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Reducing Home Health Errors for Reason Code (RC) 38107

Home health agencies (HHAs) are reminded of the following Medicare billing requirements to ensure their Requests for Anticipated Payment (RAPs) and final claims process and pay timely in the Fiscal Intermediary Standard System (FISS).

RC 38107

When a final claim is submitted to Medicare, FISS will search for a matching RAP. FISS will send the final claim to the return to provider (RTP) file (status/location T B9997) with reason code 32107 when a matching RAP is not found, or when one or more of the following fields does not match between the RAP and the final claim.

A recent analysis of claim submission errors (CSEs) showed that 38107 accounted for 26% of all CSEs received by HHAs who bill to CGS.

<table>
<thead>
<tr>
<th>FISS Field Name</th>
<th>FISS Page</th>
<th>UB-04 Form Locator (FL)</th>
<th>Data Entered</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI</td>
<td>1</td>
<td>60</td>
<td>National Provider Identifier (NPI) of the billing provider</td>
</tr>
</tbody>
</table>
| STMT DATES FROM | 1         | 6                       | **Start of care (SOC) episodes only:** Date of first Medicare billable visit in the episode  
**Recertification (subsequent) episodes:** First calendar day of the episode of care |
| ADMIT DATE      | 1         | 12                      | Date of first Medicare billable visit in the beneficiary’s initial episode with the primary HHA |
| HCPC            | 2         | 44                      | **0023 revenue code line:** Health Insurance Prospective Payment System (HIPPS) code. FISS compares the first four positions of the HIPPS code between the RAP and final claim for the same episode of care |
| SERV DATE       | 2         | 45                      | **0023 revenue code line:** First Medicare billable visit in the episode |

Examples of FISS page 1 and page 2 are shown below with the matching fields indicated.
For additional information regarding how to avoid or reduce billing errors for this reason, see the CGS Web page, Top Claim Submission Errors for Home Health Providers: Error 38107 http://www.cgsmedicare.com/hhh/education/materials/38107.html

For additional information on the data elements entered on RAPs and final claims, please see the Medicare Claims Processing Manual (Pub. 100-04, Ch. 10) http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf on the Centers for Medicare & Medicaid Services (CMS) website. Additional information about entering RAPs and final claims is available on the CGS Home Health Claims Filing Web pages at: http://www.cgsmedicare.com/hhh/education/materials/HHE_Claims_Main.html

For Home Health Providers

MM9533: Comprehensive Care for Joint Replacement Model (CJR) Provider Education

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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles2016-MLN-Matters-Articles.html

MLN Matters® Number: MM9533
Related CR Release Date: February 19, 2016
Related CR Transmittal #: R140DEMO

Change Request (CR) #: CR 9533
Effective Date: April 1, 2016
Implementation Date: April 4, 2016

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9533 supplies information to providers about the CJR model. The intent of the CJR model is to promote quality and financial accountability for episodes of care surrounding a Lower-Extremity Joint Replacement (LEJR) or reattachment of a lower extremity procedure. CJR will test whether bundled payments to certain acute care hospitals for LEJR episodes of care will reduce Medicare expenditures while preserving or enhancing
the quality of care for Medicare beneficiaries. Make sure that your billing staffs are aware of these changes.

**Background**

Section 1115A of the Social Security Act (the Act) authorizes the Centers for Medicare & Medicaid Services (CMS) to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. Under this authority, CMS published a rule to implement a new five year payment model called the Comprehensive Care for Joint Replacement (CJR) model on April 1, 2016.

Under the CJR model, acute care hospitals in certain selected geographic areas will take on quality and payment accountability for retrospectively calculated bundled payments for LEJR episodes. Episodes will begin with admission to an acute care hospital for an LEJR procedure that is paid under the Inpatient Prospective Payment System (IPPS) through Medical Severity Diagnosis-Related Group (MS-DRG) 469 (Major joint replacement or reattachment of lower extremity with MCC) or 470 (Major joint replacement or reattachment of lower extremity without MCC) and end 90 days after the date of discharge from the hospital.

**Key Points of CR9533**

**CJR Episodes of Care**

LEJR procedures are currently paid under the IPPS through: MS-DRG 469 or MS-DRG 470. The episode will include the LEJR procedure, inpatient stay, and all related care covered under Medicare Parts A and B within the 90 days after discharge. The day of discharge is counted as the first day of the 90-day bundle.

**CJR Participant Hospitals**

The model requires all hospitals paid under the IPPS in selected geographic areas to participate in the CJR model, with limited exceptions. A list of the selected geographic areas and participant hospitals is available at [https://innovation.cms.gov/initiatives/cjr](https://innovation.cms.gov/initiatives/cjr) on the Internet. Participant hospitals initiate episodes when an LEJR procedure is performed within the hospital and will be at financial risk for the cost of the services included in the bundle. Eligible beneficiaries who elect to receive care at these hospitals will automatically be included in the model.

**CJR Model Beneficiary Inclusion Criteria**

Medicare beneficiaries whose care will be included in the CJR model must meet the following criteria upon admission to the anchor hospitalization:

- The beneficiary is enrolled in Medicare Part A and Part B;
- The beneficiary’s eligibility for Medicare is not on the basis of the End-Stage Renal Disease benefit;
- The beneficiary is not enrolled in any managed care plan;
- The beneficiary is not covered under a United Mine Workers of America health plan; and
- Medicare is the primary payer.

If at any time during the episode the beneficiary no longer meets all of these criteria, the episode is canceled.

**CJR Performance Years**

CMS will implement the CJR model for 5 performance years, as detailed in the table below. Performance years for the model correlate to calendar years with the exception of performance year 1, which is April 1, 2016, through December 31, 2016.
CJR Model: 5 Performance Years

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Date for Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Year 1 (calendar year 2016):</td>
<td>Episodes that start on or after April 1, 2016, and end on or before December 31, 2016</td>
</tr>
<tr>
<td>Performance Year 2 (calendar year 2017):</td>
<td>Episodes that end between January 1, 2017, and December 31, 2017, inclusive</td>
</tr>
<tr>
<td>Performance Year 3 (calendar year 2018):</td>
<td>Episodes that end between January 1, 2018, and December 31, 2018, inclusive</td>
</tr>
<tr>
<td>Performance Year 4 (calendar year 2019):</td>
<td>Episodes that end between January 1, 2019, and December 31, 2019, inclusive</td>
</tr>
<tr>
<td>Performance Year 5 (calendar year 2020):</td>
<td>Episodes that end between January 1, 2020, and December 31, 2020, inclusive</td>
</tr>
</tbody>
</table>

CJR Episode Reconciliation Activities

CMS will continue paying hospitals and other providers and suppliers according to the usual Medicare fee-for-service payment systems during all performance years. After completion of a performance year, Medicare will compare or “reconcile” actual claims paid for a beneficiary during the 90 day episode to an established target price. The target price is an expected amount for the total cost of care of the episode. Hospitals will receive separate target prices to reflect expected spending for episodes assigned to MS-DRGs 469 and 470, as well as hip fracture status. If the actual spending is lower than the target price, the difference will be paid to the hospital, subject to certain adjustments, such as for quality. This payment will be called a reconciliation payment. If actual spending is higher than the target price, hospitals will be responsible for repayment of the difference to Medicare, subject to certain adjustments, such as for quality.

Identifying CJR Claims

To validate the retroactive identification of CJR episodes, CMS is associating the Demonstration Code 75 with the CJR initiative. This code will also be utilized in future CRs to operationalize a waiver of the three-day stay requirement for covered Skilled Nursing Facility (SNF) services, effective for CJR episodes beginning on or after January 1, 2017.

Medicare will automatically apply the CJR demonstration code to claims meeting the criteria for inclusion in the demonstration. Participant hospitals need not include demonstration code 75 on their claims. Instructions for submission of claims for SNF services rendered to beneficiaries in a CJR episode of care will be communicated once the waiver of the three-day stay requirement is operationalized.

