Medicare Bulletin

Jurisdiction 15
### HOME HEALTH PROVIDERS

- **MM9585**: Denial of Home Health Payments When Required Patient Assessment Is Not Received ................. 3
- **MM9736**: Implementation of Policy Changes for the CY 2017 Home Health Prospective Payment System ............ 4
- **MM9771**: Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement .................. 8
- **MM9782**: 2017 Annual Update to the Therapy Code List .................. 9
- **MM9820**: Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2017 .................. 13
- **MM9826**: Correcting Editing for Condition Code 54 and Updating Remittance Advice Messages on Home Health Claims .................................................. 17
- **MM9865**: Therapy Cap Values for Calendar Year (CY) 2017 .................................................. 18

### HOSPICE PROVIDERS

- **SE1628**: Documentation Requirements for the Hospice Physician Certification/Recertification .................. 19
- **SE1631**: Sample Hospice Notice of Election Statement ....... 25

### HOME HEALTH & HOSPICE PROVIDERS

- **CGS Website Updates ................................................. 27**
- **Medicare Credit Balance Quarterly Reminder .................. 28**
- **Medicare Secondary Payer (MSP) Prepayment Process .......... 29**
- **MLN Connects™ Provider eNews .................................. 30**
- **MM9533 (Revised)**: Comprehensive Care for Joint Replacement Model (CJR) Provider Education .................. 31
- **MM9681**: Modifications to the National Coordination of Benefits Agreement Crossover Process .................. 36
- **MM9708**: Internet-Only Manual, Pub. 100-06, Chapter 3, Section 90 (Provider Liability) Revision .................. 37
- **MM9716**: New Physician Specialty Code for Hospitalist ........ 38
- **MM9767**: Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) .................. 39
- **MM9769**: Claim Status Category and Claim Status Codes Update .................................................. 40
- **MM9774**: Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update .................................................. 42
- **MM9793 (Revised)**: Implementation of New Influenza Virus Vaccine Code .................................................. 43
- **MM9843**: January 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files .................................................. 44
- **New Online Education Course for Medicare Secondary Payer Claims! .................................................. 45
- **Provider Contact Center (PCC) Training .................................................. 46
- **Quarterly Provider Update .................................................. 46
- **Redetermination Requests Reminders .................................................. 47
- **Stay Informed and Join the CGS ListServ Notification Service .................................................. 48
- **Unsolicited/Voluntary Refunds .................................................. 48
- **Upcoming Educational Events .................................................. 49**

*Bold, italicized material is excerpted from the American Medical Association Current Procedural Terminology CPT codes. Descriptions and other data only are copyrighted 2017 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.*
MM9585: Denial of Home Health Payments When Required Patient Assessment Is Not Received

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/MLN MattersArticles/index.html

MLN Matters® Number: MM9585  
Related CR Release Date: October 27, 2016  
Related CR Transmittal #: R3629CP

Change Request (CR) #: CR 9585  
Effective Date: April 1, 2017  
Implementation Date: April 3, 2017

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9585 directs MACs to automate the denial of Home Health Prospective Payment System (HH PPS) claims when the condition of payment for submitting patient assessment data has not been met. Make sure that your billing staffs are aware of this change.

Background

Per the Code of Federal Regulations (CFR) at 42 CFR 484.210(e), (https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-part484.pdf) submission of an Outcome and Assessment Information Set (OASIS) assessment for all Home Health (HH) episodes of care is a condition of payment. If the OASIS is not found during medical review of an HH claim, the claim is denied. Original Medicare systems validate the HIPPS code submitted on an HH claim against the HIPPS code calculated by when the OASIS assessment is received in the Quality Information Evaluation System (QIES). If the codes do not match, the HIPPS code calculated from the OASIS assessment is used for payment. Currently, Medicare systems take no action on claims when the OASIS assessment is not found.
The Office of Inspector General (OIG) has recommended that Medicare strengthen its enforcement of OASIS as a condition of payment. In Medicare’s response to OIG report OEI-01-10-00460 (https://oig.hhs.gov/oei/reports/oei-01-10-00460.asp), the Centers for Medicare & Medicaid Services (CMS) stated its intention to use the claims-OASIS interface to do this.

Medicare implemented the initial stage in April 2015. Medicare informed providers through the MLN Matters® Special Edition article SE1504 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1504.pdf). In that article, Medicare also notified HHAs that “CMS plans to use the claims matching process to enforce this condition of payment in the earliest available Medicare systems release. At that time, Medicare will deny claims when a corresponding assessment is past due in the QIES but is not found in that system.” CR9585 provides MACs with requirements to implement this next step.

When an OASIS Assessment Has Not Been Submitted

As mentioned above, submission of an OASIS assessment is a condition of payment for HH episodes of care. OASIS reporting regulations require the OASIS to be transmitted within 30 days of completing the assessment of the beneficiary. In most cases, this 30-day period will have elapsed by the time a 60-day episode of HH services is completed and the HHA submits the final claim for that episode to Medicare. If the OASIS assessment is not found in the QIES upon receipt of a final claim for an HH episode and the receipt date of the claim is more than 30 days after the assessment completion date, Medicare systems will deny the HH claim. (While the regulation requires the assessment to be submitted within 30 days, the initial implementation of this edit will allow 40 days.) In denying the claim, Medicare will supply the following remittance messages:

- Group Code of CO
- Claim Adjustment Reason Code 272

Additional Information

The official instruction, CR9585, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3629CP.pdf. The revised portion of Chapter 10 of the "Medicare Claims Processing Manual" discusses this change further and that manual portion is attached to CR9585.

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

**MM9736: Implementation of Policy Changes for the CY 2017 Home Health Prospective Payment System**

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/index.html

<table>
<thead>
<tr>
<th>MLN Matters® Number: MM9736</th>
<th>Change Request (CR) #: CR 9736</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related CR Release Date: November 10, 2016</td>
<td>Effective Date: January 1, 2017</td>
</tr>
<tr>
<td>Related CR Transmittal #: R3655CP</td>
<td>Implementation Date: January 3, 2017</td>
</tr>
</tbody>
</table>

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, Regional
Home Health Intermediaries (RHHIs) and A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You
This article is based on Change Request (CR) 9736 which informs Medicare contractors about the implementation of a separate payment for home health agencies (HHAs) for disposable Negative Pressure Wound Therapy (NPWT) devices when furnished to a patient who receives home health services for which payment is made under the Medicare home health benefit. In addition, CR9736 will do the following:

- Implement changes to the methodology used to calculate outlier payments to HHAs and
- Create new G codes associated with registered nurse (RN) and licensed practical nurse (LPN) visits in the home health setting.

GO – What You Need to Do
Make sure that your billing staffs are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Provision of NPWT Using a Disposable Device
The Consolidated Appropriations Act of 2016 (Pub. L 114-113) requires a separate payment to be made to Home Health Agencies (HHAs) for disposable NPWT devices when furnished, on or after January 1, 2017, to an individual who receives home health services for which payment is made under the Medicare home health benefit.

