HOME HEALTH PROVIDERS

Home Health Billing Clarification for New G-Codes ........................................ 3

MM9406: Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2016 ................................................................. 4

SE1524: Selecting Home Health Claims for Probe and Educate Review: Episodes that Begin on or After August 1, 2015 .................................................. 9

HOSPICE PROVIDERS

Submit Adjustments for Oral Anti-Cancer and Anti-emetic Drugs .................................. 11

HOME HEALTH & HOSPICE PROVIDERS

CGS Website Updates .................................................................................. 11

Each Office Visit is an Opportunity to Recommend Influenza Vaccination .......................... 13

Medicare Credit Balance Quarterly Reminder .............................................. 13

MM9168: Reporting Principal and Interest Amounts When Refunding Previously Recouped Money on the Remittance Advice (RA) .................................... 14

MM9386: Update to the List of Compendia as Authoritative Sources for Use in the Determination of a “Medically-Accepted Indication” of Drugs and Biologicals Used Off-label in an Anti-Cancer Chemotherapeutic Regimen .................................................. 15

MLN Connects™ Provider eNews ............................................................... 17

NEW Fax Number for Medical Review Additional Development Requests (MR ADR) and Non-MR ADRs ................................................................. 18

News Flash Messages from the Centers for Medicare & Medicaid Services (CMS) ................................................................. 18

Provider Contact Center (PCC) Availability .............................................. 19

Quarterly Provider Update ........................................................................ 19

Requesting a Reopening: Good to Know ................................................... 20

SE1408 (Revised): Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492 .................................................. 21

Stay Informed and Join the CGS ListServ Notification Service ..................... 25

Unsolicited/Voluntary Refunds .................................................................. 25

Upcoming Educational Events .................................................................. 26
For Home Health Providers

Home Health Billing Clarification for New G-Codes

Change Request (CR) 9369 established two new G-codes, G0299 (services of a registered nurse) and G0300 (services of a licensed practical nurse) to differentiate levels of nursing services provided during a hospice stay and a home health episode of care.

CGS has received questions from home health providers in regard to billing two new G-codes (G0299 and G0300) when a final claim spans 2015/2016 dates. The Centers for Medicare & Medicaid Services (CMS) has provided clarification. For home health episodes that span January 1, 2016, report G0154 for 2015 visits. The new codes, G0299 or G0300, would be reported for visits made in 2016. The G0154 code will no longer be allowed for visits made on or after January 1, 2016.

**MM9406: Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2016**

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html)

**MLN Matters® Number:** MM9406  
**Change Request (CR) #:** CR 9406  
**Related CR Release Date:** October 23, 2015  
**Effective Date:** January 1, 2016  
**Related CR Transmittal #:** R3383CP  
**Implementation Date:** January 4, 2016

**Provider Types Affected**

This MLN Matters® Article is intended for Home Health Agencies (HHAs) submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

**Provider Action Needed**

CR 9406 informs providers about updates to the 60-day national episode rates, the national per-visit amounts, Low-Utilization Payment Adjustment (LUPA) add-on amounts, and the non-routine medical supply payment amounts under the HH PPS for CY 2016. Make sure your billing staff is aware of this update.

**Background**

The Affordable Care Act mandated several changes to Section 1895(b) of the Social Security Act (the Act) and hence the HH PPS Update for CY 2016.

Section 3131(a) of the Affordable Care Act mandated that starting in CY 2014, the Secretary must apply an adjustment to the national, standardized 60-day episode payment rate and other amounts applicable under Section 1895(b)(3)(A)(ii)(III) of the Act to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. In addition, Section 3131(a) of the Affordable Care Act mandates that this rebasing must be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the amount (or amounts), as of the date of enactment, applicable under Section 1895(b)(3)(A)(ii)(III) of the Act, and be fully implemented by CY 2017.

Section 3401(e) of the ACA requires that the market basket percentage under the HH PPS be annually adjusted by changes in economy-wide productivity for CY 2015 and each subsequent calendar year.

In addition to the Affordable Care Act mandates, Section 421(a) of the Medicare Modernization Act (MMA), as amended by Section 210 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10), provides an increase of 3 percent of the payment amount otherwise made under Section 1895 of the Act for home health services furnished in a rural area (as defined in Section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2018. The statute waives budget neutrality related to this provision, as the statute specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under Section 1895 of the Act applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.
Market Basket Update

The CY 2016 HH market basket update is 2.3 percent which is then reduced by a multi-factor productivity (MFP) adjustment of 0.4 percentage points. The resulting HH payment update is equal to 1.9 percent. HHAs that do not report the required quality data will receive a 2 percentage point reduction to the HH payment update of 1.9 percent.

National Standardized 60-Day Episode Payment

As described in the CY 2016 final rule, to determine the CY 2016 national, standardized 60-day episode payment rate, CMS applies a wage index budget neutrality factor of 1.0011 and a case-mix budget neutrality factor of 1.0187 to the previous calendar year’s national, standardized 60-day episode rate ($2,961.38). In order to account for nominal case-mix growth from CY 2012 to CY 2013, CMS applies a payment reduction of 0.97 percent to the CY 2016 national, standardized 60-day episode payment rate. This reduction will also be applied to the CY 2017 and CY 2018 national, standardized 60-day episode payment rate. CMS then applies an $80.95 reduction (which is 3.5 percent of the CY 2010 national, standardized 60-day episode rate of $2,312.94) to the national, standardized 60-day episode rate. Lastly, the national, standardized 60-day episode payment rate is updated by the CY 2016 HH payment update percentage of 1.9 percent for HHAs that submit the required quality data and by 1.9 percent minus 2 percentage points or -0.1 percent for HHAs that do not submit quality data. These two episode payment rates are shown in Tables 1 and 2 below. These payments are further adjusted by the individual episode’s case-mix weight and by the wage index.