Waivers and Amendments of Medicare Program Rules

The CJR model waives certain existing payment system requirements to provide additional flexibilities to hospitals participating in CJR, as well as other providers that furnish services to beneficiaries in CJR episodes. The purpose of such flexibilities would be to increase LEJR episode quality and decrease episode spending or provider and supplier internal costs, or both, and to provide better, more coordinated care for beneficiaries and improved financial efficiencies for Medicare, providers, and beneficiaries.

Post-Discharge Home Visits

In order for Medicare to pay for home health services, a beneficiary must be determined to be “home bound.” A beneficiary is considered to be confined to the home if the beneficiary has a condition, due to an illness or injury, that restricts his or her ability to leave home except with the assistance of another individual or the aid of a supportive device (that is, crutches, a cane, a wheelchair or a walker) or if the beneficiary has a condition such that leaving his or her home is medically contraindicated. Additional information regarding the homebound requirement is available in the “Medicare Benefit Policy Manual;” Chapter 7, Home Health Services, Section 30.1.1, Patient Confined to the Home (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf).

Medicare policy allows physicians and Non-Physician Practitioners (NPPs) to furnish and bill for visits to any beneficiary’s home or place of residence under the Medicare Physician

For those CJR beneficiaries who could benefit from home visits by licensed clinical staff for purposes of assessment and monitoring of their clinical condition, care coordination, and improving adherence with treatment, CMS will waive the “incident to” direct physician supervision requirement to allow a beneficiary who does not qualify for Medicare home health services to receive post-discharge visits in his or her home or place of residence any time during the episode, subject to the following conditions:

- Licensed clinical staff will provide the service under the general supervision of a physician or NPP. These staff can come from a private physician office or may be either an employee or a contractor of the participant hospital.
- Services will be billed under the MPFS by the supervising physician or NPP or by the hospital or other party to which the supervising physician has reassigned his or her billing rights.
- Up to 9 post discharge home visits can be billed and paid per beneficiary during each CJR episode, defined as the 90-day period following the anchor hospitalization.
- The service cannot be furnished to a CJR beneficiary who has qualified, or would qualify, for home health services when the visit was furnished.
- All other Medicare rules for coverage and payment of services incident to a physician’s service continue to apply.

As described in the “Medicare Claims Processing Manual”, Chapter 12, Sections 40-40.4, (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf) Medicare policy generally does not allow for separate billing and payment for a postoperative visit furnished during the global period of a surgery when it is related to recovery from the surgery. However, for CJR, CMS will allow the surgeon or other practitioners to bill and be paid separately for a post-discharge home visit that was furnished in accordance with these conditions. All other Medicare rules for global surgery billing during the 90 day post-operative period continue to apply.

CMS expects that the post-discharge home visits by licensed clinical staff could include patient assessment, monitoring, assessment of functional status and fall risk, review of medications, assessment of adherence with treatment recommendations, patient education, communication and coordination with other treating clinicians, and care management to improve beneficiary connections to community and other services.

The service will be billed under the MPFS with a HCPCS G-code (G9490) specific to the CJR post-discharge home visit, as listed in Attachment A. The post-discharge home visit HCPCS code will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for post-discharge home visits for the CJR model will be accepted only when the claim contains the CJR specific HCPCS G-Code. Although CMS is associating the Demonstration Code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-Code.

Additional information on billing and payment for the post-discharge home visit HCPCS G-Code will be available in the April 2016 release of the MPFS Recurring Update. Future updates to the relative value units (RVUs) and payment for this HCPCS code will be included in the MPFS final rules and recurring updates each year.
Billing and Payment for Telehealth Services

Medicare policy covers and pays for telehealth services when beneficiaries are located in specific geographic areas. Within those geographic areas, beneficiaries must be located in one of the health care settings that are specified in the statute as eligible originating sites. The service must be on the list of approved Medicare telehealth services. Medicare pays a facility fee to the originating site and provides separate payment to the distant site practitioner for the service. Additional information regarding Medicare telehealth services is available in the “Medicare Benefit Policy Manual,” Chapter 15, Section 270 (https://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/bp102c15.pdf) and the “Medicare Claims Processing Manual,” Chapter 12, Section 190 (https://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/clm104c12.pdf).

Under CJR, CMS will allow a beneficiary in a CJR episode in any geographic area to receive services via telehealth. CMS also will allow a home or place of residence to be an originating site for beneficiaries in a CJR episode. This will allow payment of claims for telehealth services delivered to beneficiaries at eligible originating sites or at their residence, regardless of the geographic location of the beneficiary. CMS will waive these telehealth requirements, subject to the following conditions:

- Telehealth services cannot substitute for in-person home health visits for patients under a home health episode of care.
- Telehealth services performed by social workers for patients under a home health episode of care will not be covered under the CJR model.
- The telehealth geographic area waiver and the allowance of home as an originating site under the CJR model does not apply for instances where a physician or allowed NPP is performing a face-to-face encounter for the purposes of certifying patient eligibility for the Medicare home health benefit.
- The principal diagnosis code reported on the telehealth claim cannot be one that is specifically excluded from the CJR episode definition.
- If the beneficiary is at home, the physician cannot furnish any telehealth service with a descriptor that precludes delivering the service in the home (for example, a hospital visit code).
- If the physician is furnishing an evaluation and management visit via telehealth to a beneficiary at home, the visit must be billed by one of nine unique HCPCS G-codes developed for the CJR model that reflect the home setting.
- For CJR telehealth home visits billed with HCPCS codes G9484, G9485, G9488, and G9489, the physician must document in the medical record that auxiliary licensed clinical staff were available on site in the patient’s home during the visit or document the reason that such a high-level visit would not require such personnel.
- Physicians billing distant site telehealth services under these waivers must include the GT modifier on the claim, which attests that the service was furnished in accordance with all relevant coverage and payment requirements.
- The facility fee paid by Medicare to an originating site for a telehealth service will be waived if the service was originated in the beneficiary’s home.

The telehealth home visits will be billed under the MPFS with one of nine HCPCS G-code specific to the CJR telehealth home visits. Those codes are G9481, G9482, G9483, G9484, G9485, G9586, G9487, G9488, and G9499. Attachment A of CR9533 provides the long descriptors of these codes. The telehealth home visit HCPCS codes will be payable for CJR model beneficiaries beginning April 1, 2016, the start date of the first CJR model performance year. Claims submitted for telehealth home visits for the CJR model will be accepted only when the claim contains one of nine of the CJR specific HCPCS G-Code. Although CMS is
associating the Demonstration Code 75 with the CJR initiative, no demonstration code is needed or required on Part B claims submitted with the post-discharge home visit HCPCS G-Code. Additional information on billing and payment for the telehealth home visit HCPCS G-Codes will be available in the April 2016 release of the MPFS Recurring Update. Future updates to the RVUs and payment for these HCPCS codes will be included in the MPFS final rules and recurring updates each year.

**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**

**MM9549: April 2016 Update of the Hospital Outpatient Prospective Payment System (OPPS)**

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html).

**MLN Matters® Number**: MM9549

**Change Request (CR) #**: CR 9549

**Related CR Release Date**: February 26, 2016

**Effective Date**: April 1, 2016

**Related CR Transmittal #:** R3471CP

**Implementation Date**: April 4, 2016

**Provider Types Affected**

This MLN Matters® Article is intended for providers and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice (HH&H) MACs, for services provided to Medicare beneficiaries paid under the Outpatient Prospective Payment System (OPPS).

**Provider Action Needed**

Change Request (CR) 9549 describes changes to and billing instructions for various payment policies implemented in the April 2016 OPPS update.

The April 2016 Integrated Outpatient Code Editor (I/OCE) and OPPS Pricer will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in CR9549. The I/OCE update is in CR9553. Upon release of that CR, an MLN Matters article (MM9553) related to the updated I/OCE will be posted on the Centers for Medicare & Medicaid Services (CMS) website. Make sure your billing staffs are aware of these changes.

