services end because of physician’s orders, HHAs have the option of issuing the NOMNC alone or both the NOMNC and the HHCCN.
- HHCCN requirements apply only when home health services are expected to be partially or fully covered by Medicare. When a beneficiary is not receiving services that are expected to be covered under the Medicare home health benefit, the HHCCN is not required. For example, if a dual eligible beneficiary (having both Medicare and Medicaid) is not receiving any Medicare covered home health services, HHCCN issuance wouldn’t be required when changes of care occur. (Note: HHAs are required to issue the ABN to dual eligible beneficiaries when applicable. See Chapter 30, Section 50.15.4 C).
- If needed, HHAs must provide verbal assistance in other languages to assist beneficiaries in understanding the document. HHAs should document any types of translation assistance used in the “Additional Information” section of the notice.

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.

Questions regarding the HHCCN can be emailed to: RevisedABN_ODF@cms.hhs.gov
MM8404: Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131

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: MM8404
Related CR Release Date: September 6, 2013
Related CR Transmittal #: R2782CP
Related Change Request (CR) #: CR 8404
Effective Date: December 9, 2013
Implementation Date: December 9, 2013

Provider Types Affected
This MLN Matters® article is intended for physicians, providers (including home health agencies) and suppliers that submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (MACs), regional home health intermediaries (RHHIs), home health & hospice, Medicare administrative contractors (HHH MACs), and durable medical equipment Medicare administrative contractors (DME MACs)) for services to Original Medicare beneficiaries.

Provider Action Needed
This article is based on CR 8404 which provides: 1) instructions for home health agency (HHA) use of the Advance Beneficiary Notice of Noncoverage (ABN) to replace the outgoing Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296, Option Box 1; 2) ABN issuance guidelines for therapy services and therapy specific examples; and 3) minor editorial changes to clarify existing manual instructions regarding ABN issuance.

Home health agencies and therapy providers should make sure that their health care and billing staff are aware of these ABN policy changes. All other providers should note that there have been no substantive changes to the ABN form or general instructions for issuance and can reference MM7821 (available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7821.pdf) for general ABN information.

Background
Section 1879 of the Social Security Act (the Act) protects Fee-For-Service (FFS) beneficiaries from payment liability (in certain situations) unless the beneficiary is given advance notice of his/her potential liability. The ABN informs beneficiaries about such possible non-covered charges and fulfills this notification requirement when Limitation of Liability (LOL) applies.

CMS is expanding use of the ABN to include issuance by HHA providers for Part A and Part B items and services. The ABN will replace the Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296, Option Box 1 that is currently used by HHAs. The mandatory date for all HHAs to begin use of the ABN and discontinue use of the HHABN will be posted at http://cms.gov/Medicare/Medicare-General-Information/BNI/HHABN.html on the CMS website. The guidelines for ABN use published in Chapter 30, Section 50 of the "Medicare Claims Processing Manual" and the ABN form instructions apply to HHAs unless otherwise noted.
Key Points from the Updated Chapter 30 Section 50

HHA Use of ABN – General Use

HHAs are required to issue an ABN to Original Medicare beneficiaries in specific situations where “Limitation on Liability” (LOL) protection is afforded under Section 1879 of the Act for items and/or services that the HHA believes Medicare will not cover (see Table 1 below). In these circumstances, if the beneficiary chooses to receive the items/services in question and Medicare does not cover the home care, HHAs may use the ABN to shift liability for the non-covered home care to the beneficiary. ABNs are not used in managed care; however, when a beneficiary transitions to Medicare managed care from Original Medicare during a home health episode, ABN issuance is required when there are potential charges to the beneficiary that fall under the LOL projections. HHAs should contact their RHHI if they have questions on the ABN or related instructions, since RHHIs process home health claims for Original Medicare. The following chart summarizes the statutory provisions related to ABN issuance for LOL purposes.

### Table 1: Statutory Provisions Related to ABN Issuance for LOL purposes

<table>
<thead>
<tr>
<th>Application of LOL for the Home Health Benefit Citation from the Act</th>
<th>Brief Description of Situation</th>
<th>Recommended Explanation for “Reason Medicare May Not Pay” section of ABN</th>
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<tbody>
<tr>
<td>Section 1862(a)(1)(A)</td>
<td>Care is not reasonable and necessary</td>
<td>Medicare does not pay for care that is not medically reasonable and necessary.</td>
</tr>
<tr>
<td>Section 1862(a)(9)</td>
<td>Custodial care is the only care delivered</td>
<td>Medicare does not usually pay for custodial care, except for some hospice services.</td>
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<tr>
<td>Section 1879(g)(1)(A)</td>
<td>Beneficiary is not homebound</td>
<td>Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit.</td>
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<tr>
<td>Section 1879(g)(1)(B)</td>
<td>Beneficiary does not need skilled nursing care on an intermittent basis.</td>
<td>Medicare requires part-time or intermittent need for skilled nursing care in order to cover services under the home health benefit.</td>
</tr>
</tbody>
</table>

If one of the above situations applies and the beneficiary chooses to receive the home care items/services that may not be covered by Medicare, HHAs must issue the ABN to the beneficiary to notify him/her of potential financial responsibility. In addition, when Medicare considers an item or service experimental (e.g., a “Research Use Only” or “Investigational Use Only” laboratory test), payment for the experimental item or service is denied under Section 1862(a)(1) of the Act as not reasonable and necessary. In circumstances such as this, the beneficiary must be given an ABN.

### HHA Triggering Events

HHAs may be required to provide an ABN to an Original Medicare beneficiary when a triggering event occurs. Table 2, below, outlines triggering events specific to HHAs.