Table 1: For HHAs that DO Submit Quality Data – National 60-Day Episode Amounts Updated by the MFP adjusted Home Health Market Basket Update for CY 2016 Before Case-Mix Adjustment, Wage Index Adjustment Based on the Site of Service for the Beneficiary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,961.38</td>
<td>X 1.0011</td>
<td>X 1.0187</td>
<td>X 0.9903</td>
<td>-$80.95</td>
<td>X 1.019</td>
<td>=$2,965.12</td>
</tr>
</tbody>
</table>

Table 2: For HHAs that DO NOT Submit Quality Data – National 60-Day Episode Amounts Updated by the MFP adjusted Home Health Market Basket Update for CY 2016 Before Case-Mix Adjustment, Wage Index Adjustment Based on the Site of Service for the Beneficiary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,961.38</td>
<td>X 1.0011</td>
<td>X 1.0187</td>
<td>X 0.9903</td>
<td>-$80.95</td>
<td>X 0.999</td>
<td>=$2,906.92</td>
</tr>
</tbody>
</table>

National Per-Visit Rates

To calculate the CY 2016 national per-visit payment rates, CMS starts with the CY 2015 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0010 to ensure budget neutrality for LUPA per-visit payments after applying the CY 2016 wage index, and then applies the maximum rebasing adjustments to the per-visit rates for each discipline. The per-visit rates are then updated by the CY 2016 HH payment update of 1.9 percent for HHAs that submit the required quality data and by -0.1 percent for HHAs that do not submit quality data. The per-visit rates are shown in Tables 3 and 4.

Table 3: For HHAs that DO Submit Quality Data – CY 2016 National Per-Visit Amounts for LUPAs and Outlier Calculations Updated by the MFP adjusted HH Market Basket Update, Before Wage Index Adjustment

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2015 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>2016 Rebasing Adjustment</th>
<th>CY 2016 HH Payment Update Percentage</th>
<th>CY 2016 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$57.89</td>
<td>X 1.0010</td>
<td>+$1.79</td>
<td>X 1.019</td>
<td>$60.87</td>
</tr>
</tbody>
</table>
### Table 3: For HHAs that DO Submit Quality Data – CY 2016 National Per-Visit Amounts for LUPAs and Outlier Calculations Updated by the MFP adjusted HH Market Basket Update, Before Wage Index Adjustment

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2015 Per-Visit Payment</th>
<th>Wage Index Budget Multiples</th>
<th>2016 Rebasining Adjustment</th>
<th>CY 2016 HH Payment Update Percentage</th>
<th>CY 2016 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Social Services</td>
<td>$204.91</td>
<td>X 1.0010</td>
<td>+$6.34</td>
<td>X 1.019</td>
<td>$215.47</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$140.70</td>
<td>X 1.0010</td>
<td>+$4.35</td>
<td>X 1.019</td>
<td>$147.95</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$139.75</td>
<td>X 1.0010</td>
<td>+$4.32</td>
<td>X 1.019</td>
<td>$146.95</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$127.83</td>
<td>X 1.0010</td>
<td>+$3.96</td>
<td>X 1.019</td>
<td>$134.42</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$151.88</td>
<td>X 1.0010</td>
<td>+$4.70</td>
<td>X 1.019</td>
<td>$159.71</td>
</tr>
</tbody>
</table>

### Table 4: For HHAs that DO NOT Submit Quality Data – CY 2016 National Per-Visit Amounts for LUPAs and Outlier Calculations Updated by the MFP adjusted HH Market Basket Update, Before Wage Index Adjustment

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2015 Per-Visit Payment</th>
<th>Wage Index Budget Multiples</th>
<th>2016 Rebasining Adjustment</th>
<th>CY 2016 HH Payment Update Percentage</th>
<th>CY 2016 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$57.89</td>
<td>X 1.0010</td>
<td>+$1.79</td>
<td>X 0.999</td>
<td>$59.68</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$204.91</td>
<td>X 1.0010</td>
<td>+$6.34</td>
<td>X 0.999</td>
<td>$211.24</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$140.70</td>
<td>X 1.0010</td>
<td>+$4.35</td>
<td>X 0.999</td>
<td>$145.05</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$139.75</td>
<td>X 1.0010</td>
<td>+$4.32</td>
<td>X 0.999</td>
<td>$144.07</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$127.83</td>
<td>X 1.0010</td>
<td>+$3.96</td>
<td>X 0.999</td>
<td>$131.79</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$151.88</td>
<td>X 1.0010</td>
<td>+$4.70</td>
<td>X 0.999</td>
<td>$156.58</td>
</tr>
</tbody>
</table>

### LUPA Add-On Payments

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. Beginning in CY 2014, CMS calculates the payment for the first visit in a LUPA episode by multiplying the per-visit rate by a LUPA add-on factor specific to the type of visit (skilled nursing, physical therapy, speech-language pathology). The specific requirements for the new LUPA add-on calculation are described in CR 8380, Transmittal 2828 ([https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2828CP.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2828CP.pdf)) dated November 27, 2013. The LUPA add-on adjustment factors are displayed in Table 5.

### Table 5: CY 2016 LUPA Add-On Factors

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>Add-On Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td>1.8451</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>1.6700</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>1.6266</td>
</tr>
</tbody>
</table>

### Non-Routine Supply Payments

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by an NRS conversion factor. To determine the CY 2016 NRS conversion factors, CMS starts with the CY 2015 NRS conversion factor ($53.23) and applies a 2.82 percent rebasing adjustment as described in the CY 2016 final rule. CMS then updates the conversion factor by the CY 2016 HH payment update of 1.9 percent for HHAs that submit the required quality data and by -0.1 percent for HHAs that do not submit quality data. CMS does not apply a standardization factor as the NRS payment amount calculated from the conversion factor is not wage or case-mix adjusted when the final payment amount is computed. The NRS conversion factor for CY 2016 payments for HHAs that do submit the required quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b.
Table 6a: CY 2016 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2015 NRS Conversion Factor</th>
<th>2016 Rebas ing Adjustment</th>
<th>CY 2016 HH Payment Update Percentage</th>
<th>CY 2016 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$53.23</td>
<td>X 0.9718</td>
<td>X 1.019</td>
<td>$52.71</td>
</tr>
</tbody>
</table>

Table 6b: CY 2016 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2016 NRS Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.22</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$51.35</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$140.80</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$209.18</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$322.57</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$554.79</td>
</tr>
</tbody>
</table>

The NRS conversion factor for CY 2016 payments for HHAs that do not submit quality data is shown in Table 7a and the payment amounts for the various NRS severity levels are shown in Table 7b.