Key points in CR9736

Change in the Methodology Used to Calculate Outlier Payments
Currently, the Centers for Medicare and Medicaid Services (CMS) calculates the estimated cost for an episode using the number of visits by discipline and multiplying them by the national per-visit rates finalized in our rules. The Report to Congress on home health access to care and payment for vulnerable patient populations (required per Section 3131(d) of the Affordable Care Act), indicated that HHAs can make a profit on outlier episodes by providing shorter visits than what is assumed in the national per-visit rates. Therefore, the current methodology for calculating the cost of an episode of care potentially overestimates the costs associated with an episode where shorter visits are provided than is assumed in the national per-visit rates. In addition, the study findings noted that certain types of patients may be associated with lower margins, such as those who require parenteral nutrition or require substantial assistance with bathing. These types of patients, on average, typically require longer visits and are thus more costly to treat.

Analysis of calendar year 2015 data indicates that there is significant variation in the visit length by discipline for outlier episodes. Those agencies with 5 percent or more of their total payments as outlier payments are providing shorter but more frequent skilled nursing visits than agencies with less than 5 percent of their total payments as outlier payments.

Creation of New G Codes for RN and LPN In Home Health Episodes
Effective for January 1, 2016, CMS divided the G0154 code into two different codes (codes G0299 and G0300) that differentiate RN from LPN and may be used in both HH and hospice settings. This change was made in order to furnish a hospice add-on payment that is only payable for RN visits (not LPN visits) through the Service Intensity Add-on Payment.

As of CY 2015, CMS now annually recalibrates the HH case-mix weights. The weights are determined by calculating the cost for each episode of care, grouping the episodes by similar
levels of resource use, and comparing the group’s average resource use to overall mean. The cost of an episode of care is calculated using the BLS average hourly wage rate for the discipline that performed the visit multiplied by the minutes per visit reported on the HH claim. Currently, CMS has separate G-codes for therapist versus therapist assistant visits so they are able to use the appropriate BLS average hourly wage rate depending on whether the visit was performed by a therapist or an assistant. However, for skilled nursing services, because G0163 and G0164 are for an RN or LPN, CMS has to assume a certain percentage are performed by a RN versus an LPN.

Since CMS has begun differentiating direct skilled nursing using the two new G-codes (codes G0299 and G0300), CMS believes it is appropriate to differentiate G0163 and G0164 as well so that there is no longer a need to use an assumption in calculating the cost per episode when those two services are performed, allowing for increased payment precision.

**Provision of NPWT Using a Disposable Device**

As described in the Consolidated Appropriations Act of 2016 (Pub. L 114-113), the separate payment amount for an applicable disposable device will be set equal to the amount of the payment that would otherwise be made under the Medicare Hospital Outpatient Prospective Payment System (OPPS) using the Level I Healthcare Common Procedure Coding System (HCPCS) code, otherwise referred to as Current Procedural Terminology (CPT-4) codes.

Currently CPT codes 97607 and 97608 (APC 5052), with status indicator “T” (Procedure or Service, Multiple Procedure Reduction Applies), include payment for both performing the service and the disposable NPWT device:

- **HCPCS 97607** - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters.
- **HCPCS 97608** - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.

To avoid duplication of payment, for instances where the sole purpose for an HHA visit is to perform NPWT using a disposable device (integrated system of a vacuum pump, receptacle for collecting exudate, and dressings for the purposes of wound therapy), Medicare will not pay for a skilled nursing or therapy visit under the HH PPS. Rather, performing NPWT using a disposable device for a patient under a home health plan of care is being separately reimbursed the OPPS amount relating to payment for covered OPD services. In this situation, the HHA bills under type of bill 034X and reports the appropriate revenue code (0559, 042X, 043X), along with the appropriate HCPCS code (97607 or 97608).

**NOTE:** This visit is not reported on the HH PPS claim (type of bill 32x).

If NPWT using a disposable device is performed during the course of an otherwise covered home health visit (e.g., to perform a catheter change), the visit would be covered as normal but the HHA must not include the time spent performing NPWT in their visit charge or in the length of time reported for the visit. Performing NPWT using a disposable device for a patient under a home health plan of care will be separately reimbursed the OPPS amount relating to payment for covered OPD services. In this situation, the HHA bills under type of bill 034X and reports revenue code (0559, 042X, 043X) along with the appropriate HCPCS code (97607 or 97608).
**Denial Message**

When a claim with HCPCS 97607 and 97608 on TOB 034X is identified as not falling within a HH episode, your MAC will deny lines reporting revenue code 0559 (Skilled Nursing Care, Comprehensive Visit) using the following remittance advice codes:

- **Group Code: CO**
- **CARC:** 170 (Payment is denied when performed/billed by this type of provider.  
  Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.)
- **RARC:** N95 (Services subjected to Home Health Initiative medical review/cost report audit.)

**Change in the Methodology Used to Calculate Outlier Payments**

Given the analysis described above, as well as the findings from the 3131(d) study, CMS is concerned the current methodology for calculating outlier payments creates a financial disincentive for providers to treat medically complex beneficiaries that require longer visits. In addition, the current methodology does not accurately calculate the precise cost of an episode of care for instances where the length of the visit is greater than or less than the average length of a visit assumed in the national per visit rates. Therefore, CMS is changing the methodology used to calculate outlier payments to a cost per unit approach rather than a cost per visit approach.

HHAs currently report visit lengths in 15 minute increments (15 minutes = 1 unit). To implement this new methodology, the national per visit rates will be converted into per unit rates (as described in Attachment 1 in CR9367). The new per unit rates will then be used to calculate the estimated cost of an episode to determine whether the claim will receive an outlier payment and the amount of payment for an episode of care. This change in the methodology will be budget neutral as CMS would still target to pay up to, but no more than, 2.5 percent of total HH PPS payments as outlier payments.

In conjunction with the change to a cost-per unit approach to estimate episode costs and determine whether an outlier episode should receive outlier payments, CMS is implementing a cap on the amount of time per day that would be counted toward the estimation of an episode’s costs for outlier calculation purposes, limiting the amount of time per day (summed across the six disciplines of care) at 8 hours or 32 units total.

For rare instances when more than one discipline of care is provided and there is more than 8 hours of care provided in one day, the episode cost associated with the care provided during that day will be calculated using a hierarchical method based on the cost per unit per discipline. The discipline of care with the lowest associated cost per unit will be discounted in the calculation of episode cost in order to cap the estimation of an episode’s cost at 8 hours of care per day.