### Table 2: Triggering Events for ABN issuance by HHAs*

<table>
<thead>
<tr>
<th>Event</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Initiation</td>
<td>When an HHA expects that Medicare will not cover an item and/or service delivered under a planned course of treatment from the start of a spell of illness, OR before the delivery of a one-time item and/or service that Medicare is not expected to cover.</td>
</tr>
<tr>
<td>Reduction</td>
<td>When an HHA expects that Medicare coverage of an item or service will be reduced or stopped during a spell of illness while continuing others, including when one home health discipline ends but others continue.</td>
</tr>
<tr>
<td>Termination</td>
<td>When an HHA expects that Medicare coverage will end for all items and services in total.</td>
</tr>
</tbody>
</table>

*ABN issuance is only required when the HHA is going to provide the beneficiary with the item or service that is being initiated, reduced, or terminated as described in this Table. If the beneficiary does not want the item or service that is being initiated, reduced, or terminated, no ABN is required.
• HHA Initiations
The HHA must issue a beneficiary an ABN prior to delivering care that is usually covered by Medicare, but in this particular instance, the item or service may not be or is not covered by Medicare because:

- The care is not medically reasonable and necessary;
- The beneficiary is not confined to his/her home (is not considered homebound);
- The beneficiary does not need skilled nursing care on an intermittent basis; or
- The beneficiary is receiving custodial care only.

**Note:** If the HHA believes that Medicare will not (or may not) pay for care for a reason other than ones listed directly above, issuance of the ABN is not required.

**INITIATION EXAMPLE:** A beneficiary requires skilled nursing wound care 3 times weekly; however, she is not confined to the home. She wants the care done at her home by the HHA. The HHA must issue the ABN to this beneficiary before providing the home care that will not be paid for by Medicare. This allows the beneficiary to make an informed decision on whether to receive the non-covered care, and to accept the financial obligation.

An ABN, signed at initiation of home health care for items and/or services not covered by Medicare, is effective for up to a year; as long as the items/services being given remain unchanged from those listed on the notice.

Any one-time care that is provided and completed in a single encounter is considered an initiation in terms of triggering events, and is subject to ABN issuance requirements if applicable. When an HHA performs a beneficiary's initial assessment prior to admission but does not admit him/her; an ABN is not required if there is no charge for the assessment. However, if an HHA charges for an assessment, it must provide notice to the beneficiary before performing and charging for this service.

Since Medicare has specific requirements for payment of home health services, there may be occasions in which a payment requirement is not met, and therefore, the HHA expects that Medicare will not pay for the services. The HHA cannot use the ABN to transfer liability to the beneficiary when there is concern that a billing requirement may not be met. (For example, a home health agency cannot issue an ABN at initiation of home care services in order to charge the beneficiary if the provider face to face encounter requirement is not met.)

• HHA Reductions
Reductions involve any decrease in services or supplies, such as frequency, amount, or level of care that an HHA provides and/or that is part of the Plan of Care (POC). If a reduction occurs for an item or service that will no longer be covered by Medicare, but the beneficiary wants to continue to receive the item or service and will assume the financial charges, the HHA must issue the ABN prior to providing the noncovered items or services. (Technically, this is an initiation of noncovered services following a reduction of services).

**REDUCTION WITH SUBSEQUENT INITIATION EXAMPLE:** A beneficiary requires Physical Therapy (PT) for gait retraining 5 times per week for 2 weeks, then reduce to 3 times weekly for 2 weeks. After 2 weeks of PT, the beneficiary wants to continue therapy 5 times a week even though this amount of therapy is no longer medically reasonable and necessary. The HHA would issue an ABN so that he understands the situation and can consent to financial responsibility for the PT not covered by Medicare.

• HHA Terminations
A termination is the cessation of all HHA-provided Medicare covered services. If a beneficiary wants to continue receiving home health care that will not be covered by Medicare for any of the statutory reasons listed in Table 1 and a physician orders
the services; the HHA must issue the beneficiary an ABN in order to charge the beneficiary or a secondary insurer. If the beneficiary will not be getting any further home care after discharge, there is no need for ABN issuance.

When all Medicare covered home health care is terminated, HHAs may sometimes be required to deliver the Notice of Medicare Provider Non-Coverage, (NOMNC), CMS-10123. The NOMNC informs beneficiaries of the right to an expedited determination by a Quality Improvement Organization (QIO) if they feel that termination of home health services is not appropriate. Detailed information and instructions for issuing the NOMNC can be found on the CMS website under the link for “FFS ED Notices” at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html on the CMS website.

If a beneficiary requests a QIO review upon receiving a NOMNC, the QIO will make a fast decision on whether covered services should end. If the QIO decides that Medicare covered care should end and the beneficiary wishes to continue receiving care from the HHA even though Medicare will not pay, an ABN must be issued since this would be an initiation of non-covered care.

If a beneficiary is eligible for both Original Medicare and Medicaid (dually eligible) or is covered by Original Medicare and another insurance program or payer (such as waiver programs, Office on Aging funds, community agencies (e.g., Easter Seals) or grants), ABN requirements still apply.

**Effect of Other Insurers/Payers**

For example, when a beneficiary is a dual eligible and receives home health services that are covered only under Medicaid, but are not covered by Medicare for one of the reasons listed in Table 1; an ABN must be issued at the initiation of this care to inform the beneficiary that Medicare will likely deny the services.

Some States have specific rules regarding HHA completion of liability notices in situations where dual eligible beneficiaries need to accept liability for Medicare noncovered care that Medicaid will cover. Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is recognized as the “payer of last resort” (meaning other Federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid assumes any remaining charges).

On the ABN, the first check box under the “Options” section indicates the choice to bill Medicare and is equivalent to the third checkbox on the outgoing HHABN. HHAs serving dual eligibles should comply with existing HHABN State policy within their jurisdiction as applicable to the ABN unless the State instructs otherwise.