**Key Points of CR9549**

Key changes to and billing instructions for various payment policies implemented in the April 2016 OPPS updates are as follows:

**Neurostimulator HCPCS Codes C1822 and C1820**

**HCPCS Code C1822**

As described in the January 2016 Update of the OPPS (see MM9486 at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9486.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9486.pdf), January 2016 OPPS Update), HCPCS code C1822 (Generator, neurostimulator...
(implantable), high frequency, with rechargeable battery and charging system) was added to the OPPS pass-through list as a new pass-through device effective January 1, 2016. HCPCS code C1822 is based on a clinical trial that demonstrated that a high frequency spinal cord stimulator operated at 10,000 Hz and paresthesia-free provides a substantial clinical improvement in pain management versus a low-frequency spinal cord stimulator.

**HCPCS Code C1820**

In the January 2016 OPPS Update, CMS added the words “non-high-frequency” to the descriptor of C1820. CMS is revising the descriptor for C1820 back to its original language and deleting “non-high-frequency” from the descriptor such that the descriptor again states the following: Generator, neurostimulator (implantable), with rechargeable battery and charging system. Neurostimulator generators that are not high frequency should be reported with C1820.


**Billing Instructions for Intensity Modulated Radiation Therapy (IMRT) Planning**

Payment for the services identified by CPT codes 77014, 77280, 77285, 77290, 77295, 77305 through 77321, 77331, and 77370 are included in the Ambulatory Payment Classification (APC) payment for CPT code 77301 (IMRT planning). These codes should not be reported in addition to CPT code 77301 when provided prior to or as part of the development of the IMRT plan.

**Laboratory Drug Testing HCPCS Codes G0477-G0483 Effective January 1, 2016**

HCPCS codes G0477-G0483 were published on the CMS website after the release of the January 2016 I/OCE. Consequently, CMS was unable to include them in the January 2016 I/OCE release. These codes are being added to the April 2016 I/OCE release with an effective date of January 1, 2016, and are assigned to Status Indicator (SI) of “Q4” (Conditionally packaged laboratory tests) under the hospital OPPS. The descriptors for Codes G0477-G0483 are listed in Table 1.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0477</td>
<td>Drug test</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service</td>
<td>Q4</td>
</tr>
<tr>
<td>G0478</td>
<td>Drug test</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) read by instrument-assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.</td>
<td>Q4</td>
</tr>
<tr>
<td>G0479</td>
<td>Drug test</td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service.</td>
<td>Q4</td>
</tr>
<tr>
<td>G0480</td>
<td>Drug test def 1-7 classes</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPMA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed.</td>
<td>Q4</td>
</tr>
</tbody>
</table>
Table 1 - Laboratory Drug Testing HCPCS Codes G0477-G0483

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>OPPS SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0481</td>
<td>Drug test def 8-14 classes</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all source(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed.</td>
<td>Q4</td>
</tr>
<tr>
<td>G0482</td>
<td>Drug test def 15-21 classes</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all source(s), includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed.</td>
<td>Q4</td>
</tr>
<tr>
<td>G0483</td>
<td>Drug test def 22+ classes</td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all source(s), includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed.</td>
<td>Q4</td>
</tr>
</tbody>
</table>

Drugs, Biologicals, and Radiopharmaceuticals

Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2016

For Calendar Year (CY) 2016, payment for nonpass-through drugs, biologicals and therapeutic radiopharmaceuticals is made at a single rate of ASP + 6 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological or therapeutic radiopharmaceutical. In CY 2016, a single payment of ASP + 6 percent for pass-through drugs, biologicals and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items. Payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as later quarter ASP submissions become available. Updated payment rates effective April 1, 2016, and drug price restatements are available in the April 2016 update of the OPPS Addendum A and Addendum B at [http://www.cms.gov/HospitalOutpatientPPS](http://www.cms.gov/HospitalOutpatientPPS) on the CMS website.

Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2016

Ten drugs and biologicals have been granted OPPS pass-through status effective April 1, 2016. See codes listed in Table 2.

Table 2 - Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2016

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9137</td>
<td>Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 I.U.</td>
<td>1844</td>
<td>G</td>
</tr>
<tr>
<td>C9138</td>
<td>Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwiq), 1 I.U.</td>
<td>1846</td>
<td>G</td>
</tr>
<tr>
<td>C9461</td>
<td>Choline C 11, diagnostic, per study dose</td>
<td>9461</td>
<td>G</td>
</tr>
<tr>
<td>C9470</td>
<td>Injection, aripiprazole lauroxil, 1 mg</td>
<td>9470</td>
<td>G</td>
</tr>
<tr>
<td>C9471</td>
<td>Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg</td>
<td>9471</td>
<td>G</td>
</tr>
<tr>
<td>C9472</td>
<td>Injection, talimogene laherparepvec, 1 million plaque forming units (PFU)</td>
<td>9472</td>
<td>G</td>
</tr>
<tr>
<td>C9473</td>
<td>Injection, mepolizumab, 1 mg</td>
<td>9473</td>
<td>G</td>
</tr>
<tr>
<td>C9474</td>
<td>Injection, irinotecan liposome, 1 mg</td>
<td>9474</td>
<td>G</td>
</tr>
<tr>
<td>C9475</td>
<td>Injection, necitumumab, 1 mg</td>
<td>9475</td>
<td>G</td>
</tr>
<tr>
<td>J7503</td>
<td>Tacrolimus, extended release, (envarsus xr), oral, 0.25 mg</td>
<td>1845</td>
<td>G</td>
</tr>
</tbody>
</table>
Revised Status Indicator for HCPCS Codes

The status indicator for CPT code 90653 (Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use) will change from SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=L (Not paid under OPPS paid at reasonable cost, not subject to deductible or coinsurance).

The status indicator for HCPCS code J0130 (Injection abciximab, 10 mg) will change from SI=K (Paid under OPPS; separate APC payment) to SI=N (Paid under OPPS; payment is packaged into payment for other services).

The status indicator for HCPCS code J0583 (Injection, bivalirudin, 1 mg) will change from SI=K (Paid under OPPS; separate APC payment) to SI=N (Paid under OPPS; payment is packaged into payment for other services).

The status indicator for HCPCS code J1443 (Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron) will change from SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=N (Paid under OPPS; payment is packaged into payment for other services).

The status indicator for HCPCS code J2704 (Injection, Propofol, 10mg) will change from SI=E (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI=N (Paid under OPPS; payment is packaged into payment for other services).

These codes and the effective dates for the status indicator changes are listed in Table 3.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>Status Indicator</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>90653</td>
<td>Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use</td>
<td>L</td>
<td>11/24/2015</td>
</tr>
<tr>
<td>J0130</td>
<td>Injection abciximab, 10 mg</td>
<td>N</td>
<td>1/1/2016</td>
</tr>
<tr>
<td>J0583</td>
<td>Injection, bivalirudin, 1 mg</td>
<td>N</td>
<td>1/1/2016</td>
</tr>
<tr>
<td>J1443</td>
<td>Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron</td>
<td>N</td>
<td>1/1/2016</td>
</tr>
<tr>
<td>J2704</td>
<td>Injection, Propofol, 10mg</td>
<td>N</td>
<td>1/1/2016</td>
</tr>
</tbody>
</table>

Drugs and Biologicals Based on ASP Methodology with Restated Payment Rates

Some drugs and biologicals based on ASP methodology will have payment rates that are corrected retroactively. These retroactive corrections typically occur on a quarterly basis. The list of drugs and biologicals with corrected payments rates will be accessible on the first date of the quarter at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates.html) on the CMS website.

Providers may resubmit claims that were impacted by adjustments to previous quarter’s payment files.

Revised Billing Instruction for Stereotactic Radiosurgery (SRS) Planning and Delivery

Effective for cranial single session stereotactic radiosurgery procedures (CPT code 77371 or 77372) furnished on or after January 1, 2016, until December 31, 2017, costs for certain adjunctive services (for example, planning and preparation) are not factored into the APC payment rate for APC 5627 (Level 7 Radiation Therapy). Rather, the ten planning and preparation codes listed in Table 4, will be paid according to their assigned status indicator when furnished 30 days prior or 30 days post SRS treatment delivery.