**Creation of New G Codes for RN and LPN in Home Health Episodes**

Given the reporting needs articulated above, CMS is requesting that G0163 and G0164 be retired, effective January 1, 2017, and instead replaced with four new G-codes:

1. **G0493** - Skilled services of a registered nurse (RN) for the observation and assessment of the patient’s condition, each 15 minutes (the change in the patient’s condition requires skilled nursing personnel to identify and evaluate the patient’s need for possible modification of treatment in the home health or hospice setting).
2. **G0494** - Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient’s condition, each 15 minutes (the change in the patient’s
condition requires skilled nursing personnel to identify and evaluate the patient’s need for possible modification of treatment in the home health or hospice setting).

3. G0495 - Skilled services of a registered nurse (RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

4. G0496 - Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

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

**MM9771: Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement**

The Centers for Medicare & Medicaid Services (CMS) has issued the following [Medicare Learning Network® (MLN) Matters](https://www.cms.gov/Medicare/Coding/HCPCS/downloads/MLNMattersArticles/index.html) 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/index.html

<table>
<thead>
<tr>
<th>MLN Matters® Number: MM9771</th>
<th>Change Request (CR) #: CR 9771</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related CR Release Date: October 7, 2016</td>
<td>Effective Date: January 1, 2017</td>
</tr>
<tr>
<td>Related CR Transmittal #: R3618CP</td>
<td>Implementation Date: January 3, 2017</td>
</tr>
</tbody>
</table>

**Provider Types Affected**

This MLN Matters® Article is intended for Home Health Agencies (HHAs) and other providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

**Provider Action Needed**

Change Request (CR) 9771 provides the 2017 annual update to the list of HCPCS codes used by Medicare systems to enforce consolidated billing of home health services. Make sure that your billing staffs are aware of these changes.

**Background**

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.
The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, K codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency.

The HCPCS codes in the table below are being added to the HH consolidated billing therapy code list, effective for services on or after January 1, 2017. These codes replace HCPCS codes: 97001, 97002, 97003, 97004.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>97161</td>
<td>PT EVAL LOW COMPLEX 20 MIN</td>
</tr>
<tr>
<td>97162</td>
<td>PT EVAL MOD COMPLEX 30 MIN</td>
</tr>
<tr>
<td>97163</td>
<td>PT EVAL HIGH COMPLEX 45 MIN</td>
</tr>
<tr>
<td>97164</td>
<td>PT RE-EVAL EST PLAN CARE</td>
</tr>
<tr>
<td>97165</td>
<td>OT EVAL LOW COMPLEX 30 MIN</td>
</tr>
<tr>
<td>97166</td>
<td>OT EVAL MOD COMPLEX 45 MIN</td>
</tr>
<tr>
<td>97167</td>
<td>OT EVAL HIGH COMPLEX 60 MIN</td>
</tr>
<tr>
<td>97168</td>
<td>OT RE-EVAL EST PLAN CARE</td>
</tr>
</tbody>
</table>

G0279 and G0280 are deleted from the HH consolidated billing therapy code list. These codes were replaced with 0019T and should have been removed from the list in earlier updates. Effective January 1, 2015, these codes were redefined for another purpose. MACs will adjust claims denied due to HH consolidated billing with HCPCS codes G0279 and G0280 and line item dates of service on or after January 1, 2015, if brought to their attention.

Additional Information


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

For Home Health Providers

**MM9782: 2017 Annual Update to the Therapy Code List**

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

**MLN Matters® Number:** MM9782  
**Change Request (CR) #:** CR 9782  
**Related CR Release Date:** November 10, 2016  
**Effective Date:** January 1, 2017  
**Related CR Transmittal #:** R3654CP  
**Implementation Date:** January 3, 2017

**Provider Types Affected**

This MLN Matters® Article is intended for physicians, therapists, and other providers, including Comprehensive Outpatient Rehabilitation Facilities (CORFs), submitting claims to
Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

**What You Need to Know**

This article is based on Change Request (CR) 9782 which updates the therapy code list for Calendar Year (CY) 2017 by adding eight “always therapy” codes (97161 – 97168) for physical therapy (PT) and occupational therapy (OT) evaluative procedures. CR 9782 also deletes the four codes currently used to report these services (97001 – 97004). Make sure your billing staffs are aware of these updates.

**Background**

Section 1834(k)(5) of the Social Security Act requires that all claims for outpatient rehabilitation therapy services and CORF services be reported using the uniform coding system. The Calendar Year (CY) 2017 Healthcare Common Procedure Coding System and Current Procedural Terminology, Fourth Edition (HCPCS/CPT-4) is the coding system used for reporting these services.

For CY 2017, the Current Procedural Terminology (CPT) Editorial Panel created eight new codes (97161-97168) to replace the 4-code set (97001-97004) for Physical Therapy (PT) and Occupational Therapy (OT) evaluative procedures. The new CPT code descriptors for PT and OT evaluative procedures include specific components that are required for reporting as well as the corresponding typical face-to-face times for each service.

**Evaluation Codes.** The CPT Editorial Panel created three new codes to replace each existing PT and OT evaluation code, 97001 and 97003, respectively. These new evaluation codes are based on patient complexity and the level of clinical decision-making – low, moderate and high complexity: for PT, codes 97161, 97162 and 97163; and for OT, codes 97165, 97166 and 97167.

**Re-evaluation Codes.** One new PT code, 97164, and one new OT code, 97168, were created to replace the existing codes – 97002 and 97004, respectively. The re-evaluation codes are reported for an established patient’s when a revised plan of care is indicated.

Just as their predecessor codes were, the new codes are “always therapy” and must be reported with the appropriate therapy modifier, GP or GO, to indicate that the services are furnished under a PT or OT plan of care, respectively.

The new PT Evaluative procedure codes are listed in the chart below with their short descriptors* and the required corresponding therapy modifier:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor*</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>97161</td>
<td>PT EVAL LOW COMPLEX 20 MIN</td>
<td>GP</td>
</tr>
<tr>
<td>97162</td>
<td>PT EVAL MOD COMPLEX 30 MIN</td>
<td>GP</td>
</tr>
<tr>
<td>97163</td>
<td>PT EVAL HIGH COMPLEX 45 MIN</td>
<td>GP</td>
</tr>
<tr>
<td>97164</td>
<td>PT RE-EVAL EST PLAN CARE</td>
<td>GP</td>
</tr>
</tbody>
</table>

The new OT Evaluative procedure codes are listed in the chart below with their short descriptors* and the required OT therapy modifier:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor*</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>97165</td>
<td>OT EVAL LOW COMPLEX 30 MIN</td>
<td>GO</td>
</tr>
<tr>
<td>97166</td>
<td>OT EVAL MOD COMPLEX 45 MIN</td>
<td>GO</td>
</tr>
<tr>
<td>97167</td>
<td>OT EVAL HIGH COMPLEX 60 MIN</td>
<td>GO</td>
</tr>
<tr>
<td>97168</td>
<td>OT RE-EVAL EST PLAN CARE</td>
<td>GO</td>
</tr>
</tbody>
</table>
Additional Information


The therapy code list of “always” and “sometimes” therapy services is available at http://www.cms.gov/Medicare/Billing/TherapyServices/index.html.