**Note:** If a State has issued a directive to select the third checkbox on the HHABN, HHAs must mark the first check box when issuing the ABN.

Where there is no State specific directive, HHAs are permitted to instruct beneficiaries to select Option 1 on the ABN when a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer. HHAs may add a statement in the “Additional Information” section to help a dual eligible better understand the payment situation such as, “We will submit a claim for this care to your other insurance,” or “Your Medical Assistance plan will pay for this care.”

HHAs may also use the “Additional Information” on the ABN to include agency specific information on secondary insurance claims or a blank line for the beneficiary to insert secondary insurance information. Agencies can pre-print language in the “Additional Information” section of the notice.
HHA Exceptions to ABN Notification Requirements

ABN issuance is NOT required in the following HHA situations:

- Initial assessments (in cases where beneficiaries are not admitted) for which HHAs do not charge;
- Care that is never covered by Medicare under any circumstances (i.e., an HHA offers complimentary hearing aid cleaning and maintenance);
- Telehealth monitoring used as an adjunct to regular covered HH care; or
- Noncovered items/services that are part of care covered in total under a Medicare bundled payment (e.g., HH Prospective Payment System (PPS) episode payment).

Other HHA ABN Guidance

1. **ABN for Voluntary Notice by HHAs**
   HHAs may use the voluntary ABN, as a courtesy, to alert beneficiaries of impending financial obligation for items and services that are never covered by Medicare as described in the “Medicare Claims Processing Manual,” Chapter 30 (Financial Liability Protections), Section 50.3.2 (Voluntary ABN Uses).

2. **Effect of Initial Payment Determinations on Liability**
   An ABN informs a beneficiary of his/her HHA’s expectation with regard to Medicare coverage. If the care described on the ABN is actually provided, Medicare makes a payment determination on the items and/or services at issue when adjudicating the related claim. Such adjudications may uphold the provider’s expectation, in which case the beneficiary will remain liable for payment if agreeing to accept this liability based on a valid ABN. However, adjudication may not conform to the provider’s expectation, in which case the decision made on the claim supersedes the expectation given on the ABN. That is, Medicare may cover and pay for care despite the HHA’s expectation, or deny the claim and find the provider liable. In such cases, if the HHA collected funds from the beneficiary, the HHA must promptly refund the appropriate amount to the beneficiary.

3. **Use of Abbreviations**
   When completing the ABN, HHAs must avoid using abbreviations in the body of the notice unless the abbreviation is already spelled out elsewhere. For example, an abbreviation such as “PT” that can have multiple meanings in a home health setting (part-time, physical therapy, prothrombin time) should be spelled out at least once on the ABN next to the abbreviation of the word(s). When this is done, the abbreviation can be used again on the notice. ABNs containing abbreviations that are not defined in this manner on the notice may be invalidated by contractors.

4. **Cost Estimate**
   HHAs should follow the ABN form instruction guidelines for providing cost estimates for items or services. The cost estimate must be a good faith estimate based on agency charges and the expected frequency and duration of each service. Cost estimates per visit or per number of visits weekly are acceptable. A difference in the cost estimate and actual cost will not automatically invalidate the ABN. The cost estimate must give the beneficiary an idea of what his/her out of pocket costs might be if s/he chooses to receive the care listed on the ABN.

   Cost Estimate Examples:
   - $440 for 4 weekly nursing visits in 1/13.
   - $260 for 3 physical therapy visits 1/3-1/7/13.
   - $50 for spare right arm splint.
When more than one item and/or service is at issue, the HHA must enter separate cost estimates for each item or service as clearly as possible, including information on the period of time involved when appropriate.

**Outpatient Therapy Services Use of the ABN**

Section 603(c) of the American Taxpayer Relief Act (ATRA) amended Section 1833(g)(5) of the Act to provide limitation of liability protections to beneficiaries receiving outpatient therapy services on or after January 1, 2013, when services are denied and the services provided are in excess of therapy cap amounts and don’t qualify for a therapy cap exception. This amendment affected financial liability for certain therapy services that exceed the cap.

Prior to the ATRA amendment, claims for therapy services at or above therapy caps that did not qualify for a coverage exception were denied as a benefit category denial, and the beneficiary was financially liable for the non-covered services. CMS had encouraged suppliers and providers to issue a voluntary ABN as a courtesy; however, ABN issuance wasn’t required for the beneficiary to be held financially liable.

Now, with this ATRA amendment to the Act, the provider/supplier must issue a valid, mandatory ABN to the beneficiary before providing services above the cap when the therapy coverage exceptions process isn’t applicable. ABN issuance allows the provider to charge the beneficiary if Medicare doesn’t pay. If the ABN isn’t issued when it is required and Medicare doesn’t pay the claim, the provider/supplier will be liable for the charges.

Therapists are required to issue an ABN to beneficiaries before providing them therapy that is not medically reasonable and necessary, regardless of the therapy cap. Statutory changes (mentioned above) mandate ABN issuance when therapy services are not medically reasonable and necessary and exceed the cap amount. Policies for mandatory ABN issuance for services below the therapy cap remain unchanged. If a beneficiary will be getting therapy services that will not be covered by Medicare because they are no longer medically necessary, an ABN must be issued before the services are provided so that the beneficiary can choose whether to obtain the services and accept financial responsibility for them.

**THERAPY CAP IS NOT MET - ABN MANDATORY EXAMPLE:** A beneficiary has been receiving Physical Therapy (PT) three times per week, and currently, he has achieved all his PT goals established in the Plan of Care (POC). The total amount applied to his therapy cap this year is $780. He requests continued PT services two times per week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that will not be covered by Medicare because they are no longer medically necessary.