In addition, hospitals must report modifier “CP” (Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification [C-APC] procedure) on Type of Bill (TOB) 13X claims for any other services (excluding the ten codes in table 4) that are adjunctive or related to SRS treatment but billed on a different claim and within either 30 days prior or 30 days after the date of service for either CPT code 77371 (Radiation treatment delivery, stereotactic radiosurgery, complete course of treatment cranial lesion(s) consisting
of 1 session; multi-source Cobalt 60-based) or CPT code 77372 (Linear accelerator based). The “CP” modifier need not be reported with the ten planning and preparation CPT codes listed in table 4. Adjunctive/related services include but are not necessarily limited to imaging, clinical treatment planning/preparation, and consultations. Any service related to the SRS delivery should have the CP modifier appended. CMS does not expect the “CP” modifier to be reported with services such as chemotherapy administration as this is considered to be a distinct service that is not directly adjunctive, integral, or dependent on delivery of SRS treatment.

Table 4 – Excluded Planning and Preparation CPT Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CY 2016 Short Descriptor</th>
<th>CY 2016 Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>70551</td>
<td>MRI brain stem w/o dye</td>
<td>Q3</td>
</tr>
<tr>
<td>70552</td>
<td>MRI brain stem w/dye</td>
<td>Q3</td>
</tr>
<tr>
<td>70553</td>
<td>MRI brain stem w/o &amp; w/dye</td>
<td>Q3</td>
</tr>
<tr>
<td>77011</td>
<td>CT scan for localization</td>
<td>N</td>
</tr>
<tr>
<td>77014</td>
<td>CT scan for therapy guide</td>
<td>N</td>
</tr>
<tr>
<td>77280</td>
<td>Set radiation therapy field</td>
<td>S</td>
</tr>
<tr>
<td>77285</td>
<td>Set radiation therapy field</td>
<td>S</td>
</tr>
<tr>
<td>77290</td>
<td>Set radiation therapy field</td>
<td>S</td>
</tr>
<tr>
<td>77295</td>
<td>3-d radiotherapy plan</td>
<td>S</td>
</tr>
<tr>
<td>77336</td>
<td>Radiation physics consult</td>
<td>S</td>
</tr>
</tbody>
</table>

Changes to OPPS Pricer Logic

Effective April 1, 2016, there will be four diagnostic radiopharmaceuticals (1 newly approved) and one contrast agent receiving pass-through payment in the OPPS Pricer logic. For APCs containing nuclear medicine procedures, Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical or contrast agent payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical or contrast agent with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical or contrast agent expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals and contrast agents are the "policy-packaged" portions of the CY 2016 APC payments for nuclear medicine procedures and are available on the CMS website. MACs will adjust, as appropriate, claims brought to their attention with any retroactive changes that were received prior to implementation of the April 2016 OPPS Pricer.

Coverage Determinations

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

These HCPCS codes will be included with the April 2016 I/OCE update. Status and payment indicators for these HCPCS codes will be listed in the April 2016 update of the OPPS Addendum A and Addendum B at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html on the CMS website.

Additional Information

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 “Provider Enrollment Review Process” Web page at [http://www.cgsmedicare.com/hhh/enrollment/review_process.html](http://www.cgsmedicare.com/hhh/enrollment/review_process.html) was revised to give a high level summary of the time frames involved in the processing of the CMS-855A enrollment application.
- Two new questions/answers were added to the Cost Report Frequently Asked Questions (FAQs) Web page at [http://www.cgsmedicare.com/hhh/education/faqs/crf_faqs.html](http://www.cgsmedicare.com/hhh/education/faqs/crf_faqs.html). The FAQ #9 addresses whether a cost report needs to be sent when a facility closes. FAQ #10 addresses when a new facility needs to send the cost report.
- The “Checklist for Home Health & Hospice Cost Report Submission” Web page at [http://www.cgsmedicare.com/hhh/financial/cost_reporting/office_checklist.html](http://www.cgsmedicare.com/hhh/financial/cost_reporting/office_checklist.html) was updated to specify that the CMS Form 339 is only for home health agencies. The CMS Form 339 is only required for hospice providers when submitting a cost report for a beginning period before October 1, 2014.

For Home Health and Hospice Providers

Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE) Resources Available for Home Health and Hospice (HH&H) Providers

The CGS Home Health & Hospice website at [http://www.cgsmedicare.com/hhh/index.html](http://www.cgsmedicare.com/hhh/index.html) offers a wide variety of resources that assist HH&H providers with entering, adjusting, and correcting billing transactions via the FISS DDE system. CGS encourages all providers to use these resources to research questions related to FISS DDE prior to calling the Provider Contact Center. As a Medicare provider, you are accountable for understanding information you receive from CMS and CGS. Please review the following resources, and share this with your appropriate staff.

HH&H educational resources can be accessed by clicking on Education & Resources ([http://www.cgsmedicare.com/hhh/education/materials/index.html](http://www.cgsmedicare.com/hhh/education/materials/index.html)), which is found on the left side menu of the CGS website.

- Fiscal Intermediary Standard System (FISS) Guide, [http://www.cgsmedicare.com/hhh/education/materials/fiss.html](http://www.cgsmedicare.com/hhh/education/materials/fiss.html) – This Web page provides detailed information on the DDE screens available to providers and the eligibility systems ELGA and ELGH.
detailed instructions on reporting MSP required data elements (value codes, occurrence codes, primary insurer information, etc.).

- **Home Health Claims Filing**, [http://www.cgsmedicare.com/hhh/education/materials/hhe_claims_main.html](http://www.cgsmedicare.com/hhh/education/materials/hhe_claims_main.html) – This resource provides screen prints and field descriptions for each FISS claim page, and identifies which fields are required for Requests for Anticipated Payments (RAPs), and final claims. It also provides information on special situations that may occur with your claim.

- **Hospice Claims Filing**, [http://www.cgsmedicare.com/hhh/education/materials/hospice_cf.html](http://www.cgsmedicare.com/hhh/education/materials/hospice_cf.html) – This resource provides screen prints and field descriptions for each FISS claim page for Notice of Elections (NOEs)/Transfer NOEs, and the hospice claims, and Notice of Election Termination/Revocation (NOTR). In addition, resources addressing special situations are available.


- **Online Education Center**, [http://www.cgsmedicare.com/medicare_dynamic/education/001.asp](http://www.cgsmedicare.com/medicare_dynamic/education/001.asp) – Create your profile or log in to access a variety of computer based training modules. HH&H courses are found under the J15 Courses heading. The following are specific to FISS.
  - Course 1: Overview of Claims Processing
  - Course 2: Login and Menu Options
  - Course 3: Status/Locations, Function Keys and Shortcuts
  - Course 4: Inquiry Menu Options 12, 17, and 56

- **Return to Provider (RTP)**, [http://www.cgsmedicare.com/hhh/education/materials/return_to_provider.html](http://www.cgsmedicare.com/hhh/education/materials/return_to_provider.html) – This provides an overview on the RTP file and refers to resources with detailed instructions for correcting claims in the RTP file.

- **Additional Development Request (ADR) Overview**, [http://www.cgsmedicare.com/hhh/claims/overview_adr.html](http://www.cgsmedicare.com/hhh/claims/overview_adr.html) – This resource provides an overview of the Medical Review (MR) ADR and the non-MR ADR, and refers to resources to assist in checking to see if CGS has requested information from you, and how to submit the required documentation.

In addition to the above resources, CGS offers educational events, frequently asked questions, and much more educational materials, all available under the “Education & Resources” left side menu at: [http://www.cgsmedicare.com/hhh/education/index.html](http://www.cgsmedicare.com/hhh/education/index.html)

Your feedback is important to CGS! If you have any suggestions for educational topics or materials, or general comments about our website, go to the CGS Website Feedback page at [http://www.cgsmedicare.com/feedback.html](http://www.cgsmedicare.com/feedback.html) on the CGS website. In addition, when you visit the CGS website, take a few moments and complete the ForeSee Survey. Your opinion counts!