If you have any questions, please contact a CGS Customer Service Representative by calling the CGS Provider Contact Center at 1.866.590.6703 and choose Option 1.

Table 1. For CY 2017 - New CPT Codes and Long Descriptors for PT Evaluative Procedures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97161</td>
<td>Physical therapy evaluation: low complexity, requiring these components:</td>
</tr>
<tr>
<td></td>
<td>• A history with no personal factors and/or comorbidities that impact the</td>
</tr>
<tr>
<td></td>
<td>plan of care;</td>
</tr>
<tr>
<td></td>
<td>• An examination of body system(s) using standardized tests and measures</td>
</tr>
<tr>
<td></td>
<td>addressing 1-2 elements from any of the following: body structures and</td>
</tr>
<tr>
<td></td>
<td>functions, activity limitations, and/or participation restrictions;</td>
</tr>
<tr>
<td></td>
<td>• A clinical presentation with stable and/or uncomplicated characteristics;</td>
</tr>
<tr>
<td></td>
<td>• Clinical decision making of low complexity using standardized patient</td>
</tr>
<tr>
<td></td>
<td>assessment instrument and/or measurable assessment of functional outcome.</td>
</tr>
<tr>
<td></td>
<td>Typically, 20 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>97162</td>
<td>Physical therapy evaluation: moderate complexity, requiring these components:</td>
</tr>
<tr>
<td></td>
<td>• A history of present problem with 1-2 personal factors and/or comorbidities</td>
</tr>
<tr>
<td></td>
<td>that impact the plan of care;</td>
</tr>
<tr>
<td></td>
<td>• An examination of body systems using standardized tests and measures in</td>
</tr>
<tr>
<td></td>
<td>addressing a total of 3 or more elements from any of the following: body</td>
</tr>
<tr>
<td></td>
<td>structures and functions, activity limitations, and/or participation</td>
</tr>
<tr>
<td></td>
<td>restrictions;</td>
</tr>
<tr>
<td></td>
<td>• An evolving clinical presentation with changing characteristics;</td>
</tr>
<tr>
<td></td>
<td>• Clinical decision making of moderate complexity using standardized patient</td>
</tr>
<tr>
<td></td>
<td>assessment instrument and/or measurable assessment of functional outcome.</td>
</tr>
<tr>
<td></td>
<td>Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>97163</td>
<td>Physical therapy evaluation: high complexity, requiring these components:</td>
</tr>
<tr>
<td></td>
<td>• A history of present problem with 3 or more personal factors and/or</td>
</tr>
<tr>
<td></td>
<td>comorbidities that impact the plan of care;</td>
</tr>
<tr>
<td></td>
<td>• An examination of body systems using standardized tests and measures</td>
</tr>
<tr>
<td></td>
<td>addressing a total of 4 or more elements from any of the following: body</td>
</tr>
<tr>
<td></td>
<td>structures and functions, activity limitations, and/or participation</td>
</tr>
<tr>
<td></td>
<td>restrictions;</td>
</tr>
<tr>
<td></td>
<td>• A clinical presentation with unstable and unpredictable characteristics;</td>
</tr>
<tr>
<td></td>
<td>• Clinical decision making of high complexity using standardized patient</td>
</tr>
<tr>
<td></td>
<td>assessment instrument and/or measurable assessment of functional outcome.</td>
</tr>
<tr>
<td></td>
<td>Typically, 45 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>97164</td>
<td>Re-evaluation of physical therapy established plan of care, requiring these</td>
</tr>
<tr>
<td></td>
<td>components:</td>
</tr>
<tr>
<td></td>
<td>• An examination including a review of history and use of standardized tests</td>
</tr>
<tr>
<td></td>
<td>and measures is required;</td>
</tr>
<tr>
<td></td>
<td>• Revised plan of care using a standardized patient assessment instrument</td>
</tr>
<tr>
<td></td>
<td>and/or measurable assessment of functional outcome.</td>
</tr>
<tr>
<td></td>
<td>Typically, 20 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
</tbody>
</table>
Table 2. For CY 2017: New CPT Codes and Long Descriptors for OT Evaluative Procedures

97165 - Occupational therapy evaluation, low complexity, requiring these components:
- An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem;
- An assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and
- Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component.

Typically, 30 minutes are spent face-to-face with the patient and/or family.

97166 - Occupational therapy evaluation, moderate complexity, requiring these components:
- An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance;
- An assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and
- Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component.

Typically, 45 minutes are spent face-to-face with the patient and/or family.

97167 - Occupational therapy evaluation, high complexity, requiring these components:
- An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance;
- An assessment(s) that identifies 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and
- Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component.

Typically, 60 minutes are spent face-to-face with the patient and/or family.

97168 - Re-evaluation of occupational therapy established plan of care, requiring these components:
- An assessment of changes in patient functional or medical status with revised plan of care;
- An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and
- A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required.

Typically, 30 minutes are spent face-to-face with the patient and/or family.
For Home Health Providers

MM9820: Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2017

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/index.html

MLN Matters® Number: MM9820
Related CR Release Date: October 14, 2016
Related CR Transmittal #: R3624CP
Change Request (CR) #: CR 9820
Effective Date: January 1, 2017
Implementation Date: January 3, 2017

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

Provider Action Needed
Change Request (CR) 9820 updates the national, standardized 60-day episode rates, the national per-visit rates, and the non-routine medical supply payment amounts under the HH PPS for Calendar Year (CY) 2017. Make sure your billing staff are aware of these changes.

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

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

The Medicare Modernization Act (MMA; Section 421(a)), (https://www.gpo.gov/fdsys/pkg/PLAW-108publ173/content-detail.html) as amended by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; Pub. L. 114–10; Section 210), (https://www.gpo.gov/fdsys/pkg/BILLS-114hr2enr/pdf/BILLS-114hr2enr.pdf) provides an increase of 3 percent of the payment amount otherwise made under the Social Security Act (Section 1895) for home health services furnished in a rural area (as defined in the Social Security Act (Section 1886(d)(2)(D)), (https://www.ssa.gov/OP_Home/ssact/title18/1886.htm) with respect to episodes and visits ending on or after April 1, 2010 and before January 1, 2018. The statute waives budget neutrality related to this provision, as the statute specifically states that CMS will not reduce the standard prospective payment amount (or amounts) under the Social Security Act (Section 1895) applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.
Market Basket Update

The CY 2017 HH market basket update is 2.8 percent which is then reduced by a multi-factor productivity (MFP) adjustment of 0.3 percentage points. The resulting home health (HH) payment update is equal to 2.5 percent. HHAs that do not report the required quality data will receive a 2 percentage point reduction to the HH payment update.