**THERAPY CAP HAS BEEN MET - ABN MANDATORY EXAMPLE:** A beneficiary has recently been receiving Physical Therapy (PT) three times per week, and she has achieved all her PT goals established in the POC. The total amount applied towards her therapy cap this year is $1900. She requests continued PT services two times a week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that are not medically necessary and exceed the cap in order for the therapist to transfer liability and charge the beneficiary.

In cases such as these, if Medicare denies the claim and a valid ABN was issued, financial liability shifts to the beneficiary. If the provider fails to issue an ABN for therapy that is not medically necessary, the provider will be held financially liable if Medicare denies the claim.

**Additional Information**

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: MM8441
Related Change Request (CR) #: CR 8441
Related CR Release Date: September 20, 2013
Effective Date: July 1, 2014
Related CR Transmittal #: R2789CP
Implementation Date: July 7, 2014

For Home Health Providers

MM8441: Home Health Agency Reporting Requirements for the Certifying Physician and the Physician Who Signs the Plan of Care

Provider Types Affected
This MLN Matters® article is intended for home health agencies (HHAs) submitting claims to home health & hospice Medicare administrative contractors (HH&Hs) and Part A Medicare administrative contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed
CR 8441, from which this article is taken, provides that home health agencies (HHAs) will begin reporting (on claims with dates of service on or after July 1, 2014) the National Provider Identifier (NPI) and the name of both the physician who certifies the patient’s eligibility for home health services and the physician who signs the home health plan of care (POC). You should make sure that your billing staffs are aware of this change.

Background
Medicare allows a physician (such as a hospitalist) who attends to hospitalized patients, but does not follow them into the community to: 1) Certify the need for home health care based on their face to face contact with patients in the hospital; 2) Initiate the orders and a plan of care for home health services, and 3) “hand off” the patients to their community-based physicians to review and sign the plan of care.

CR 8441, from which this article is taken, requires that, for claims with effective dates or dates of service on or after July 1, 2014, HHAs must:

- Report the National Provider Identifier (NPI) and name of the physician who certifies the patient’s eligibility for home health services; and
- Continue to report the NPI and name of the physician who signs the patient’s plan of care.

Note: You should complete both the attending physician and the other physician fields even if the certifying physician is the same as the physician who signed the plan of care.
Additional Information

The official instruction, CR 8441, issued to your Medicare contractor regarding this change may be viewed at http://cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2789CP.pdf on the CMS website.

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

For Home Health Providers

Reason Code 31790: HCPCS Code Reporting for Home Health Location of Service

CGS reviews claim submission error (CSE) data on a monthly basis to monitor billing trends and increasing errors. August 2013 data indicated a high volume of claims going to the Return to Provider (RTP) status/location (T B9997) for reason code 31790. This reason code indicates the home health claim does not include the HCPCS code Q5001, Q5002, or Q5009.

Change Request 8136, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2680CP.pdf requires home health agencies to report the HCPCS code Q5001, Q5002, or Q5009 to indicate the location where services were provided for episodes beginning on or after July 1, 2013.

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

To assist you in preventing and resolving claims RTP’d with reason code 31790, please review the following billing requirements.

- Report the HCPCS code indicating the location of service along with the 1st billable visit in the HH PPS episode.
- Report the HCPCS code only once on a claim unless the location changes.
- Report the HCPCS code on an additional line item with the revenue code and date of service, one unit, and a nominal charge.

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<tr>
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<th>HCPC</th>
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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 http://www.cgsmedicare.com. © 2013 Copyright, CGS Administrators, LLC.
If the location changes, report a new line item with the appropriate HCPCS code along with the 1st visit provided in the new location.

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

For Home Health and Hospice Providers

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:

- The “Fiscal Intermediary Standard System (FISS) Claims Processing Issues” Web page has been updated. Please access this Web page at http://www.cgsmedicare.com/hhh/claims/FFSS_Claims_Processing_Issues.html to review the updates to issues that may affect the processing of your claims.

- The “Centers for Medicare & Medicaid Services (CMS) Educational Resources” has been updated to include a link to the Quarterly Provider Updates page, which is available at https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html on the CMS website.

- The “Home Health Claims Filing” Web page at http://www.cgsmedicare.com/hhh/education/materials/HHE_Claims_Main.html was updated. Under the “Special Claims Filing Situations” section of the page, a link to the “Transfer Dispute Between HHAs” Web page was added.


- **NEW** – The “Advance Beneficiary Notice of Noncoverage (ABN)” Web page has been developed based on instructions in Change Request (CR) 8404, which provides instructions for home health providers on the use of the ABN and that it replaces the outgoing Home Health Advance Beneficiary Notice (HABN), Form CMS-R-896, Option Box 1. This new Web page is available at: https://www.cgsmedicare.com/hhh/coverage/HH_Coverage_Guidelines/abn.html
NEW – The “Home Health Change of Care Notice (HHCCN)” Web page has been developed based on instructions in Change Request (CR) 8403, which introduces the new form and provides instructions. The HHCCN form replaces the Home Health Advance Beneficiary Notice (HHABN), Option Box 2 and Option Box 3. This new Web page is available at: https://www.cgsmedicare.com/hhh/coverage/HH_Coverage_Guidelines/hhccn.html

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 on the CGS website.

For Home Health and Hospice Providers

Influenza Season is Almost Here

As the 2013-2014 influenza season quickly approaches, now is an opportune time to send reminders and schedule appointments for patients’ flu vaccinations. Seniors and people with chronic health conditions—like asthma, diabetes, and heart disease—are at a higher risk for serious complications from the flu. According to the Centers for Disease Control and Prevention, last season overall deaths attributed to flu and pneumonia were the highest in nearly a decade, and people 65 years and older accounted for half of all flu-related hospitalizations. Recommending and offering flu vaccine to Medicare beneficiaries ahead of the flu season is very crucial, as patients are more likely to get vaccinated when flu vaccination is recommended and offered by a health care professional.