**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

**MM8822: Reclassification of Certain Durable Medical Equipment HCPCS Codes Included in Competitive Bidding Programs (CBP) from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category**

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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html

**MLN Matters® Number:** MM8822  
**Effective Date:** July 1, 2016 - except in Round 1 Re-compete CBP areas where effective date is January 1, 2017  
**Implementation Date:** July 5, 2016 - except for A/B and HHH MACs where implementation is 10/3/2016

**Related CR Release Date:** February 19, 2016  
**Related CR Transmittal #:** R1626OTN  
**Change Request (CR) #:** CR 8822

**Provider Types Affected**

This MLN Matters® Article is intended for suppliers and Home Health Agencies (HHAs) submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Home Health & Hospice MACs for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provided to Medicare beneficiaries.

**What You Need to Know**

Change request (CR) 8822 provides instructions for the upcoming reclassification of certain Durable Medical Equipment (DME) Healthcare Common Procedure Coding System (HCPCS) codes, that are included in Round 2 and Round 1 Re-compete DMEPOS CBPs, from the inexpensive and routinely purchased DME payment category to the capped rental DME payment category.

CR 8822 follows CR 8566, Rescind and Replace of CR 8409: Reclassification of Certain Durable Medical Equipment from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category, which was released on March 25, 2014. You can find the associated MLN Matters® article at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8566.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8566.pdf) on the CMS website. Make sure your billing staffs are aware of these changes.
Background

Medicare defines routinely purchased DME (set forth at 42 CFR §414.220(a)(2)) as equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987. A review of expensive items that have been classified as routinely purchased equipment since 1989 (that is, new codes added to the HCPCS after 1989 for items costing more than $150) showed inconsistencies in applying the definition.

As a result, a review of the definition of routinely purchased DME was published in the Federal Register (CMS-1526-F) along with notice of DME items (codes) requiring a revised payment category. Also in that rule, the Centers for Medicare & Medicaid Services (CMS) established that DME wheelchair accessories that are capped rental items furnished for use as part of a complex rehabilitative power wheelchair (wheelchair base codes K0835 – K0864), will be paid under the associated lump sum purchase option set forth at 42 CFR § 414.229(a)(5) and section 1834(a)(7)(A)(iii) of the Social Security Act. If the beneficiary declines the purchase option, the supplier must furnish the items on a capped rental basis and payment will be made on a monthly rental basis in accordance with the capped rental payment rules.

In order to align the payment category with the required regulatory definition, the HCPCS codes in the table below will reclassify to the capped rental payment category effective:

- July 1, 2016: Items furnished in all areas except the nine Round 1 Re-compete CBAs; and
- January 1, 2017: Items furnished in the nine Round 1 Re-compete CBAs.

<table>
<thead>
<tr>
<th>HCPCS Codes for Items Reclassified to Capped Rental DME Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCPCS Code</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>E0197</td>
</tr>
<tr>
<td>E0140, E0149</td>
</tr>
<tr>
<td>E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070</td>
</tr>
<tr>
<td>E0955</td>
</tr>
</tbody>
</table>

Further Details from CR8822:

1. In Round 1 Re-compete CBAs, payment for HCPCS codes shown in the above table will be made under the inexpensive and routinely purchased (IN) payment category for dates of service July 1, 2016 through December 31, 2016. Your MAC will recognize that the capped payment category requires payment of 10 percent of the purchase price for the first three months and 7.5 percent for each of the remaining rental months 4 through 13. You should also be aware that payment amounts will be based on the lower of the supplier’s actual charge and the fee schedule amount. Your MAC will return as unprocessable claims for the inexpensive and routinely purchased codes described above that are billed with the KH, KI and KJ modifiers. Such unprocessable claims will be returned with Claim Adjustment Reason Code (CARC) 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.), Remittance Advice Remark Code (RARC) N519 (Invalid combination of HCPCS modifiers) and Group Code CO (Contractual Obligation).

2. Effective for claims with dates of service on or after July 1, 2016, for items furnished in Round 2 CBAs, your MAC will cease any IN category rental payments for the codes in the above table and start payment under the Capped Rental (CR) payment category; applying a determination of the number of rental months paid (which cannot exceed 13 rental months combined from dates of service before and after the effective date (July 1, 2016)).
3. Effective for claims with dates of service on or after January 1, 2017, for items furnished in Round 1 Re-compete CBAs, your MAC will cease any IN rental payments for these codes, and start payment under the Capped Rental (CR) payment category; applying a determination of the number of rental months paid (which cannot exceed 13 rental months combined from dates of service before and after the effective date (January 1, 2017)).

4. Effective July 1, 2016, in all areas except the nine Round 1 CBAs, your MACs will process and pay claims for wheelchair base codes K0835 – K0864): E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955 (when applicable) on a lump sum purchase basis when used with complex rehabilitative power wheelchairs.

5. Effective January 1, 2017, in all areas including the Round 1 Re-compete CBAs, your MACs will process and pay claims for the codes K0835 – K0864): E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955 (when applicable) on a lump sum purchase basis when used with complex rehabilitative power wheelchairs.

6. When Home Health/Hospice providers (HHHs) bill codes E0197, E0140, E0149, E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070 and E0955 for services outside a competitive bid area on or after July 1, 2016, payment will be made on a capped rental basis.

7. When HHHs bill E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955 for services outside a competitive bid area on or after July 1, 2016, MACs will process such claims on a lump sum purchase basis, where applicable, when used with a complex rehabilitative wheelchair base (K0835-K0864).

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

**MM9424: Updates to the “Medicare Claims Processing Manual,” Pub. 100-04, Chapters 4 and 5 to Correct Remittance Advice Messages**

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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html

**MLN Matters® Number:** MM9424  
**Change Request (CR) #:** CR 9424  
**Related CR Release Date:** March 4, 2016  
**Effective Date:** June 6, 2016  
**Related CR Transmittal #:** R3475CP  
**Implementation Date:** June 6, 2016

**Provider Types Affected**

This MLN Matters® Article is intended for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.
What You Need to Know
Change Request (CR) 9424 revises chapters 4 and 5 of the “Medicare Claims Processing Manual” to ensure that all remittance advice coding is consistent with nationally standard operating rules. It also provides a format for consistently showing remittance advice coding throughout this manual.

CR9424 directs MACs to use remittance coding that is compliant with nationally standard Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE) operating rules.

Background
Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry’s use of Electronic Data Interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs regulates the way in which group codes, Claims Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) may be used. The rule requires specific codes, which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the CAQH CORE.

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages.

With CR9424, the Centers for Medicare & Medicaid Services (CMS) makes the following adjustments to CARC/RARC usage:

- MACs will use CARC 54 without an associated RARC when denying assistant at surgery services.
- MACs will use CARC 54 without an associated RARC when denying co-surgery services.
- MACs will use CARC 16 with RARCs MA66 and N56 when returning as unprocessable claims for Outpatient Intravenous Insulin Therapy (OIVIT) billed with HCPCS code 99199.
- MACs will use CARC 16 with RARCs MA66 and N56 when returning as unprocessable claims for OIVIT billed with the incorrect diagnosis code.
- MACs will also apply reformatted, but not changed, remittance advice coding as described in the revised Chapters 4 and 5 of the “Medicare Claims Processing Manual.”

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.
MM9461: Healthcare Provider Taxonomy Codes (HPTCs) April 2016 Code Set Update

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html

MLN Matters® Number: MM9461
Related CR Release Date: February 19, 2016
Related CR Transmittal #: R3467CP
Change Request (CR) #: CR 9461
Effective Date: April 1, 2016
Implementation Date: As soon as April 1, 2016, but no later than July 5, 2016

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice MACs and Durable Medical Equipment MACs, for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 9461 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or provider specialty for a claim.

The National Uniform Claim Committee (NUCC) maintains the HPTC set for standardized classification of health care providers, and updates it twice a year with changes effective April 1 and October 1. These changes include the addition of a new code and addition of definitions to existing codes.