National, Standardized 60-Day Episode Payment

As described in the CY 2017 HH PPS final rule, in order to calculate the CY 2017 national, standardized 60-day episode payment rate, CMS applies a wage index budget neutrality factor of 0.9996 and a case-mix budget neutrality factor of 1.0214 to the previous calendar year’s national, standardized 60-day episode rate. In order to account for nominal case-mix growth from CY 2012 to CY 2014, CMS applies a payment reduction of 0.97 percent to the national, standardized 60-day episode payment rate. CMS then applies an $80.95 rebasing reduction (which is 3.5 percent of the CY 2010 national, standardized 60-day episode rate of $2,312.94) to the national, standardized 60-day episode rate. Lastly, the national, standardized 60-day episode payment rate is updated by the CY 2017 HH payment update percentage of 2.5 percent for HHAs that submit the required quality data and by 2.5 percent minus 2 percentage points, or 0.5 percent, for HHAs that do not submit quality data. These two episode payment rates are shown in Table 1 and Table 2. These payments are further adjusted by the individual episode’s case-mix weight and by the wage index.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,965.12 X 0.9996 X 1.0214 X 0.9903 -$80.95 X 1.025</td>
<td>$2,989.97</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,965.12 X 0.9996 X 1.0214 X 0.9903 -$80.95 X 1.005</td>
<td>$2,931.63</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

National Per-Visit Rates

In order to calculate the CY 2017 national per-visit payment rates, CMS starts with the CY 2016 national per-visit rates. CMS applies a wage index budget neutrality factor of 1.0000 to ensure budget neutrality for low utilization payment adjustment (LUPA) per-visit payments after applying the CY 2017 wage index, and then applies the maximum rebasing adjustments to the per-visit rates for each discipline. The per-visit rates are then updated by the CY 2017 HH payment update of 2.5 percent for HHAs that submit the required quality data and by 0.5 percent for HHAs that do not submit quality data. The per-visit rates are shown in Table 3 and Table 4.

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2016 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2017 Rebasing Adjustment</th>
<th>CY 2017 HH Payment Update</th>
<th>CY 2017 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$60.87</td>
<td>X 1.0000</td>
<td>+ $1.79</td>
<td>X 1.025</td>
<td>$64.23</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$215.47</td>
<td>X 1.0000</td>
<td>+ $6.34</td>
<td>X 1.025</td>
<td>$227.36</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$147.95</td>
<td>X 1.0000</td>
<td>+ $4.35</td>
<td>X 1.025</td>
<td>$156.11</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$146.95</td>
<td>X 1.0000</td>
<td>+ $4.32</td>
<td>X 1.025</td>
<td>$155.05</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$134.42</td>
<td>X 1.0000</td>
<td>+ $3.96</td>
<td>X 1.025</td>
<td>$141.84</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$159.71</td>
<td>X 1.0000</td>
<td>+ $4.70</td>
<td>X 1.025</td>
<td>$168.52</td>
</tr>
</tbody>
</table>
Table 4: For HHAs that DO NOT Submit Quality Data – CY 2017 National Per-Visit Amounts for LUPAs and Outlier Calculations

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>CY 2016 Per-Visit Payment</th>
<th>Wage Index Budget Neutrality Factor</th>
<th>CY 2017 Rebasing Adjustment</th>
<th>CY 2017 HH Payment Update</th>
<th>CY 2017 Per-Visit Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$60.87</td>
<td>X 1.0000</td>
<td>+ $1.79</td>
<td>X 1.005</td>
<td>$62.97</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$215.47</td>
<td>X 1.0000</td>
<td>+ $6.34</td>
<td>X 1.005</td>
<td>$222.92</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$147.95</td>
<td>X 1.0000</td>
<td>+ $4.35</td>
<td>X 1.005</td>
<td>$153.06</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$146.95</td>
<td>X 1.0000</td>
<td>+ $4.32</td>
<td>X 1.005</td>
<td>$152.03</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$134.42</td>
<td>X 1.0000</td>
<td>+ $3.96</td>
<td>X 1.005</td>
<td>$139.07</td>
</tr>
<tr>
<td>Speech-Language Pathology</td>
<td>$159.71</td>
<td>X 1.0000</td>
<td>+ 4.70</td>
<td>X 1.005</td>
<td>$165.23</td>
</tr>
</tbody>
</table>

Non-Routine Supply Payments

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by an NRS conversion factor. To determine the CY 2017 NRS conversion factors, CMS starts with the CY 2016 NRS conversion factor and applies a 2.82 percent rebasing adjustment as described in the CY 2017 HH PPS final rule. CMS then updates the conversion factor by the CY 2017 HH payment update of 2.5 percent for HHAs that submit the required quality data and by 0.5 percent for HHAs that do not submit quality data. CMS does not apply any standardization factors as the NRS payment amount calculated from the conversion factor is neither wage nor case-mix adjusted when the final payment amount is computed. The NRS conversion factor for CY 2017 payments for HHAs that do submit the required quality data is shown in Table 5a and the payment amounts for the various NRS severity levels are shown in Table 5b. The NRS conversion factor for CY 2017 payments for HHAs that do not submit quality data is shown in Table 6a and the payment amounts for the various NRS severity levels are shown in Table 6b.

Table 5a: CY 2017 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2016 NRS Conversion Factor</th>
<th>CY 2017 Rebasing Adjustment</th>
<th>CY 2017 HH Payment Update</th>
<th>CY 2017 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$52.71</td>
<td>X 0.9718</td>
<td>X 1.025</td>
<td>$52.50</td>
</tr>
</tbody>
</table>

Table 5b: CY 2017 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2017 NRS Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$ 14.16</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$ 51.15</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$ 140.24</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$ 208.35</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$ 321.29</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$ 552.58</td>
</tr>
</tbody>
</table>

Table 6a: CY 2017 NRS Conversion Factor for HHAs that DO NOT Submit the Required Quality Data

<table>
<thead>
<tr>
<th>CY 2016 NRS Conversion Factor</th>
<th>CY 2017 Rebasing Adjustment</th>
<th>CY 2017 HH Payment Update Percentage Minus 2 Percentage Points</th>
<th>CY 2017 NRS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>$52.71</td>
<td>X 0.9718</td>
<td>X 1.005</td>
<td>$51.48</td>
</tr>
</tbody>
</table>

Table 6b: CY 2017 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2017 NRS Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$ 13.89</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$ 50.15</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$ 137.51</td>
</tr>
</tbody>
</table>
Table 6b: CY 2017 Relative Weights and Payment Amounts for the 6-Severity NRS System for HHAs that DO NOT Submit Quality Data

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2017 NRS Payment Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$204.30</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$315.05</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$541.85</td>
</tr>
</tbody>
</table>

Rural Add-On

As stipulated in the MMA (Section 421(a)), the 3 percent rural add-on is applied to the national, standardized 60-day episode rate, national per-visit payment rates, LUPA add-on payments, and the NRS conversion factor when home health services are provided in rural (non-CBSA) areas for episodes and visits ending on or after April 1, 2010, and before January 1, 2018. Refer to Table 7, Table 8, Table 9a and Table 9b which follow below for the CY 2017 rural payment rates.