Generally, Medicare Part B covers one influenza vaccination and its administration per influenza season for Medicare beneficiaries without co-pay or deductible. Note: The influenza vaccine and its administration are covered under Medicare Part B. Influenza vaccine is not a Part D-covered drug.

For more information on coverage and billing of the influenza virus vaccine and its administration, please visit:

- While some providers may offer the flu vaccine, others can help their patients locate a vaccine provider within their local community. HealthMap Vaccine Finder (http://vaccine.healthmap.org/) is a free, online service where users can search for locations offering flu and other adult vaccines.

Home health and hospice providers should be aware that effective October 1, 2013, a beneficiary who is receiving hospice care must receive preventive vaccines from their hospice provider. See Change Request 8098 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1217OTN.pdf for additional information.
New Online ICD-10 Implementation Guide

To help the health care industry prepare for ICD-10, the Centers for Medicare & Medicaid Services (CMS) has developed an online ICD-10 implementation guide. This Web-based tool, which can be found on the ICD-10 Provider Resources Web page at http://cms.gov/Medicare/Coding/ICD10/ProviderResources.html on the CMS website includes a basic overview of ICD-10 as well as step-by-step guidance on how to transition to ICD-10 for small/medium practices, large practices, small hospitals, and payers. Users can easily navigate to information that is most relevant to them—wherever they are in the implementation process. The online guide also includes links to CMS ICD-10 resources and other tools to help with the ICD-10 transition. To learn more, check out the Online ICD-10 Guide.

Keep Up to Date on ICD-10


Sign up for CMS ICD-10 Industry Email Updates at http://www.cms.gov/Medicare/Coding/ICD10/CMS_ICD-10_Industry_Email_Updates.html and follow us on Twitter at: https://twitter.com/CMSGov

For Home Health and Hospice Providers

MM8182 (Revised): Standardizing the Standard - Operating Rules for Code Usage in Remittance Advice


MLN Matters® Number: MM8182 Revised
Related CR Release Date: August 30, 2013
Related CR Transmittal #: R1291OTN

Related Change Request (CR) #: CR 8182
Effective Date: October 1, 2013
Implementation Date: October 7, 2013, except January 6, 2014, for claims processed by DME MACs

Note: This article was revised on September 4, 2013, to reflect a revised CR 8182 issued on August 30. In this article, the CR release date, transmittal number, the implementation date, and the Internet address for accessing the CR were revised. This article was also revised on September 16, 2013, to add a reference to MM8365 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8365.pdf) for business scenarios, descriptions and updates related to Rule 3 of the Operating Rule Set – CORE-defined Claim Adjustment and Denials to become effective January 1, 2014. All other information remains the same.

Provider Types Affected

This MLN Matters® article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare administrative contractors (A/B MACs),
What You Need To Know

CR 8182, from which this article is taken, instructs your Medicare contractor to implement the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set for code usage in Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) by January 1, 2014.

Background

The Health Insurance Portability and Accountability Act (HIPAA) amended Title XI of the Social Security Act by adding Part C (Administrative Simplification), which requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards for certain transactions to enable health information to be exchanged more efficiently; and to achieve greater uniformity in its transmission. (Please refer to Public Law 104-191, Health Insurance Portability and Accountability Act of 1996, which you can find at http://aspe.hhs.gov/admnsimp/pl104191.htm#1173 on the internet.)

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions and by mandating the adoption of a set of operating rules for each of the HIPAA transactions. In December 2011 Congressional testimony, the National Committee on Vital and Health Statistics (NCVHS) stated that the transition to Electronic Data Interchange (EDI) from paper has been slow and “disappointing.” (You can find a copy of this testimony at http://www.ncvhs.hhs.gov/ on the internet.)

Note: The same rules will also apply to Standard Paper Remittance (SPR), as Medicare reports the same standard codes in both electronic and paper formats of remittance advice.

The EFT & ERA Operating Rule Set includes the following rules:
(Please note that CR 8182 focuses only on rule numbers 3 and 4)

1. Phase III CORE 380 EFT Enrollment Data Rule;
2. Phase III CORE 382 ERA Enrollment Data Rule;
3. Phase III Core 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule;
4. CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III Core Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule;
5. Phase III CORE 370 EFT & ERA Re-association (CCD+/835) Rule; and
6. Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.

HIPAA initially mandated the standard code sets that a health plan may use to explain to providers/suppliers how a claim/line has been adjudicated, and now the ERA/EFT Operating Rules under the Affordable Care Act are mandating a standard use of those standard codes. The ERA/EFT Operating Rules mandate consistent and uniform use of Remittance Advice (RA) codes (Group Codes, Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)) to mitigate confusion that may result in:

- Unnecessary manual provider follow-up;
- Faulty electronic secondary billing;
Inappropriate write-offs of billable charges;
Incorrect billing of patients for co-pays and deductibles, and/or
Posting delay.

Business Scenarios

The CORE Phase III ERA/EFT Operating Rules define four Business Scenarios, and specify the maximum set of the standard codes that a health plan may use. This list will be updated and maintained by a CORE Task Group when the two code committees update the lists and/or when there is need for additional combinations based on business policy change and/or Federal/State Mandate.

The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for each business scenario is specified in the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule), that is an attachment to CR 8182. This list of code combinations will be updated by CAQH CORE on a regular basis, and for Medicare, the updated list will be a part of the recurring code update CR (published 4 times a year) in the future.

Additionally, you should be aware that Medicare is implementing the code combinations that relate to these four scenarios in October 2013, as follows:

Scenario #1 - Additional Information Required -
Missing/Invalid/Incomplete Documentation
This scenario refers to situations in which additional documentation is needed from the billing provider or an ERA from a prior payer.