You should note that:

1. Valid HPTCs are those that the NUCC has approved for current use;
2. Terminated codes are not approved for use after a specific date;
3. Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears; and
4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

CR9461 implements the NUCC HPTC code set that is effective on April 1, 2016, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at http://www.wpc-edi.com/codes on the Internet.

When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by the color code:

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, © 2016 Copyright, CGS Administrators, LLC.
New items are green;
Modified items are orange; and
Inactive items are red.

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

MM9531: Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April Calendar Year (CY) 2016 Update

The Centers for Medicare & Medicaid Services (CMS) has issued the following Medicare Learning Network® (MLN) Matters article. This MLN Matters article and other CMS articles can be found on the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html

MLN Matters® Number: MM9531 Change Request (CR) #: CR 9531
Related CR Release Date: February 19, 2016 Effective Date: April 1, 2016
Related CR Transmittal #: R3469CP Implementation Date: April 4, 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.

Provider Action Needed

Change Request (CR) 9531 amends payment files that were issued to your MAC based upon the CY 2016 Medicare Physician Fee Schedule (MPFS) Final Rule published in the Federal Register on November 16, 2015. These payment files are to be effective for services furnished between January 1, 2016, and December 31, 2016. Please make sure your billing staff is aware of these changes.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians’ services.

MACs will not search their files to either retract payment for claims already paid or to retroactively pay claims, however, they will adjust claims that you bring to their attention.

The key changes for the April update that are effective as of January 1, 2016 are as follows:

- CPT/HCPCS code G0464 is assigned a procedure status of I;
- Code 10030 is assigned Global period days of 000;
- Code 77014 is assigned a PC/TC Indicator of 1; and
- Code 80055 is assigned a procedure status of X.

Other changes that are effective for services performed on or after April 1, 2016 are as follows:
Codes G9481-G9490 are new and are assigned Type of Service of 1. See the MNL Matters article MM9533 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9533.pdf for further details of these new codes.

Additional Information


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

For Home Health and Hospice Providers

**MM9553: April 2016 Integrated Outpatient Code Editor (I/OCE) Specifications Version 17.1**

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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html

**MLN Matters® Number:** MM9553  **Change Request (CR) #:** CR 9553

**Related CR Release Date:** March 11, 2016  **Effective Date:** April 1, 2016

**Related CR Transmittal #:** R3477CP  **Implementation Date:** April 4, 2016

**Provider Types Affected**

This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs), including Home Health and Hospices (HH+H) MACs, for services provided to Medicare beneficiaries.
What You Need to Know

Change Request (CR) 9553 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications that will be used under the Outpatient Prospective Payment System (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes. The I/OCE specifications will be posted at http://www.cms.gov/OutpatientCodeEdit/ on the Centers for Medicare & Medicaid Services (CMS) website. These specifications contain the appendices mentioned in the table below.

Key Changes for April 2016 I/OCE

The modifications of the IOCE for the April 2016 v17.1 release are summarized in the following table. Note that some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the ‘Effective Date’ column.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
</table>
| 10/1/2015      | 2, 3, 86      | Update diagnosis editing for ICD-10 diagnosis codes (see quarterly data files, Dx10Map):  
• Removes age restrictions for specific newborn and pediatric diagnosis codes that are to be used throughout the patient’s lifetime;  
• Additions and removal of age edits for specific maternity diagnosis codes;  
• Removes sex restriction for specific diagnosis codes currently restricted for female patients; and  
• Additional codes added to the list of manifestation diagnosis codes. |
<p>| 1/1/2016       |               | Implement new logic to identify pass-through drugs and biologicals present for payment offset; output each offset amount condition present with Payer Value codes QR, QS, QT and identify the pass-through drug or biological procedures for payment offset with new payment adjustment flag values (see OPPS special processing logic, Table 5, Table 7 and Appendix G). |
| 1/1/2016       |               | Implement new logic to identify terminated device intensive procedures reported with modifier 73; output the device portion amount with Payer Value code QQ and identify the device intensive procedure reported with modifier 73 with a payment adjustment flag (see OPPS special processing logic, Table 5, Table 7 and Appendix G). |
| 1/1/2016       |               | Implement new logic to identify device credit conditions for device intensive Ambulatory Payment Classifications (APCs) when Condition Code 49, 50 or 53 is present; output the device credit amount with Payer Value code QQ and identify the device intensive procedure with a payment adjustment flag (see OPPS special processing logic, Table 5, Table 7 and Appendix G). |
| 4/1/2016       | 6, 91         | Implement edit 91 for Rural Health Clinic (RHC) claims with bill type 71x to be returned if non-covered services are reported (see special processing logic for FQHC PPS claims, Appendix F (a) and Appendix M); update the description for edit 91 to include RHC. Implement edit 6 for RHC (see Appendix F (a)). |
| 1/1/2016       |               | Update the program logic for CT scan payment reduction when not meeting National Electrical Manufacturers Association (NEMA) standards to assign payment adjustment flag 14 to the multiple imaging composite APC line if CT modifier is not present but there are composite constituent codes present that do report modifier CT (see OPPS special processing logic and Appendix K). |
| 1/1/2016       | 45            | Update the logic for edit 45 to include criteria for inpatient separate procedures reported on the same claim as a comprehensive APC procedure with a Status Indicator (SI) = J1. |
| 1/1/2016       |               | Update Appendix L to include procedure codes with SI = C in the list of non-allowed procedures by SI for OPPS claims. |
| 1/1/2016       |               | Update the program logic for pass-through device payment offset to not provide the offset if the primary comprehensive APC procedure (SI = J1) is not paired with a pass-through device code present on the claim (see OPPS special processing logic and Appendix L). |
| 1/1/2016       |               | Update Appendix E with a note for setting the Payment Method Flag to 2 for laboratory codes with SI = Q4 that result in final assignment of SI = A. |</p>
<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Edits Affected</th>
<th>Modification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the program logic for comprehensive APC 5881 (inpatient procedure where patient expired) to correctly exclude services designated as comprehensive APC exclusions when reported on the same day when APC 5881 is assigned.</td>
</tr>
<tr>
<td>1/1/2015</td>
<td></td>
<td>Update program logic for comprehensive APC processing to recognize modifier 50 for comprehensive APC procedures that may be eligible for complexity adjustment (see Appendix L).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the program logic for Grandfathered Tribal Federally Qualified Health Center (FQHC) claims to identify the single payable visit (payment indicator 14) for each day if the claim contains multiple days (see Appendix M).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the program logic for Grandfathered Tribal FQHC claims to assign the composite adjustment flag only for the single payable visit for the day (see Appendix M).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Modify the output of the Payer Value Code and Amount field to pass blanks for the Value Code label (QN-QW) and zero-fill the Amount portion of the field if conditions for payment offset are not present on the claim (see Table 5 of the I/OCE specifications). Note: If conditions for edit 24 (Date out of OCE range) are present, Payer Value Code and Amount is blank (no zero-fill). Add the following new Payer Value Codes to the field output (see Table 5):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• QP: Placeholder reserved for future use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• QQ: Terminated procedure with pass-through device OR condition for device credit present</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• QR: First APC pass-through drug or biological offset</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• QS: Second APC pass-through drug or biological offset</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• QT: Third APC pass-through drug or biological offset</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Revise the following Payer Value Code descriptions:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• QN: First APC device offset</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• QO: Second APC device offset</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Add the following new Payment Adjustment Flag values (see Table 7 and Appendix G):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 15: Placeholder reserved for future use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 16: Terminated procedure with pass-through device</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 17: Condition for device credit present</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 18: Offset for first pass-through drug or biological</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 19: Offset for second pass-through drug or biological</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 20: Offset for third pass-through drug or biological</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Revise the following Payment Adjustment Flag descriptions:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 12: Offset for first device pass-through</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 13: Offset for second device pass-through</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Correction of the issue with the interactive PC IOCE product that caused claims to not complete processing to the output report when the pass-through device offset amount was greater than $999.99.</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>The following clarifying information is added (no change to software program logic):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Direct Referral logic to include J1 procedures (page 46) with the SI = T criteria</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Critical Care packaged ancillary codes (page 11): update SI values for codes subject to modifier 59 exception.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Conditionally packaged laboratory codes (page 12): laboratory codes that are always packaged with SI = N, and removal of SI J1 and J2 (comprehensive APCs) from list of OPPS services by SI under which laboratory codes with SI = Q4 are changed to SI = A for claims with bill type 13x.</td>
</tr>
<tr>
<td>11/24/2015</td>
<td>67</td>
<td>Add mid-quarter editing for Food and Drug Administration (FDA) approval of code 90653 (SI changed to L).</td>
</tr>
</tbody>
</table>
Update the following procedure lists for the release (see quarterly data files):

- Procedures not recognized under OPPS (SI=B)
- Conditionally packaged laboratory services (SI=Q4)
- FQHC non-covered services
- Device offset pairs
- Device list (edit 92)
- Comprehensive APC exclusions
- New pass-through drug and biological/APC offset
- New device intensive procedures for terminated procedure and device credit (Value Code QQ)

Make all HCPCS/APC/SI changes as specified by CMS (quarterly data files).