Table 7: CY 2017 National, Standardized 60-Day Payment Amounts for Services Provided in a Rural Area

<table>
<thead>
<tr>
<th>For HHAs that DO Submit Quality Data</th>
<th>For HHAs that DO NOT Submit Quality Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2017 National, Standardized 60-Day Episode Payment Rate</td>
<td>Multiply by the 3 Percent Rural Add-On</td>
</tr>
<tr>
<td>$2,989.97</td>
<td>X 1.03</td>
</tr>
</tbody>
</table>

Table 8: CY 2017 National Per-Visit Amounts for Services Provided in a Rural Area

<table>
<thead>
<tr>
<th>HH Discipline Type</th>
<th>For HHAs that DO submit quality data</th>
<th>For HHAs that DO NOT submit quality data</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH Aide</td>
<td>CY 2017 Per-visit rate</td>
<td>Multiply by the 3 Percent Rural Add-On</td>
</tr>
<tr>
<td>$64.23</td>
<td>X 1.03</td>
<td>$66.16</td>
</tr>
<tr>
<td>MSS</td>
<td>$227.36</td>
<td>X 1.03</td>
</tr>
<tr>
<td>OT</td>
<td>$156.11</td>
<td>X 1.03</td>
</tr>
<tr>
<td>PT</td>
<td>$155.05</td>
<td>X 1.03</td>
</tr>
<tr>
<td>SN</td>
<td>$141.84</td>
<td>X 1.03</td>
</tr>
<tr>
<td>SLP</td>
<td>$168.52</td>
<td>X 1.03</td>
</tr>
</tbody>
</table>

Table 9a: CY 2017 NRS Conversion Factor for Services Provided in Rural Areas

<table>
<thead>
<tr>
<th>For HHAs that DO submit quality data</th>
<th>For HHAs that DO NOT submit quality data</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2017 Conversion Factor</td>
<td>Multiply by the 3 Percent Rural Add-On</td>
</tr>
<tr>
<td>$52.50</td>
<td>X 1.03</td>
</tr>
</tbody>
</table>

Table 9b: CY 2017 Relative Weights and Payment Amounts for the 6-Severity NRS System for Services Provided in Rural Areas

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight</th>
<th>CY 2017 NRS Payment Amounts for Rural Areas</th>
<th>For HHAs that DO submit quality data</th>
<th>For HHAs that DO NOT submit quality data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.59</td>
<td>0.2698</td>
<td>$14.30</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$52.68</td>
<td>0.9742</td>
<td>$51.65</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$144.46</td>
<td>2.6712</td>
<td>$141.63</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$214.62</td>
<td>3.9686</td>
<td>$210.42</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$330.96</td>
<td>6.1198</td>
<td>$324.47</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$569.21</td>
<td>10.5254</td>
<td>$558.06</td>
</tr>
</tbody>
</table>
These changes are implemented through the Home Health Pricer software in Medicare’s shared systems.

Additional Information


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

For Home Health Providers

MM9826: Correcting Editing for Condition Code 54 and Updating Remittance Advice Messages on Home Health Claims

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/index.html

<table>
<thead>
<tr>
<th>MLN Matters® Number: MM9826</th>
<th>Effective Date: Claims received on or after April 1, 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related CR Release Date: October 27, 2016</td>
<td>Implementation Date: April 3, 2017</td>
</tr>
<tr>
<td>Related CR Transmittal #: R3630CP</td>
<td></td>
</tr>
<tr>
<td>Change Request (CR) #: CR 9826</td>
<td></td>
</tr>
</tbody>
</table>

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9826 informs MACs about corrections to Medicare systems to require condition code 54 on Home Health (HH) appropriately. The system edit that enforces proper reporting of condition code 54 should only set when no skilled visits are reported by the provider. Currently, the edit is also setting when skilled service lines are denied during review. CR9826 also updates remittance advice coding combinations to ensure compliance with industry standards. CR9826 contains no new policy.

Background

CR9474 updated Original Medicare systems to accept and process condition code 54 in cases when a HH claim contained no skilled visits in a billing period and a policy exception is documented at the Home Health Agency (HHA). A system edit requires condition code 54 to be present when a claim for an episode of continuing care is submitted for payment with no skilled visits. This edit is functioning properly with regard to visits submitted as non-covered by the HHA. Shortly after CR9474 was implemented, MACs reported that the edit is also setting on claims that were submitted with covered skilled visits but those visits were non-covered during medical review. CR9826 corrects this problem.

As a result of CR9826, Medicare will return claims to the HHA when the type of bill is 0327 or 0329 and the From Date is not equal to the Admission Date, and no revenue code 042x, 043x, 044x or 055x line with covered charges is present upon receipt of the claim, and condition code 20, 21 or 54 is not present and the claim receipt date is on or after July 1,
2016. This revises the criteria for CR9474 in order to exclude lines for which charges are
moved from covered to non-covered during adjudication.

Medicare has determined the remittance advice code pair used when the HH outlier
limit is applied is not compliant with industry standards. The Remittance Advice Remark
Code (RARC) that was created for this policy, N523, is no longer part of any compliant
code pair and will no longer be used. When an outlier amount is withheld due to the HH
outlier limitation policy, MACs will use Group Code CO and Claim Adjustment Reason
Code (CARC) 119.

Additional Information
The official instruction, CR9826, issued to your MAC regarding this change is available
R3630CP.pdf.

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
MM9865: Therapy Cap Values
for Calendar Year (CY) 2017

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/index.html

MLN Matters® Number: MM9865
Related CR Release Date: November 4, 2016
Related CR Transmittal #: R3644CP

Change Request (CR) #: CR 9865
Effective Date: January 1, 2017
Implementation Date: January 3, 2017

Provider Types Affected
This MLN Matters® Article is intended for physicians, therapists, and other providers
submitting claims to Medicare Administrative Contractors (MACs), including Home Health &
Hospice MACs, for outpatient therapy services provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9865, from which this article was developed, describes the amounts
and policies for outpatient therapy caps for CY 2017. For physical therapy and speech-
language pathology combined, the 2017 therapy cap will be $1,980. For occupational
therapy, the cap for 2017 will be $1,980. Make sure that your billing staffs are aware of
these therapy cap value updates.

Background
The Balanced Budget Act of 1997 (P.L. 105-33), Section 4541(c) applies annual financial
limitations on expenses considered incurred for outpatient therapy services under Medicare
Part B per beneficiary, commonly referred to as “therapy caps.” Therapy caps are updated
each year based on the Medicare Economic Index.