Scenario #2 - Additional Information Required –
Missing/Invalid/Incomplete Data from Submitted Claim
This scenario refers to situations in which additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

Scenario #3 - Billed Service Not Covered by Health Plan
This scenario refers to situations in which the billed service is not covered by the health plan.

Scenario #4 - Benefit for Billed Service Not Separately Payable
This scenario refers to situations in which the billed service or benefit is not separately payable by the health plan.

Finally, by October 7, 2013, the Medicare Remit Easy Print (MREP) and PC Print software will be modified as necessary.

Additional Information

The official instruction, CR 8182, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1291OTN.pdf on the CMS website. You will find a copy of the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule) 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.
MM8268 (Revised): Redaction of Health Insurance Claim Numbers (HICNs) in Medicare Redetermination Notices (MRNs)

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the MM8268 Medicare Learning Network® (MLN) Matters article, “Redaction of Health Insurance Claim Numbers (HICNs) in Medicare Redetermination Notices (MRNs),” which was published in the September 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: MM8268 Revised Related Change Request (CR) #: CR 8268
Related CR Release Date: September 25, 2013 Effective Date: January 1, 2014
Related CR Transmittal #: R1296OTN Implementation Date: January 6, 2014

Note: This article was revised on September 27, 2013, to reflect the release of a new Change Request (CR), dated September 25, 2013. The revised CR instructs contractors not to auto-populate the HICNs on reconsideration request forms. The transmittal number, CR release date and Web address for the CR also changed. All other information remains the same.

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

What You Need to Know
This article is based on CR 8268, which instructs the MACs to redact HICNs on all MRNs. Make sure that your billing staffs are aware of this change.

Background
Medicare contractors are required to issue a notice of Medicare redetermination after an appeal is requested in accordance with 42 CFR Section 405.956. One of the elements in the MRN is the beneficiary’s HICN. To ensure that contractors protect personally identifiable information, CMS is requesting that all contractors redact the HICNs in the MRNs. The HICNs will be redacted by replacing 5 or more values of the HICN with Xs or asterisks (*) with the last 4 or 5 digits of the HICN displayed. This applies to HICNs with both alpha and numeric digits.

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

MM8348: Display of ICD-10 Local Coverage Determinations (LCDs) on the Medicare Coverage Database (MCD)

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: MM8348
Related CR Release Date: September 6, 2013
Related CR Transmittal #: R1293OTN

Effective Date: October 7, 2013
Implementation Date: April 10, 2014

Provider Types Affected
This MLN Matters® article is intended for physicians, other providers, and suppliers who submit claims to Medicare claims administration contractors (carriers, 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.

Provider Action Needed
This article is based on CR 8348 which is issued by CMS to ensure that International Classification of Diseases, Tenth Revision (ICD-10) LCDs and articles are published in the Medicare Coverage Database (MCD) in a timely manner to allow providers sufficient time to make provider specific billing system changes. Make sure that your billing staff is aware of these changes.

Background
CR 8348 instructs that all ICD-10 LCDs and associated ICD-10 articles will be published on the Medicare Coverage Database (MCD) no later than April 10, 2014. All other LCDs and articles (i.e., those LCDs and articles that do not contain ICD-10 information, or articles not attached to an LCD) will be published on the MCD no later than September 4, 2014.

Note: All LCDs and Articles will receive a new LCD/Article ID number. For example, LCD ID 1234 might become LCD ID 4567.

The new LCD/Article ID number could have an impact on MACs local systems, such as changing their Medicare Summary Notice to capture the new LCD/Article ID number.

CMS has determined that although new LCD numbers will be assigned to the ICD-10 LCD policies, the policies will not be considered new policies. CMS considers this type of update to be a coding revision that does not change the intent of coverage/non-coverage within an LCD. Therefore, if a MAC only translates ICD-9 codes to the appropriate ICD-10 code, the policy does not need to be vetted through their Carrier Advisory Committee or be sent through the public comment and notice process.

However, if a MAC decides to revise more than just the ICD-10 code(s), they will follow the normal LCD development process outlined in the “Medicare Program Integrity Manual” (Publication 100-08, Chapter 13 (Local Coverage Determinations)) at http://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/pim83c13.pdf on the CMS website.
For Home Health and Hospice Providers

**MM8378 (Revised): New Claim Adjustment Reason Code (CARC) to Identify a Reduction in Payment Due to Sequestration**

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the MM8386 Medicare Learning Network® (MLN) Matters article, “New Claim Adjustment Reason Code (CARC) to Identify a Reduction in Federal Spending Due to Sequestration,” which was published in the September 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

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**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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**MM8378 (Revised): New Claim Adjustment Reason Code (CARC) to Identify a Reduction in Payment Due to Sequestration**

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the MM8386 Medicare Learning Network® (MLN) Matters article, “New Claim Adjustment Reason Code (CARC) to Identify a Reduction in Federal Spending Due to Sequestration,” which was published in the September 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

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**MLN Matters® Number:** MM8378 *Revised*  
**Related Change Request (CR) #:** CR 8378  
**Related CR Release Date:** July 25, 2013  
**Effective Date:** June 3, 2013  
**Related CR Transmittal #:** R2739CP  
**Implementation Date:** January 6, 2014

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**Note:** This article was revised on September 5, 2013, to revise the title to be consistent with the Change Request. All other information is unchanged.

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**Provider Types Affected**

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

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**Provider Action Needed**

This article is based on CR 8378 which informs Medicare contractors about a new Claim Adjustment Reason Code (CARC) reported when payments are reduced due to Sequestration. Make sure that your billing staffs are aware of these changes.