Table 7a: CY 2016 NRS Conversion Factor for HHAs that DO NOT Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2015 NRS Conversion Factor</th>
<th>2016 Rebas ing Adjustment</th>
<th>CY 2016 HH Payment Update Percentage</th>
<th>CY 2016 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$53.23</td>
<td>X 0.9718</td>
<td>X 0.999</td>
<td>$51.68</td>
</tr>
</tbody>
</table>

Table 7b: CY 2016 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2016 NRS Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$13.94</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$50.35</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$138.05</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$205.10</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$316.27</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$543.95</td>
</tr>
</tbody>
</table>

**Rural Add-On**

As stipulated in section 421(a) of the MMA, the 3 percent rural add-on is applied to the national standardized 60-day episode rate, national per-visit payment rates, LUPA add-on payments, and the NRS conversion factor when home health services are provided in rural (non-CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2018. Refer to Tables 8 through 10b for the CY 2016 rural payment rates.

Table 8a: CY 2016 Payment Amounts for 60-Day Episodes for Services Provided in a Rural Area Before Case-Mix and Wage Index Adjustment for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>CY 2016 National, Standardized 60-Day Episode Payment Rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2016 Rural National Standardized 60-Day Episode Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,965.12</td>
<td>X 1.03</td>
<td>$3,054.07</td>
</tr>
</tbody>
</table>

Table 8b: CY 2016 Payment Amounts for 60-Day Episodes for Services Provided in a Rural Area Before Case-Mix and Wage Index Adjustment for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>CY 2016 National, Standardized 60-Day Episode Payment Rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2016 Rural National Standardized 60-Day Episode Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,906.92</td>
<td>X 1.03</td>
<td>$2,994.13</td>
</tr>
</tbody>
</table>
Table 9a: CY 2016 Per-Visit Amounts for Services Provided in Rural Area, Before Wage Index Adjustment for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>Home Health Discipline Type</th>
<th>CY 2016 Per-Visit Rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2016 Rural Per-Visit Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH Aide</td>
<td>$60.87</td>
<td>X 1.03</td>
<td>$62.70</td>
</tr>
<tr>
<td>MSS</td>
<td>$215.47</td>
<td>X 1.03</td>
<td>$221.93</td>
</tr>
<tr>
<td>OT</td>
<td>$147.95</td>
<td>X 1.03</td>
<td>$152.39</td>
</tr>
<tr>
<td>PT</td>
<td>$146.95</td>
<td>X 1.03</td>
<td>$151.36</td>
</tr>
<tr>
<td>SN</td>
<td>$134.42</td>
<td>X 1.03</td>
<td>$138.45</td>
</tr>
<tr>
<td>SLP</td>
<td>$159.71</td>
<td>X 1.03</td>
<td>$164.50</td>
</tr>
</tbody>
</table>

Table 9b: CY 2016 Per-Visit Amounts for Services Provided in Rural Area, Before Wage Index Adjustment for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>Home Health Discipline Type</th>
<th>CY 2016 Per-Visit Rate</th>
<th>Multiply by the 3 Percent Rural Add-On</th>
<th>CY 2016 Rural Per-Visit Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH Aide</td>
<td>$59.68</td>
<td>X 1.03</td>
<td>$61.47</td>
</tr>
<tr>
<td>MSS</td>
<td>$211.24</td>
<td>X 1.03</td>
<td>$217.58</td>
</tr>
<tr>
<td>OT</td>
<td>$145.05</td>
<td>X 1.03</td>
<td>$149.40</td>
</tr>
<tr>
<td>PT</td>
<td>$144.07</td>
<td>X 1.03</td>
<td>$148.39</td>
</tr>
<tr>
<td>SN</td>
<td>$131.79</td>
<td>X 1.03</td>
<td>$135.74</td>
</tr>
<tr>
<td>SLP</td>
<td>$156.58</td>
<td>X 1.03</td>
<td>$161.28</td>
</tr>
</tbody>
</table>

Table 10a: CY 2016 Conversion Factor for Services Provided in Rural Areas

<table>
<thead>
<tr>
<th>For HHAs that DO Submit Quality Data</th>
<th>For HHAs that DO NOT Submit Quality Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2016 Conversion Rates</td>
<td>CY 2016 Rural Conversion Factor</td>
</tr>
<tr>
<td>Multiply by the 3 Percent Add-On</td>
<td>CY 2016 Conversion Rates</td>
</tr>
<tr>
<td>CY 2016 Rural Conversion Factor</td>
<td>Multiply by the 3 Percent Rural Add-On</td>
</tr>
<tr>
<td></td>
<td>CY 2016 Rural Conversion Factor</td>
</tr>
<tr>
<td>$52.71</td>
<td>$54.29</td>
</tr>
<tr>
<td>X 1.03</td>
<td>$51.68</td>
</tr>
<tr>
<td></td>
<td>X 1.03</td>
</tr>
<tr>
<td></td>
<td>$53.23</td>
</tr>
</tbody>
</table>

Table 10b: CY 2016 Relative Weights and Payment Amounts for the 6-Severity NRS System for Services Provided in Rural Areas

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>Total CY 2016 NRS Payment Amount for Rural Areas</th>
<th>Relative Weight</th>
<th>Total CY 2016 NRS Payment Amount for Rural Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.65</td>
<td>0.2698</td>
<td>$14.36</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$52.89</td>
<td>0.9742</td>
<td>$51.86</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$145.02</td>
<td>2.6712</td>
<td>$142.19</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$215.46</td>
<td>3.9686</td>
<td>$211.25</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$332.24</td>
<td>6.1198</td>
<td>$325.76</td>
</tr>
<tr>
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Clarification Regarding the Use of the “Initial Encounter” Seventh Character, Applicable to Certain ICD-10-CM Code Categories, under the HH PPS

The ICD-10-CM coding guidelines regarding the use of the seventh character assignment for diagnosis codes in Chapter 19, “Injury, Poisoning, and Certain Other Consequences of External Causes (S00–T88)” were revised. Based upon the revised guidance, coding certain diagnosis codes as “initial encounters” would be appropriate when the patient is receiving active treatment during a home health episode. Initial encounters are not based on chronology of care or whether the patient is seeing the same or a new provider for the same condition.