Implement version 22.1 of the NCCI (as modified for applicable outpatient institutional providers).

Note: Readers should also read through the entire document and note the highlighted sections, which also indicate changes from the prior release of the software.

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**

**MM9554: April Quarterly Update for 2016 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule**

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: [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html)

**MLN Matters® Number:** MM9554  
**Change Request (CR) #:** CR 9554  
**Related CR Release Date:** February 26, 2016  
**Effective Date:** April 1, 2016  
**Related CR Transmittal #:** R3472CP  
**Implementation Date:** April 4, 2016

**Provider Types Affected**

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

**What You Need to Know**

Change Request (CR) 9554 provides the April quarterly update for the Medicare DMEPOS fee schedule. The instructions include information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. Because there are no updates from the previous quarter (January through March 2016), an April update to the 2016 DMEPOS and Parenteral and Enteral Nutrition (PEN) fee schedule files is not scheduled for release. However, an April 2016 DMEPOS Rural ZIP code file containing Quarter Two, 2016 rural ZIP Code changes is being provided to the MACs.
The April 2016 DMEPOS Rural ZIP code Public Use File (PUF) at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched), containing the rural ZIP codes effective for Quarter 2, 2016, will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the above file.

**Background**


Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by §1834(a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR §414.102 for Parenteral and Enteral Nutrition (PEN), splints and casts, and Intraocular Lenses (IOLs) inserted in a physician’s office.

Additionally, Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from Competitive Bidding Programs (CBPs) for DME. Section 1842(s)(3)(B) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs. CMS issued a final rule on November 6, 2014 (79 FR 66223), on the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs.

CMS issued a final rule on November 6, 2014 (79 FR 66223), on the methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs. The CBP product categories, HCPCS codes and Single Payment Amounts (SPAs) included in each Round of the CBP are available on the Competitive Bidding Implementation Contractor (CBIC) website ([http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home](http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home)).

The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjusted payment amount methodologies discussed above as well as codes that are not subject to the fee schedule CBP adjustments. To apply the adjusted fees rural payment rule for areas within the contiguous United States, the DMEPOS and PEN fee schedule files have been updated, effective January 1, 2016, to include rural payment amounts for certain HCPCS codes.

Beginning January 1, 2016, the ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts based on information from the competitive bidding program. ZIP codes for non-continental Metropolitan Statistical Areas (MSA) are not included in the DMEPOS Rural ZIP code file.


**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

Provider Contact Center (PCC) Training

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>
<th>PCC Training/Closures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday, May 12, 2016</td>
<td>8:00 a.m. – 10:00 a.m. Central Time</td>
</tr>
<tr>
<td>Thursday, May 26, 2016</td>
<td></td>
</tr>
<tr>
<td>Monday, May 30, 2016 (Memorial Day)</td>
<td>Office Closed</td>
</tr>
</tbody>
</table>

Memorial Day Holiday

While we celebrate the Memorial Day holiday with our families, our offices will be closed on Monday, May 30, 2016. Our data center has informed us that the Fiscal Intermediary Standard System (FISS) and access to the ELGA and ELGH eligibility screens will not be available on May 30. In addition, the system will not cycle that night, which means that claims will not be sent to the Common Working File (CWF) on May 30, 2016. Medicare Remittance Advices, Electronic Remittance Advices (ERAs), Medicare paper checks, and Electronic Funds Transfers (EFTs) will not be produced Monday night.

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 available to access eligibility information through the Internet. For additional information, go to http://www.cgsmedicare.com/hhh/index.html and click the “myCGS” button on the left side of the Web page.


For Home Health and Hospice Providers

SE1605: Provider Enrollment Revalidation – Cycle 2

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: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html

<table>
<thead>
<tr>
<th>MLN Matters® Number: SE1605</th>
<th>Change Request (CR) #: N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related CR Release Date: N/A</td>
<td>Effective Date: N/A</td>
</tr>
<tr>
<td>Related CR Transmittal #: N/A</td>
<td>Implementation Date: N/A</td>
</tr>
</tbody>
</table>

Provider Types Affected

This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers who are enrolled in Medicare and required to revalidate through their Medicare Administrative Contractors (MACs), including Home Health & Hospice.
MACs (HH&H MACs), Medicare Carriers, Fiscal Intermediaries, and the National Supplier Clearinghouse (NSC)). These contractors are collectively referred to as MACs in this article.

**Provider Action Needed**

**STOP – Impact to You**

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. The Centers for Medicare & Medicaid Services (CMS) has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. In an effort to streamline the revalidation process and reduce provider/supplier burden, CMS has implemented several revalidation processing improvements that are captured within this article.

**CAUTION – What You Need to Know**

Special Note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers/suppliers should continue to submit changes (for example, changes of ownership, change in practice location or reassignments, final adverse action, changes in authorized or delegated officials or, any other changes) as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

**GO – What You Need to Do**

1. Check [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) for the provider/suppliers due for revalidation;

2. If the provider/supplier has a due date listed, CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate. When either of these occur:
   - Submit a revalidation application through Internet-based PECOS located at [https://pecos.cms.hhs.gov/pecos/login.do](https://pecos.cms.hhs.gov/pecos/login.do), the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or
   - Complete the appropriate CMS-855 application available at [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html);
   - If applicable, pay your fee by going to [https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do](https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do); and
   - Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

**Background**

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. This cycle of revalidation applies to those providers/suppliers that are currently and actively enrolled.

**What’s ahead for your next Medicare enrollment revalidation?**

**Established Due Dates for Revalidation**

CMS has established due dates by which the provider/supplier’s revalidation application must reach the MAC in order for them to remain in compliance with Medicare’s provider enrollment requirements. The due dates will generally be on the last day of a month (for example, June 30, July 31 or August 31). Submit your revalidation application to your MAC within 6 months.
of your due date to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges. Generally, this due date will remain with the provider/supplier throughout subsequent revalidation cycles.

- The list will be available at http://go.cms.gov/MedicareRevalidation and will include all enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a “TBD” (To Be Determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at http://go.cms.gov/MedicareRevalidation on the CMS website.

**IMPORTANT:** The list identifies billing providers/suppliers only that are required to revalidate. If you are enrolled solely to order, certify, and/or prescribe via the CMS-855O application or have opted out of Medicare, you will not be asked to revalidate and will not be reflected on the list.

- Due dates are established based on your last successful revalidation or initial enrollment (approximately 3 years for DME suppliers and 5 years for all other providers/suppliers).
- In addition, the MAC will send a revalidation notice within 2-3 months prior to your revalidation due date either by e-mail (to e-mail addresses reported on your prior applications) or regular mail (at least two of your reported addresses: correspondence, special payments and/or your primary practice address) indicating the provider/supplier’s due date.

Revalidation notices sent via e-mail will indicate “URGENT: Medicare Provider Enrollment Revalidation Request” in the subject line to differentiate from other e-mails. If all of the e-mails addresses on file are returned as undeliverable, your MAC will send a paper revalidation notice to at least two of your reported addresses: correspondence, special payments and/or primary practice address.