An exception for the therapy caps for reasonable and medically necessary services has been
in place since CY 2006. Originally required by Section 5107 of the Deficit Reduction Act of
2005, the exceptions process for the therapy caps has been continuously extended multiple
times through subsequent legislation.
The current therapy caps exceptions process, as required by Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015, expires on December 31, 2017.

CR 9865 establishes that therapy caps for CY 2017 will be $1,980. MACs will update to this amount for physical therapy and speech-language pathology combined, and for occupational therapy.

Additional Information

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

**For Hospice Providers**

**SE1628: Documentation Requirements for the Hospice Physician Certification/Recertification**

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

**MLN Matters® Number:** SE1628  
**Change Request (CR) #:** N/A  
**Related CR Release Date:** November 22, 2016  
**Effective Date:** N/A  
**Related CR Transmittal #:** N/A  
**Implementation Date:** N/A

**Provider Types Affected**

This special edition MLN Matters article is intended for hospices and for physicians who prepare certifications or recertifications for benefit periods for Medicare beneficiaries electing the hospice benefit.

**What You Need to Know**

This article provides information on specific elements that are required for a physician certification and recertification as stated in the “Medicare Benefit Policy Manual,” Chapter 9, Section 20.1- Timing and Content of Certification ([https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf)). This article is intended to provide guidance on the requirements for a valid physician certification and recertification. The article is informational only and does not convey any new or revised policy. In addition, any examples provided in this article are for illustration purposes only and do not in any way imply this is the only acceptable format. Hospice providers may choose to design their own forms or format, so long as all requirements of a valid physician certification are met.

**Background**

In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. A valid physician certification or recertification is required for each benefit period that the beneficiary is on the Medicare hospice benefit. This article is intended to provide guidance on the requirements for a valid physician certification and recertification.

A written certification must be on file in the hospice beneficiary’s record prior to submission of a claim to your Medicare Administrative Contractor (MAC). Clinical information and other documentation that support the medical prognosis must accompany the certification.
Content of Written Certifications, including Initial and Subsequent Certifications

A complete written certification must include:

1. The statement that the individual’s medical prognosis is that the beneficiary’s life expectancy is 6 months or less if the terminal illness runs its normal course
   
   **Guidance:** A simple statement on the certification/recertification that states, the beneficiary has a medical prognosis of 6 months or less if the terminal illness runs its normal course.

2. Patient-specific clinical findings and other documentation supporting a life expectancy of 6 months or less
   
   **Guidance:** The certification should give specific clinical findings, for example, signs, symptoms, laboratory testing, weights, anthropomorphic measurements, oral intake.

3. The signature(s) of the physician(s), the date signed, and the benefit period dates that the certification or recertification covers (for more on signature requirements, see the “Medicare Program Integrity Manual,” Chapter 3, Section 3.3.2.4) ([https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf)).
   
   **Guidance:**
   - **Physician signature and date signed:** The physician must sign and make an appropriate date entry for his/her signature, for example, John Smith M.D. MM/DD/YY. If the physician signature is not legible, you may type or print the name below the signature. Another alternative to ensure a legible signature is to submit a signature log with the physician’s printed name and signature. Also, note that the location of the physician signature for the narrative and attestation is important. See the example below regarding the physician signature.
   
   - **Certification/Recertification benefit period:** Make an entry on the certification that gives the specific “from” and “through” dates, for example, benefit period date MM/DD/YY to MM/DD/YY. Simply stating benefit period 3 is not acceptable documentation. The “from” and “through” dates must appear on the certification.

4. As of October 1, 2009, the physician’s brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less is part of the certification and recertification forms, or is an addendum to the certification and recertification forms.
   - If the narrative is part of the certification or recertification form, then the narrative must be located immediately above the physician’s signature.
   - If the narrative exists as an addendum to the certification or recertification form, in addition to the physician’s signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.
   - The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient’s medical record or, if applicable, his or her examination of the patient. The physician may dictate the narrative.
   - The narrative must reflect the patient’s individual clinical circumstances and cannot contain check boxes or standard language used for all patients. The physician must synthesize the patient’s comprehensive medical information in order to compose this brief clinical justification narrative.
Guidance: According to the “Medicare Benefit Policy Manual,” Chapter 9, Section 20.1, Timing and Content of Certification, the regulations state if the narrative is part of the certification or recertification form, then the narrative must be located immediately above the physician signature. As part of the narrative, the narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient’s medical record or, if applicable, his or her examination of the patient. It would not be acceptable to have any other language such as the certification from and through dates, the attestation of a face-to-face, or any other documentation located between the narrative and the physicians signature.

5. Face-to-Face Encounter and Attestation. For recertification’s on or after 1/1/2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice beneficiary prior to the beginning the beneficiary’s third benefit period, and prior to each subsequent benefit period. The face-to-face encounter (when applicable) is a part of the recertification. For Additional Information and guidance on the face-to-face encounter, refer to the “Medicare Benefit Policy Manual,” Chapter 9, Section 20.1.

Examples of the Narrative for a Physician Certification

**Example 1: Initial Certification of Terminal Illness (With narrative included)**

I certify that John Doe is terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course.

Certification period dates: 1/1/2016 to 3/30/2016

**Brief narrative statement:** (Review the individual’s clinical circumstances and synthesize the medical information to provide clinical justification for admission to the hospice services) 78 year old male with a diagnosis of stage 4 lung cancer. Completed three rounds of chemotherapy, but cancer has metastasized to the liver and bone. Patient no longer wants to continue chemotherapy and states he wants comfort measures only. Increased dyspnea and pain over past 2 weeks. Is now oxygen dependent with 2LNC and requires morphine every 6 hours for bone pain and shortness of breath.

Attestation: I confirm that I composed this narrative and it is based on my review of the patient’s medical record and/or examination of the patient (circle one).

Physician (printed name): Dr. Marcus Welby
Physician (signature): Dr. Marcus Welby
Date: 1/1/2016

**Example 2: Initial Certification of Terminal Illness (Narrative as an addendum)**

I certify that John Doe is terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course.