A revised translation list effective January 1, 2016, will be posted on the CMS website. Also effective, January 1, 2016, the Home Health Prospective Payment System Grouper logic will be revised to award points for certain initial encounter codes based upon the revised ICD-
10-CM coding guidelines for M0090 dates on or after October 1, 2015. HHAs should review their OASIS records and claims submitted between October 1, 2015 and December 31, 2015, to determine if they should submit a modification of their assessment and adjust their claim with a revised HIPPS code that was assigned to the OASIS record based upon the revised grouper logic.

These changes are implemented through the Home Health Pricer software found in Medicare contractor standard systems.

Additional Information

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

For Home Health Providers
SE1524: Selecting Home Health Claims for Probe and Educate Review: Episodes that Begin on or After August 1, 2015

The Centers for Medicare & Medicaid Services (CMS) has issued the following Special Edition Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html

MLN Matters® Number: SE1524
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Change Request (CR) #: N/A
Effective Date: Episodes beginning on or after August 1, 2015
Implementation Date: N/A

Provider Types Affected
This Special Edition MLN Matters® article is intended for Home Health Agencies (HHAs) submitting claims to Medicare Administrative Contractors (MACs) for home health services provided to Medicare beneficiaries.

Provider Action Needed
STOP – Impact to You
MACs, in conjunction with the Centers for Medicare & Medicaid Services (CMS), will be conducting medical review and reporting under the Home Health Probe & Educate medical review strategy. These reviews relate to claims submitted by HHAs related to Medicare home health services and patient eligibility (certification/re-certification), as outlined in CMS-1611-F (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1611-F.html).

CAUTION – What You Need to Know
Final rule CMS-1611-F eliminates the requirement of a face-to-face encounter narrative as part of the certification of patient eligibility for home health services.

GO – What You Need to Do
Make sure that your billing staff is aware of these revised policies.
Background
On November 6, 2014, CMS issued CMS-1611-F, Calendar Year (CY) 2015 Home Health Prospective Payment System (HH PPS) Final Rule. The changes, discussed below, were effective beginning January 1, 2015.

- Final rule CMS-1611-F eliminates the requirement of a face-to-face encounter narrative as part of the certification of patient eligibility for home health services.
- In determining whether the patient is or was eligible to receive services under the Medicare home health benefit at the start of care, documentation in the certifying physician’s medical records and/or the acute/post-acute care facility’s medical records (if the patient was directly admitted to home health) is to be used as the basis for certification of home health eligibility.
- The certifying physician can incorporate information obtained from or generated by the HHA into his or her medical record, to support the patient’s homebound status and need for skilled care, by including it in his or her documentation and signing and dating to demonstrate review and concurrence.

CMS is implementing a Probe and Educate medical review strategy to assess and promote provider understanding and compliance with the Medicare home health eligibility requirements. CMS is issuing guidance to MACs about how to select home health claims for review during the “Probe and Educate” program for home health episodes that began on or after August 1, 2015.

CMS anticipates MACs will begin sending Additional Documentation Requests (ADRs) after October 1, 2015, and that the first round of claim reviews and provider education will conclude in approximately one year. This document contains a summary of the technical direction that CMS will issue to the MACs.

Claims Subject to Review as Part of the Probe and Educate Process
CMS will direct Home Health MACs to select a sample of 5 claims for pre-payment review from each HHA within their jurisdiction. As they are completing the Probe and Educate reviews, MACs will focus on the HHA’s compliance with the policy outlined in CMS-1611-F, as well as to make sure all other coverage and payment requirements are met.

Based on the results of these initial reviews, MACs will conduct provider specific educational outreach. CMS will instruct MACs to deny each non-compliant claim and to outline the reasons for denial in a letter to the HHA, which will be sent at the conclusion of the probe review. We will also instruct the MACs to offer individualized telephone calls/education to all providers with errors in their claim sample. During such calls, the MAC will discuss the reasons for denials, provide pertinent education and reference materials, and answer questions.

In addition to these educational outreach efforts, for those providers that are identified as having moderate or major concerns, the MACs will repeat the Probe and Educate process for dates of services occurring after education has been provided. The following table outlines MAC actions following HHA probe reviews.
### Table of Concerns and Actions

<table>
<thead>
<tr>
<th>5 claim sample</th>
<th>No or Minor Concerns</th>
<th>Moderate/Major Concerns</th>
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<td></td>
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<td>Action</td>
</tr>
<tr>
<td></td>
<td>0-1*</td>
<td>2-5*</td>
</tr>
</tbody>
</table>
| Action         | For each provider with no or minor concerns, CMS will direct the MAC to:  
1. Deny non-compliant claims; and  
2. Send detailed review results letters explaining each denial.  
3. Send summary letter that:  
   • Offers the provider a one-to-one phone call to discuss claim denials if any; and  
   • Indicates that no more reviews will be conducted under the Probe & Educate process.  
4. Await further instruction from CMS | For each provider with major to moderate concerns CMS will direct the MAC to:  
1. Deny non-compliant claims; and  
2. Send detailed review results letters explaining each denial.  
3. Send summary letter that:  
   • Offers the provider a one-to-one phone call to discuss claim denials; and  
   • Indicates the review contractor will REPEAT Probe & Educate process with an additional five claim sample; and.  
4. Repeat Probe & Educate of five claims with dates on or after the implementation the implementation of education. |

*Note: If the HHA fails to submit five claims, the provider will be considered of moderate concern (unless four claims were reviewed and the MAC approved all four).