**NOTE:** Providers/suppliers who are within 2 months of their listed due dates on http://go.cms.gov/MedicareRevalidation but have not received a notice from their MAC to revalidate, are encouraged to submit their revalidation application.

- To assist with submitting complete revalidation applications, revalidation notices for individual group members, will list the identifying information of the organizations that the individual reassigns benefits.

**Large Group Coordination**

Large groups (200+ members) accepting reassigned benefits from providers/suppliers identified on the CMS list will receive a letter from their MACs listing the providers linked to their group that are required to revalidate for the upcoming 6 month period. A spreadsheet detailing the applicable provider’s Name, National Provider Identifier (NPI) and Specialty will also be provided. CMS encourages the groups to work with their practicing practitioners to ensure that the revalidation application is submitted prior to the due date. We encourage all groups to work together as only one application from each provider/supplier is required, but the provider must list all groups they are reassigning to on the revalidation application submitted for processing. MACs will have dedicated provider enrollment staff to assist in the large group revalidations.

Groups with less than 200 reassignments will not receive a letter or spreadsheet from their MAC, but can utilize PECOS or the CMS list available on http://go.cms.gov/MedicareRevalidation to determine their provider/supplier’s revalidation due dates.

**Unsolicited Revalidation Submissions**

All unsolicited revalidation applications submitted more than 6 months in advance of the provider/supplier’s due date will be returned.
• What is an unsolicited revalidation?
  ▪ If you are not due for revalidation in the current 6 month period, your due date will be listed as “TBD” (To Be Determined). This means that you do not yet have a due date for revalidation. Please do not submit a revalidation application if there is NOT a listed due date.
  ▪ Any off-cycle or ad hoc revalidations specifically requested by CMS or the MAC are not considered unsolicited revalidations.
  ▪ If your intention is to submit a change to your provider enrollment record, you must submit a ‘change of information’ application using the appropriate CMS-855 form.

Submitting Your Revalidation Application

**IMPORTANT: Each provider/supplier is required to revalidate their entire Medicare enrollment record.**

A provider/supplier’s enrollment record includes information such as the provider’s individual practice locations and every group that benefits are reassigned (that is, the group submits claims and receives payments directly for services provided). This means the provider/supplier is recertifying and revalidating all of the information in the enrollment record, including all assigned NPIs and Provider Transaction Access Numbers (PTANs).

If you are an individual who reassigns benefits to more than one group or entity, you must include all organizations to which you reassign your benefits on one revalidation application. If you have someone else completing your revalidation application for you, encourage coordination with all entities to which you reassign benefits to ensure your reassignments remain intact.

The fastest and most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to [https://pecos.cms.hhs.gov/pecos/login.do](https://pecos.cms.hhs.gov/pecos/login.do). PECOS allows you to review information currently on file and update and submit your revalidation via the Internet. Once completed, YOU MUST electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper certification statement along with all required supporting documentation to your appropriate MAC IMMEDIATELY.

PECOS ensures accurate and timelier processing of all types of enrollment applications, including revalidation applications. It provides a far superior alternative to the antiquated paper application process.

To locate the paper enrollment applications, refer to [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html) on the CMS website.

Getting Access to PECOS:

To use PECOS, you must get approved to access the system with the proper credentials which are obtained through the Identity and Access Management System, commonly referred to as “I&A”. The I&A system ensures you are properly set up to submit PECOS applications. Once you have established an I&A account you can then use PECOS to submit your revalidation application as well as other enrollment application submissions.

If you have questions regarding filling out your application via PECOS, please contact the MAC that sent you the revalidation notice. You may also find a list of MAC’s at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf on the CMS website.

For questions about accessing PECOS (such as login, forgot username/password) or I&A, contact the External User Services (EUS) help desk at 1.866.484.8049 or at EUSSupport@cgi.com.

Deactivations Due to Non-Response to Revalidation or Development Requests

It is important that you submit a complete revalidation application by your requested due date and you respond to all development requests from your MACs timely. Failure to submit a complete revalidation application or respond timely to development requests will result in possible deactivation of your Medicare enrollment.

If your application is received substantially after the due date, or if you provide additional requested information substantially after the due date (including an allotted time period for US or other mail receipt) your provider enrollment record may be deactivated. Providers/suppliers deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

**NOTE:** The reactivation date after a period of deactivation will be based on the receipt date of the new full and complete application. Retroactive billing privileges back to the period of deactivation will **not** be granted. Services provided to Medicare patients during the period between deactivation and reactivation are the provider’s liability.

Revalidation Timeline and Example

Providers/suppliers may use the following table/chart as a guide for the sequence of events through the revalidation progression.

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeframe</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revalidation list posted</td>
<td>Approximately 6 months prior to due date</td>
<td>March 30, 2016</td>
</tr>
<tr>
<td>Issue large group notifications</td>
<td>Approximately 6 months prior to due date</td>
<td>March 30, 2016</td>
</tr>
<tr>
<td>MAC sends email/letter notification</td>
<td>75 – 90 days prior to due date</td>
<td>July 2 - 17, 2016</td>
</tr>
<tr>
<td>MAC sends letter for undeliverable e-mails</td>
<td>75 – 90 days prior to due date</td>
<td>July 2 - 17, 2016</td>
</tr>
<tr>
<td>Revalidation due date</td>
<td>September 30, 2016</td>
<td></td>
</tr>
<tr>
<td>Apply payment hold/issue reminder letter (group members)</td>
<td>Within 25 days after due date</td>
<td>October 25, 2016</td>
</tr>
<tr>
<td>Deactivate</td>
<td>60 – 75 days after due date</td>
<td>November 29 – December 14, 2016</td>
</tr>
</tbody>
</table>

Application Fees

Institutional providers of medical or other items or services and suppliers are required to submit an application fee for revalidations. The application fee is $554.00 for Calendar Year (CY) 2016. CMS has defined “institutional provider” to mean any provider or supplier that submits an application via PECOS or a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms.

All institutional providers (that is, all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit the 2016 enrollment fee (reference 42 CFR 424.514) with their revalidation application. You may submit your fee by ACH debit, or credit card. To pay your application fee, go to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do and submit payment as directed. A confirmation screen will display
indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you include this receipt with your uploaded documents on PECOS or mail it to the MAC along with the Certification Statement for the enrollment application. CMS will notify the MAC that the application fee has been paid. Revalidations are processed only when fees have cleared.

**SUMMARY:**

- CMS will post the revalidation due dates for the upcoming revalidation cycle on [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) for all providers/suppliers. This list will be refreshed periodically. Check this list regularly for updates.
- MACs will continue to send revalidation notices (either by e-mail or mail) within 2-3 months prior to your revalidation due date. When responding to revalidation requests, be sure to revalidate your entire Medicare enrollment record, including all reassignment and practice locations. If you have multiple reassignments/billing structures, you must coordinate the revalidation application submission with all parties.
- If a revalidation application is received but incomplete, the MACs will develop for the missing information. If the missing information is not received within 30 days of the request, the MACs will deactivate the provider/supplier's billing privileges.
- If a revalidation application is not received by the due date, the MAC may place a hold on your Medicare payments and deactivate your Medicare billing privileges.
- If billing privileges are deactivated, a reactivation will result in the same PTAN but an interruption in billing during the period of deactivation. This will result in a gap in coverage.
- If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.

**Additional Information**

To find out whether a provider/supplier has been mailed a revalidation notice go to [http://go.cms.gov/MedicareRevalidation](http://go.cms.gov/MedicareRevalidation) on the CMS website.


The MLN fact sheet titled “The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations” is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf) on the CMS website.
To access PECOS, your Authorized Official must register with the PECOS Identification and Authentication system. To register for the first time go to https://pecos.cms.hhs.gov/pecos/PecosiAConfirm.do?transferReason=CreateLogin to create an account.

For additional information about the enrollment process and Internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment Web page at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html 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 3.

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 and complete the required information.

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.