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**Background**

As required by law, President Obama issued a sequestration order on March 1, 2013, canceling budgetary resources across the Federal Government. As a result, Medicare Fee-For-Service claims, with dates of service or dates of discharge on or after April 1, 2013, incur a two percent reduction in Medicare payment. CMS previously assigned CARC 223 (Adjustment code for mandated Federal, State or Local law/regulation that is not already covered by another code and is mandated before a new code can be created) to explain the adjustment in payment.

Effective June 3, 2013, a new CARC was created and will replace CARC 223 on all applicable claims. The new CARC is as follows:

- **253 - Sequestration - Reduction in Federal Spending**
Also, Medicare contractors will not take any action on claims processed prior to implementation of CR 8378.

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

MM8386 (Revised): October Update to the Calendar Year (CY) 2013 Medicare Physician Fee Schedule Database (MPFSDB)

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the MM8386 Medicare Learning Network® (MLN) Matters article, “October Update to the Calendar Year (CY) 2013 Medicare Physician Fee Schedule Database (MPFSDB),” which was published in the September 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: MM8386 Revised Related Change Request (CR) #: CR 8386
Related CR Release Date: September 10, 2013 Effective Date: October 1, 2013
Related CR Transmittal #: R2784CP Implementation Date: October 7, 2013

Note: This article was revised on September 10, 2013, to reflect the revised CR 8386 issued on September 10. In the article, 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 physicians and other providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services that are paid under the Medicare Physician Fee Schedule Database (MPFSDB).

What You Need To Know
This article is based on CR 8386 and instructs Medicare contractors to download and implement a new MPFSDB, effective October 1, 2013.

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

CR 8386, from which this article is taken, announces that the MPFSDB has been updated effective October 1, 2013; and new payment files were issued to your contractor(s) based upon the CY 2013 Medicare Physician Fee Schedule (MPFS) Final Rule (published in the Federal Register on November 16, 2012); as modified by the
American Taxpayer Relief Act of 2012 (applicable January 1, 2013, see http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html), and the October 1, 2013, updated payment files.

Key changes for the October are as follows:

- Medicare contractors add HCPCS code G9187 (BPCI Home Visit) to their systems with an effective date of October 1, 2013; and
- The effective date of HCPCS code G0460 (Autologous Platelet-Rich Plasma (PRP) for Chronic Non-Healing Wounds) is adjusted to be August 2, 2012.

For more information and access to the CY 2013 Final Rule, see the “Physician Fee Schedule” webpage available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html on the CMS website.

CMS will notify your contractors when the new files are available for retrieval, and CR 8386 instructs them to provide you 30 days’ notice before implementing the changes. Further, while they do not have to search their files to either retract payment for claims already paid, or to retroactively pay claims; they will adjust claims that you bring to their attention.

**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**

**MM8434: Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - January 2014**

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/Transmittals/2013-Transmittals.html

**MLN Matters® Number:** MM8434  
**Related Change Request (CR) #:** CR 8434  
**Related CR Release Date:** September 20, 2013  
**Effective Date:** January 1, 2014  
**Related CR Transmittal #:** R2793CP  
**Implementation Date:** January 6, 2014

**Provider Types Affected**

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

**What You Need to Know**

CMS issued CR 8434 to provide the DMEPOS Competitive Bidding Program (CBP) January 2014 quarterly update. CR 8434 provides specific instructions for implementing
Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new CBP 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 awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition 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 CBP was to be phased in so that competition under the program would first occur in 10 Metropolitan Statistical Areas (MSAs) areas in 2007. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008 and made other limited changes. As required by MIPPA, CMS conducted the supplier competition in nine MSAs in 2009, referring to it as the Round 1 Rebid. The Round 1 Rebid contracts and prices became effective on January 1, 2011.

MIPPA also delayed the competition for Round 2 from 2009 to 2011 and authorized national mail-order competitions after 2010. The Affordable Care Act expanded the number of Round 2 MSAs from 70 to 91. Contracts and prices for Round 2 and the national mail-order program for diabetic testing supplies went into effect on July 1, 2013.

CMS is required by law to recompete contracts for the DMEPOS CBP at least once every three years. The Round 1 Rebid contract period for all product categories except mail-order diabetic supplies expires on December 31, 2013. (The Round 1 Rebid mail-order diabetic supply contracts expired on December 31, 2012.) CMS is conducting the Round 1 Recompete in the same competitive bidding areas as the Round 1 Rebid.

You can find additional information on the DMEPOS CBP at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html](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](http://www.dmecompetitivebid.com/palmetto/cbic.nsf) on the Internet. The information at this site includes information on all rounds of the CBP, including product categories; single payment amounts for the Round 1 Rebid, Round 2, and the national mail-order program for diabetic testing supplies; and the ZIP codes of areas included in the CBP.

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

**MM8446: Claim Status Category and Claim Status Codes Update**


**MLN Matters® Number:** MM8446  
**Related Change Request (CR) #:** CR 8446  
**Related CR Release Date:** September 20, 2013  
**Related CR Transmittal #:** R2792CP  
**Effective Date:** January 1, 2014  
**Implementation Date:** January 6, 2014

**Provider Types Affected**

This MLN Matters® article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FI), 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**

CMS issued CR 8446, from which this article is taken, and 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.**


**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 8446 (January 1, 2014), your Medicare contractor will:

1. Complete the entry of all applicable code text changes and new codes;
2. Terminate the use of deactivated codes; and
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**

**MM8448: January 2014 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files**


**MLN Matters® Number:** MM8448  
**Related Change Request (CR) #:** CR 8448  
**Related CR Transmittal #:** R2780CP  
**Related CR Release Date:** September 6, 2013  
**Effective Date:** January 1, 2014  
**Implementation Date:** January 6, 2014

**Provider Types Affected**

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

**Provider Action Needed**

This article is based on CR 8448 which instructs Medicare contractors to download and implement the January 2014 Average Sales Price (ASP) drug pricing files; and, if released by the CMS, the October 2013, July 2013, April 2013, and January 2013 drug pricing files for Medicare Part B drugs.