### 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 Hospice Providers**

**Submit Adjustments for Oral Anti-Cancer and Anti-emetic Drugs**

The Centers for Medicare & Medicaid Services (CMS) issued the Medicare Learning Network (MLN) Matters® article, MM9255, “Reporting of Anti-Cancer and Anti-Emetic Drugs.” This article explained that a Common Working File (CWF) edit restricted the hospice type of bill for certain anti-cancer and anti-emetic drugs. As a result, CMS instructed hospices to remove the drug codes from their claims to allow them to process until the error is corrected on January 4, 2016.

Beginning on/after January 4, 2016, hospice providers are encouraged to submit claim adjustments to add the unreported drug services in order to represent all their service costs in the claims data.


**For Home Health and Hospice Providers**

**CGS Website Updates**

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

Please review the following updates:

- The “Review of Documentation” section of the “Medical Review Additional Development Request (ADR) Process” Web page at [http://www.cgsmedicare.com/hhh/medreview/adr_process.html](http://www.cgsmedicare.com/hhh/medreview/adr_process.html) was updated to include that for demand denials
(condition code 20), CGS has 60 days from the date the documentation is received to review the documentation.

- The “Home Health Payment Rates” Web Page at http://www.cgsmedicare.com/hhh/claims/fees/hhpps_rates.html was updated with the calendar year 2016 rates.


- The “Home Health Denial Reason Codes” Web page at http://www.cgsmedicare.com/hhh/medreview/hh_drc.html and the “Hospice Denial Reason Codes” Web page at http://www.cgsmedicare.com/hhh/medreview/hos_drc.html were updated to include the new standard messages provided by the Centers for Medicare & Medicaid Services (CMS) for use when adjudicating home health and hospice claims.

- The “Medical Review Widespread Edits” Web page at http://www.cgsmedicare.com/hhh/medreview/med_review_edits.html was updated to remove the 52xxT edit from the home health list.

- The new Online Education Course (OEC), “FISS Course 2: Login and Menu Options” is now available from the “Online Education Center” at http://www.cgsmedicare.com/medicare_dynamic/education/001.asp for home health and hospice providers.

- The “Hospice Prescription Drug Reporting Table” quick resource tool (QRT) at http://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_presdrugreportingtable.pdf has been updated to include the link to the 2016 Table of Drugs from the Centers for Medicare & Medicaid Services (CMS) website.

- The “Summary of Hospice Changes” QRT at http://www.cgsmedicare.com/hhh/education/materials/pdf/summary_hospice_tools.pdf was updated to include a summary of the Change Requests 8877 and 9114.

- The “Hospice Medicare Billing Codes Sheet” QRT at http://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_medicare_billing_codes_sheet.pdf and the “Home Health Medicare Billing Codes Sheet” QRT at http://www.cgsmedicare.com/hhh/education/materials/pdf/home_health_billing_codes.pdf were updated to include the new skilled nursing HCPCS codes G0299 and G0300, which are valid for services on/after January 1, 2016, and to update HCPCS code G0154, which is not valid for services on/after January 1, 2016.

- The following Web pages/resources have been updated with the new fax number for additional development requests (ADRs). For more information, refer to the article, “NEW Fax Number for Medical Review Additional Development Requests (MR ADR) and Non-MR ADRs” found later in this bulletin.

  - Home Health Probe and Education Medical review – http://www.cgsmedicare.com/hhh/medreview/hh_probe_educate_mr.html
  - Requesting an Exception for an Untimely NOE – http://www.cgsmedicare.com/hhh/education/materials/requesting_exception_un timely_noes.html
For Home Health and Hospice Providers
Each Office Visit is an Opportunity to Recommend Influenza Vaccination

Protect your patients, your staff, and yourself. Medicare Part B covers one influenza vaccination and its administration each influenza season for Medicare beneficiaries.

If medically necessary, Medicare may cover additional seasonal influenza vaccinations.

- Preventive Services Educational Tool - [https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf](https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf)
- CDC Influenza website - [http://www.cdc.gov/FLU/](http://www.cdc.gov/FLU/)

For Home Health and Hospice Providers
Medicare Credit Balance Quarterly Reminder

This article is a reminder to submit the Quarterly Medicare Credit Balance Report. The next report is due in our office postmarked by **January 30, 2016**, for the quarter ending **December 31, 2015**. A Medicare credit balance is an amount determined to be refundable to the Medicare program for an improper or excess payment made to a provider because of patient billing or claims processing errors.

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

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

To ensure timely receipt and processing, send the CMS-838/Certification within 30 days of the quarter end date using one of the options below:

- **Reports may be faxed to:** MCBR Receipts
  
  **Attn:** Credit Balance Reporting
  
  **Fax:** 1.615.664.5987
Please note that if you have or will be submitting an adjustment, please send the UB-04 along with the CMS-838 form.

• If you are issuing a refund check for a credit balance:
  Send the CMS-838 and a copy of the refund check using one of the options listed above.

  Send the refund check with a copy of the CMS-838 or documentation that indicates the check is for a credit balance, the quarter end date, and provider number associated with the check to the following address:

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

If you have general questions related to the Credit Balance report, refer to the CGS Credit Balance Report (Form CMS-838) website at http://www.cgsmedicare.com/hhh/financial/CMS-588.html or call the Provider Contact Center at 1.877.299.4500 (Option 1). If you have questions about withholding, call 1.877.299.4500 and select Option 4.

**For Home Health and Hospice Providers**

**MM9168: Reporting Principal and Interest Amounts When Refunding Previously Recouped Money on the Remittance Advice (RA)**

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html

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<td>Related CR Release Date: November 6, 2015</td>
<td>Effective Date: July 1, 2016</td>
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<tr>
<td>Related CR Transmittal #: R1570OTN</td>
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**Provider Types Affected**

This MLN Matters® Article is intended for physicians, providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

**Provider Action Needed**

Change Request (CR) 9168 explains to providers who received a favorable appeals decision that it will be easier and consequently more transparent to identify the claim and/or the refund of principal and interest paid by Medicare. Your MAC will make sure that the remittance advices are reporting the refunded principal and interest amounts separately, and provide individual claim information. CR9168 applies to electronic remittance advice (ERA) only.
Background
Currently reporting of refunded principal and interest amounts for all related claims on the Remittance Advice (RA) is shown as one lump sum amount. This practice creates problems for the provider community as this is not conducive to posting payment properly. Providers have the money but are not able to identify the claim and/or the refund of principal and interest paid by Medicare.

CR9168 instructs MACs to report the principal and interest separately, and also to provide individual claim information. Specifically, the reporting will be in the Provider Level Balance (PLB) segment of the 835 as follows:

**PLB Details - Reporting Principal Refunds**
- PLB03-1: WW to report overpayment recovery (negative sign for the amount in PLB04) being refunded
- PLB03-2 Positions 1 – 25: Account Payable (AP) Invoice Number
- PLB03-2 Positions 26 – 50: Claim Adjustment Account Receivable (AR) number
- PLB 04: Refund Amount (Principal Refund Amount)

**PLB Details - Reporting Interest Refunds**
- PLB03-1: RU to report interest paid (negative sign for the amount in PLB04)
- PLB03-2 Positions 1 – 25: AP Invoice Number
- PLB03-2 Positions 26 – 50: Claim Adjustment AR number
- PLB04: Interest Amount on Refund

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**

**MM9386: Update to the List of Compendia as Authoritative Sources for Use in the Determination of a “Medically-Accepted Indication” of Drugs and Biologicals Used Off-label in an Anti-Cancer Chemotherapeutic Regimen**

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html)

**MLN Matters® Number:** MM9386  
**Change Request (CR) #:** CR9386  
**Related CR Release Date:** November 6, 2015  
**Effective Date:** August 12, 2015  
**Related CR Transmittal #:** R212BP  
**Implementation Date:** February 10, 2016
Provider Types Affected
This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know
This article is based on Change Request (CR) 9386 which announces that effective for services on or after August 12, 2015, the Centers for Medicare & Medicaid Services (CMS) is adding Wolters Kluwer Lexi-Drugs® to the list of authoritative compendia for use in the determination of a medically-accepted indication of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen.

Background

1. American Medical Association Drug Evaluations (AMA-DE);
2. United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication; and

These authoritative sources could be used in the determination of a “medically-accepted indication” of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen, unless:

- The Secretary of Health and Human Services (HHS) determined that the use is not medically appropriate; or
- The use is identified as not indicated in one or more such compendia.

This provision was implemented through instructions to the MACs in the “Medicare Benefit Policy Manual” (Chapter 15, Section 50.4.5).

Due to changes in the pharmaceutical reference industry:

- The AHFS-DI was the only remaining statutorily-named compendia available for CMS reference;
- The AMA-DE and USP-DI are no longer published;
- Thomson Micromedex designated Drug Points was the successor to USP-DI; but
- Drug Points has since been deleted from the list of recognized compendia.

In January 2008, CMS established, via the Physician Fee Schedule Final Rule for calendar year 2008:

- A process for revising the list of compendia, as authorized under the Social Security Act (Section 1861(t)(2)), and
- A definition for “compendium.”

This sub-regulatory process for revising the list of compendia is described in the “Medicare Benefit Policy Manual” (Chapter 15, Section 50.4.5.1).
Based on this process, CMS updated the list in 2008 to include the following four compendia:

1. Existing - American Hospital Formulary Service-Drug Information (AHFS-DI),
2. Effective June 5, 2008 - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium,
3. Effective June 10, 2008 - Truven Health Analytics Micromedex DrugDex, and

On August 12, 2015, CMS announced the addition of Wolters Kluwer Lexi-Drugs® to the above list of four compendia used by the Medicare program in the determination of a “medically-accepted indication” for off-label drugs and biologics used in an anticancer chemotherapeutic treatment regimen. This is effective for services on or after August 12, 2015.

Further details on this issue are in the revised Chapter 15, Section 50.4.5.1 of the “Medicare Benefit Policy Manual,” which is an attachment to CR9386.

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 Connects™ Provider eNews

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

For Home Health and Hospice Providers

NEW Fax Number for Medical Review Additional Development Requests (MR ADR) and Non-MR ADRs

Home health and hospice providers should be aware that CGS has new fax numbers for providers to submit documentation in response to additional development requests (ADRs). The old fax number is still active, but will be terminated sometime in February of 2016. Please review the following and make sure your appropriate staff is aware of this information.

<table>
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<tr>
<th>Medical Review ADR (MR ADR) Fax Number</th>
<th>Non-MR ADR Fax Number</th>
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<tbody>
<tr>
<td>1.615.664.5981</td>
<td>1.615.664.5982</td>
</tr>
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For additional information about MR ADRs, and Non-MR ADRs, please refer to the following resources:

- Additional Development Request (ADR) Overview CGS Web page  
  http://www.cgsmedicare.com/hhh/claims/overview_adr.html
- Medical Review Additional Development Request (ADR) Process CGS Web page  
  http://www.cgsmedicare.com/hhh/medreview/adr_process.html
- Requesting an Exception for an Untimely NOE CGS Web page  
  http://www.cgsmedicare.com/hhh/education/materials/requesting_exception_untimely_noes.html

For Home Health and Hospice Providers

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

- Revised products from the Medicare Learning Network®
  - REVISED “837P and Form CMS-1500” Web-Based Training (WBT) has been revised and is now available - https://learner.mlnls.com/Default.aspx
- Subscribe to the MLN Connects® Provider eNews (https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819): a weekly electronic publication with the latest Medicare program information, including MLN Connects® National Provider Call announcements, claim and Pricer information, and Medicare Learning Network® educational product updates.
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). The list below indicates when the home health and hospice PCC at 1.877.299.4500 (option 1) will be closed for training.