Medicare will use the January 2014 ASP and Not Other Classified (NOC) drug pricing files to:

- Determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2014, with dates of service January 1, 2014, through March 31, 2014; and
- Update the drug payment limits for claims for infusion drugs furnished through a covered item of DME processed or reprocessed on or after January 1, 2014, with dates of service on or after January 1, 2014.

You should make sure that your billing staffs are aware of these changes.

**Background**

The Medicare Modernization Act of 2003 (MMA) Section 303(c) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost, or prospective payment, basis.
The Average Sales Price (ASP) methodology is based on quarterly data that manufacturers submit to CMS; who will quarterly supply Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs. 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).


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

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2014 ASP and ASP NOC</td>
<td>January 1, 2014, through March 31, 2014</td>
</tr>
<tr>
<td>October 2013 ASP and ASP NOC</td>
<td>October 1, 2013, through December 31, 2013</td>
</tr>
<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>
</tbody>
</table>

Please note that: 1) The ASP and NOC drug pricing files will contain the applicable payment allowance limits (i.e., 106% ASP, 106% Wholesale Acquisition Cost (WAC), or 95% Actual Wholesale Price (AWP)); and as a result, your Medicare contractor will not make any additional payment calculations; 2) For any drug or biological not listed in the ASP or NOC drug pricing files, your contractor will determine the payment allowance limits in accordance with the policy described in the Medicare Claims Processing Manual, Chapter 17 (Drugs and Biologicals), Section 20.1.3 (Exceptions to Average Sales Price (ASP) Payment Methodology); which you can find at http://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/downloads/clm104c17.pdf on the CMS website; and 3) Your MAC will seek payment allowances from their local carrier for drugs and biologicals that are not on the ASP file.

In addition, you should be aware that your MAC will not search and adjust claims that have already been processed unless you bring them to their attention.

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

MLN Education Products Update**

The following products have recently been released or updated by the Centers for Medicare & Medicaid Services (CMS). To review all of the educational products available, go to the MLN Products Web page at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html on the CMS website.

- The **ICD-10 Classification Enhancements**, Fact Sheet, ICN 903187, Hard Copy-

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 http://www.cgsmedicare.com. © 2013 Copyright, CGS Administrators, LLC.
• The “General Equivalence Mappings Frequently Asked Questions,” Booklet, ICN 901743, at http://www.cms.gov/Medicare/Coding/ICD10/Downloads/GEMs-CrosswalksBasicFAQ.pdf has been revised and is available in downloadable format only.

• Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Contact Information, Fact Sheet, ICN 903766, at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_Contact_FactSheet_ICN903766.pdf is available in downloadable format only.

For Home Health and Hospice Providers

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

• ICD-10: Implementation for Physicians, Partial Code Freeze, and MS-DRG Conversion Project MLN Connects™ Video - Are you ready to transition to ICD-10 on October 1, 2014? In this MLN Connects™ video on the CMS YouTube Channel at http://www.youtube.com/watch?v=WLGofe1nP Ao&feature=youtu.be, Pat Brooks and Dr. Daniel Duvall from the Hospital and Ambulatory Policy Group of the Center for Medicare discuss the transition to ICD-10 for medical diagnosis and inpatient procedure coding:
  ▪ Hints for a smooth transition to ICD-10 in physician offices
  ▪ ICD-10 Implementation and preparation strategies
  ▪ Partial freeze prior to ICD-10 implementation
  ▪ Medicare Severity Diagnosis Related Grouper (MS-DRG) Conversion Project at CMS

• Want to stay connected about the latest new and revised Medicare Learning Network® (MLN) products and services? Subscribe to the MLN Educational Products electronic mailing list! For more information about the MLN and how to register for this service, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MLNProducts_listserv.pdf and start receiving updates immediately!

• MLN Matters® Articles Index: Have you ever tried to search MLN Matters® articles for information regarding a certain issue, but you did not know what year it was published? To assist you next time in your search, try the CMS article indexes that are published at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html on the CMS website. These indexes resemble the index in the back of a book and contain keywords found in the articles, including HCPCS codes and modifiers. These are published every month. Just search on a keyword(s) and you will find articles that contained those word(s). Then just click on one of the related article numbers and it will open that document. Give it a try.
System and 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, Option 1) will be closed for training.

<table>
<thead>
<tr>
<th>CSR Training Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday, November 11, 2013 (Federal Holiday)</td>
<td>8:00 a.m. – 4:30 p.m. (Central Time)</td>
</tr>
</tbody>
</table>

System Availability/Cycles—Thanksgiving Holiday

While we celebrate the Thanksgiving holiday with our families, our office will be closed on Thursday and Friday, November 28 and 29, 2013. Our data center has informed us that the Fiscal Intermediary Standard System (FISS) will not be available on Thursday, November 28, 2013. However, FISS, ELGA, and ELGH will be available on Friday, November 29, 2013. In addition, FISS will not cycle, which means that claims will not be sent to the Common Working File (CWF) either night. Medicare Remittance Advices, Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfer (EFTs) will not be produced on November 28 and 29.

The Interactive Voice Response (IVR) (1.877.220.6289) is available for assistance in obtaining patient eligibility information, claim and deductible information, and general information. For information about the IVR, access the IVR User Guide at http://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf on the CGS website. In addition, CGS’ Internet portal, myCGS, is 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 Web page.

For Home Health and Hospice Providers

November 2013 Webinar Schedule

The Provider Outreach and Education (POE) department offers several educational programs through webinars and teleconferences throughout the year. However, at this time, no events are scheduled in November. Please visit the “Calendar of Educational Events” Web page at https://www.cgsmedicare.com/hhh/education/webinars.html for future 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.