<table>
<thead>
<tr>
<th>Date</th>
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<tr>
<td>Friday, January 1, 2016</td>
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<td>Monday, January 18, 2016</td>
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<tr>
<td>Thursday, January 14, 2016</td>
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<tr>
<td>Thursday, January 28, 2016</td>
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System Availability/Cycles — Martin Luther King Jr.’s Birthday

In observation of Martin Luther King Jr.’s birthday, our office will be closed on Monday, January 18, 2016. Our data center has informed us that the Fiscal Intermediary Standard System (FISS) and access to the ELGA/ELGH eligibility system will be available January 18, 2016. However, FISS will not cycle on January 18, 2016, which means that claims will not be sent to the Common Working File (CWF) during the nightly cycle. Medicare Remittance Advices, Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfer (EFTs) will not be produced on January 18, 2016.

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](http://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf) on the CGS website. In addition, CGS’ Internet portal, myCGS, is available to access eligibility information through the Internet. For additional information, go to [http://www.cgsmedicare.com/hhh/index.html](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

Quarterly Provider Update

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

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

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

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

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

**For Home Health and Hospice Providers**

**Requesting a Reopening: Good to Know**

CGS recently updated the “Reopenings” Web page at http://www.cgsmedicare.com/hhh/appeals/Reopenings.html to reflect guidelines that apply when requesting a reopening of a claim that is beyond the filing timeframe. Because this process is a change, and the Provider Contact Center (PCC) has received questions from providers, please be sure to share the following items with your billing staff.

- **Type of Bill (TOB)** – The TOB must end with the letter “Q” (e.g. 32Q, 81Q, 82Q). If you enter your reopening via the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE) options 33 (home health) or 35 (hospice), after selecting the claim, you will need to change the TOB.

- **Document Control Number (DCN)** – When submitting a reopening request via FISS DDE, the DCN of the claim to be reopened is auto plugged. However, when using another software to submit the reopening request, providers should ensure that the correct DCN is entered. The DCN is available on your Medicare Remittance Advice (RA) or Electronic Remittance Advice (ERA). In addition, the DCN displays on the FISS Claim page 01 in the DCN field.

- **Timely Filing Period** – If a reopening request (TOB xxQ) is submitted for a claim and the normal timely filing period (that is, filed within one year of the date of service) has not expired, CGS will send the reopening request to the Return to Provider (RTP) file with reason code 39994, instructing the provider to submit an adjustment claim.

**Resources:**


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

SE1408 (Revised): Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492

The Centers for Medicare & Medicaid Services (CMS) has revised the following Special Edition Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2015-MLN-Matters-Articles.html

MLN Matters® Number: SE1408 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Change Request (CR) #: CR 7492
Effective Date: October 1, 2014
Implementation Date: N/A

Note: This article was revised on October 30, 2015, to add language to Table A on page 3 regarding Inpatient Psychiatric Facilities (IPFs) and Long Term Care Hospital (LTCH) PPS. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2015. As a result of CR7492 (and related MLN Matters® Article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013, implementation date for ICD-10. This article updates MM7492 to reflect the October 1, 2015, implementation date. Make sure your billing and coding staffs are aware of these changes.

Key Points of SE1408

General Reporting of ICD-10

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

General Claims Submissions Information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be Returned to Provider (RTP) as unprocessable. Likewise, professional and supplier claims containing ICD-9 codes for dates
of services on or after October 1, 2015, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code. Likewise, Medicare will also RTP all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim. For claims with dates of service prior to October 1, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2015. Institutional claims containing ICD-10 codes for services prior to October 1, 2015, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Will the Centers for Medicare & Medicaid Services (CMS) allow for dual processing of ICD-9 and ICD-10 codes (accept and process both ICD-9 and ICD-10 codes for dates of service on and after October 1, 2015)?

No, CMS will not allow for dual processing of ICD-9 and ICD-10 codes after ICD-10 implementation on October 1, 2015. Many providers and payers, including Medicare have already coded their systems to only allow ICD-10 codes beginning October 1, 2015. The scope of systems changes and testing needed to allow for dual processing would require significant resources and could not be accomplished by the October 1, 2015, implementation date. Should CMS allow for dual processing, it would force all entities with which we share data, including our trading partners, to also allow for dual processing. In addition, having a mix of ICD-9 and ICD-10 codes in the same year would have major ramifications for CMS quality, demonstration, and risk adjustment programs.

Claims that Span the ICD-10 Implementation Date

There may be times when a claim spans the ICD-10 implementation date for institutional, professional, and supplier claims. For example, the beneficiary is admitted as an inpatient in late September, 2015 and is discharged after October 1, 2015. Another example is a DME claim for monthly billing that spans between September and October, 2015 (that is, the monthly billing dates are September 15, 2015 – October 14, 2015). The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

<p>| Table A – Institutional Providers | | |
|---|---|---|---|
| <strong>Bill Type(s)</strong> | <strong>Facility Type/Services</strong> | <strong>Claims Processing Requirement</strong> | <strong>Use FROM or THROUGH Date</strong> |
| 11X | Inpatient Hospitals (including TEFRA hospitals, Inpatient Prospective Payment System (PPS) hospitals and Critical Access Hospitals (CAHs)) | If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10. | THROUGH |</p>
<table>
<thead>
<tr>
<th>Bill Type(s)</th>
<th>Facility Type/Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>11X</td>
<td>Inpatient Psychiatric Facility (IPF) and Long Term Care Hospital (LTCH) PPS</td>
</tr>
<tr>
<td>12X</td>
<td>Inpatient Part B Hospital Services</td>
</tr>
<tr>
<td>13X</td>
<td>Outpatient Hospital</td>
</tr>
<tr>
<td>14X</td>
<td>Non-patient Laboratory Services</td>
</tr>
<tr>
<td>18X</td>
<td>Swing Beds</td>
</tr>
<tr>
<td>21X</td>
<td>Skilled Nursing (Inpatient Part A)</td>
</tr>
<tr>
<td>22X</td>
<td>Skilled Nursing Facilities (Inpatient Part B)</td>
</tr>
<tr>
<td>23X</td>
<td>Skilled Nursing Facilities (Outpatient)</td>
</tr>
<tr>
<td>32X</td>
<td>Home Health (Inpatient Part B)</td>
</tr>
<tr>
<td>3X2</td>
<td>Home Health – Request for Anticipated Payment (RAPs)*</td>
</tr>
<tr>
<td>34X</td>
<td>Home Health – (Outpatient)</td>
</tr>
<tr>
<td>71X</td>
<td>Rural Health Clinics</td>
</tr>
<tr>
<td>72X</td>
<td>End Stage Renal Disease (ESRD)</td>
</tr>
<tr>
<td>73X</td>
<td>Federally Qualified Health Clinics (prior to 4/1/10)</td>
</tr>
<tr>
<td>74X</td>
<td>Outpatient Therapy</td>
</tr>
<tr>
<td>75X</td>
<td>Comprehensive Outpatient Rehab facilities</td>
</tr>
<tr>
<td>76X</td>
<td>Community Mental Health Clinics</td>
</tr>
</tbody>
</table>

**Claims Processing Requirement**

<table>
<thead>
<tr>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>FROM</td>
</tr>
<tr>
<td>THROUGH</td>
</tr>
</tbody>
</table>

*NOTE: If the hospital claim has a discharge and/or through date on or after 10/1/15, and a benefits exhaust occurrence code with a September 2015 date does not exist, the entire claim is billed using ICD-10.

If a benefits exhaust occurrence code with a September 2015 date exists, the provider must split bill the claim using the benefits exhaust occurrence code date as the through date on the first claim and bill with ICD-9 codes. The subsequent claim is billed as a no pay claim with appropriate ICD-10 coding.

*See Note*

**Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.**

**FROM**

**NOTES:**

- RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015.

- If a benefits exhaust occurrence code with a September 2015 date exists, the entire claim is billed using ICD-10.

- If a benefits exhaust occurrence code with a September 2015 date does not exist, the entire claim is billed using ICD-10.

- If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.

- Use FROM or THROUGH.

- If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.

- If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10.

**RETURN TO TABLE OF CONTENTS**

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### Table A – Institutional Providers

<table>
<thead>
<tr>
<th>Bill Type(s)</th>
<th>Facility Type/Services</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>77X</td>
<td>Federally Qualified Health Clinics (effective 4/4/10)</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>81X</td>
<td>Hospice- Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>82X</td>
<td>Hospice – Non hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
<tr>
<td>83X</td>
<td>Hospice – Hospital Based</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>85X</td>
<td>Critical Access Hospital</td>
<td>Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later.</td>
<td>FROM</td>
</tr>
</tbody>
</table>

### Table B - Special Outpatient Claims Processing Circumstances

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-day /1-day Payment Window</td>
<td>Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2015, the claim must be billed with ICD-10 for those bundled outpatient services.</td>
<td>THROUGH</td>
</tr>
</tbody>
</table>

### Table C – Professional Claims

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>All anesthesia claims</td>
<td>Anesthesia procedures that begin on 9/30/2015 but end on 10/1/2015 are to be billed with ICD-9 diagnosis codes and use 9/30/2015 as both the FROM and THROUGH date.</td>
<td>FROM</td>
</tr>
</tbody>
</table>

### Table D – Supplier Claims

<table>
<thead>
<tr>
<th>Supplier Type</th>
<th>Claims Processing Requirement</th>
<th>Use FROM or THROUGH Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DMEPOS</td>
<td>Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/2015 (i.e., the FROM date of service occurs prior to 10/1/2015 and the TO date of service occurs after 10/1/2015).</td>
<td>FROM</td>
</tr>
</tbody>
</table>

### Additional Information


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

### Document History

- This article was revised on June 27, 2015, to clarify language on page 2 under “Claims that Span the ICD-10 Implementation Date.”
- The article was revised on October 30, 2015, to add information in Table A regarding Inpatient Psychiatric Facilities (IPF) and Long Term Care Hospital (LTCH) PPS guidance.
For Home Health and Hospice Providers
Stay Informed and Join the CGS ListServ Notification Service

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

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

- It’s free! There is no cost to subscribe or to receive information.
- You only need a valid e-mail address to subscribe.
- Multiple people/e-mail addresses from your facility can subscribe. We recommend that all staff (clinical, billing, and administrative) who interacts with Medicare topics register individually. This will help to facilitate the internal distribution of critical information and eliminates delay in getting the necessary information to the proper staff members.

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

For Home Health and Hospice Providers
Unsolicited/Voluntary Refunds

Providers need to be aware that the acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Medicare administrative contractors (MACs) receive unsolicited/voluntary refunds from providers. These voluntary refunds are not related to any open accounts receivable. Providers billing MACs typically make these refunds by submitting adjustment bills, but they occasionally submit refunds via check. Providers billing carriers usually send these voluntary refunds by check.

Related CR 3274 is intended mainly to provide a detailed set of instructions for MACs regarding the handling and reporting of such refunds. The implementation and effective dates of that CR apply to the carriers and intermediaries. But, the important message for providers is that the submission of such a refund related to Medicare claims in no way limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to those or any other claims.


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

Upcoming Educational Events

The CGS Provider Outreach and Education department offers educational events through webinars and teleconferences throughout the year. Registration for live events is required. For upcoming events, please refer to the Calendar of Events Home Health & Hospice Education Web page at http://www.cgsmedicare.com/hhh/education/Education.html. CGS suggests that you bookmark this page and visit it often for the latest educational opportunities.