Certification period dates: 1/1/2016 to 3/30/2016

Physician (printed Name): Dr. Marcus Welby
Physician (Signature): Dr. Marcus Welby
Date: 1/1/2016

**Please note:** Physician Narrative Addendum below. (Physician Narrative Addendum must accompany the Initial Certification of Terminal Illness (CTI) when the Narrative is not included on the certification).
Example 2 Physician Narrative Addendum

Name of beneficiary: John Doe
Certification period dates: 1/1/2016 to 3/30/2016
Brief narrative statement: (Review the individual’s clinical circumstances and synthesize the medical information to provide clinical justification for admission to the hospice services) 78 year old male with a diagnosis of stage 4 lung cancer. Completed three rounds of chemotherapy but cancer has metastasized to the liver and bone. Patient no longer wants to continue chemotherapy and states he wants comfort measures only. Increased dyspnea and pain over the past two weeks. Is now oxygen dependent with 2LNC and requires morphine every 6 hours for bone pain and shortness of breath.
Attestation: I confirm that I composed this narrative and it is based on my review of the patient’s medical record and/or examination of the patient (circle one).
Physician (printed name): Dr. Marcus Welby
Physician (signature): Dr. Marcus Welby
Date: 1/1/2016

Example 3: Recertification of Terminal Illness (At 90 days and each subsequent 60 days) (With narrative included)

I certify that John Doe is terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course.
Certification period dates: 3/31/2016 to 6/28/2016
Brief narrative statement: (Review the individual’s clinical circumstances and synthesize the medical information to provide clinical justification for admission to the hospice services) 78 year old male with a diagnosis of stage 4 lung cancer who has been receiving hospice services since 1/1/2016. Oxygen dependent and has been increased to 6LNC. Increasing somnolence and is only out of bed for short periods of time with max assist. Poor appetite and is only taking small sips of water and broth. Evident cachexia. Receiving morphine every 2 hours for pain.
Attestation: I confirm that I composed this narrative and it is based on my review of the patient’s medical record and/or examination of the patient (circle one).
Physician (printed name): Dr. Marcus Welby
Physician (signature): Dr. Marcus Welby
Date: 1/1/2016
For 3rd and subsequent benefit periods: N/A (not the third or subsequent benefit period): Face to face encounter Hospice Physician
Attestation: I confirm that I had a face-to-face encounter with (Beneficiary's Name) on __/__/___ (date) and that I used the clinical findings from that encounter in determining continued eligibility for hospice care.
Hospice medical director/hospice physician/NP (Printed Name): __________________________
Hospice medical director/hospice physician/NP (Signature): __________________________
Date: __________
Example 4: Recertification of Terminal Illness (At 90 days and each subsequent 60 days) (With narrative as addendum)

I certify that John Doe is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Certification period dates: 3/31/2016 to 6/28/2016  
Physician (printed name): Dr. Marcus Welby  
Physician (Signature): Dr. Marcus Welby  
Date: 03/30/2016  
Physician Narrative Addendum (Must accompany Certification/Recertification Form if not included in the CTI)

Name of Beneficiary: John Doe  
Certification period dates: 3/31/2016 to 6/28/2016  
Brief narrative statement: (Review the individual’s clinical circumstance and synthesize the medical information to provide clinical justification for admission to hospice services) 78 year old male with a diagnosis of stage 4 lung cancer who has been receiving hospice services since 1/1/2016. Oxygen dependent and has been increased to 6LNC. Increasing somnolence and is only out of bed for short periods of time with max assist. Poor appetite and is only taking small sips of water and broth. Evident cachexia. Receiving morphine every 2 hours for pain.  
Attestation: I confirm that I composed this narrative and it is based on my review of the patient’s medical record and/or examination of the patient (circle one).  
Physician (printed name): Dr. Marcus Welby  
Physician (signature): Dr. Marcus Welby  
Date: 3/30/2016

Example 5: Recertification of Terminal Illness (At 90 days and each subsequent 60 days) (With narrative & Face-to-Face attestation included)

I certify that Jane Smith is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Brief narrative statement: (Review the individual’s clinical circumstances and synthesize the medical information to provide clinical justification for admission to hospice services). 83 year old female with end-state CHF, NYHA Class IV. Dyspnea at rest. Bilateral 2+ pitting edema in feet, calves and thighs not responsive to diuretic therapy. Increasing episodes of angina. Was ambulatory one month ago but is now bedbound and sleeps most of the time. Is arousable but with increasing confusion. Taking only small sips of water. Patient has been under hospice services since 1/1/2016.  
Attestation: I confirm that I composed this narrative and it is based on my review of the patient’s medical record and/or examination of the patient (circle one)  
Physician (printed name): Dr. Marcus Welby  
Physician (signature): Dr. Marcus Welby  
Date: 06/28/2016  
Attestation of Face-to-Face Encounter (For 3rd and subsequent benefit periods): N/A (not the third or subsequent benefit period):  
Conducted by certifying physician: I confirm that I had a face-to-face encounter with (Beneficiary’s Name) on (___/___/____) and that I used the clinical findings from that encounter in determining continued eligibility for hospice care.  
Hospice Medical Director (Printed name): John Doe, M.D.  
Hospice Medical Director (Signature): John Doe  
Date: 06/28/2016  
Conducted by Allowed Provider Type: I confirm that a face-to-face encounter occurred with Jane Smith on 06/27/2016 (date) and the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course.  
Hospice physician/NP (printed name): Mary Jones, CRNP  
Hospice physician/NP (Signature): Mary Jones, CRNP  
Date: 06/27/2016
Example 6: Recertification of Terminal Illness (At 90 days and each subsequent 60 days) (With narrative but without face-to-face attestation included)

I certify that Jane Smith is terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course.


Brief narrative statement: (Review the individual’s clinical circumstances and synthesize the medical information to provide clinical justification for admission to hospice services)

83 year old female with end-state CHF, NYHA Class IV. Dyspnea at rest. Bilateral 2+ pitting edema in feet, calves and thighs not responsive to diuretic therapy. Increasing episodes of angina. Was ambulatory 1 month ago but is now bedbound and sleeps most of the time. Is arousable but with increasing confusion. Taking only small sips of water. Patient has been under hospice services since 1/1/2016.

Attestation: I confirm that I composed this narrative and it is based on my review of the patient’s medical record and/or examination of the patient (circle one).

Physician (printed name): Dr. Marcus Welby
Physician (Signature): Dr. Marcus Welby
Date: 06/28/2016

Example 7: Recertification of Terminal Illness (At 90 days and each subsequent 60 days) (With narrative & face-to-face attestation included)

I certify that Jane Smith is terminally ill with a life expectancy of 6 months or less if the terminal illness runs its normal course. Certification period dates: 06/29/2016 – 08/27/2016

Brief narrative statement: (Review the individual’s clinical circumstances and synthesize the medical information to provide clinical justification for admission to hospice services)

83 year old female with end-state CHF, NYHA Class IV. Dyspnea at rest. Bilateral 2+ pitting edema in feet, calves and thighs not responsive to diuretic therapy. Increasing episodes of angina. Was ambulatory one month ago but is now bedbound and sleeps most of the time. Is arousable but with increasing confusion. Taking only small sips of water. Patient has been under hospice services since 1/1/2016.

Attestation: I confirm that I composed this narrative and it is based on my review of the patient’s medical record and/or examination of the patient (circle one).

Physician (printed name): Dr. Marcus Welby
Physician (Signature): Dr. Marcus Welby
Date: 06/28/2016

Attestation of Face-to-Face Encounter (For 3rd and subsequent benefit periods)

Hospice Medical Director (Printed name): Dr. Marcus Welby
Hospice Medical Director (Signature): Dr. Marcus Welby
Date: 06/28/2016

Conducted by Allowed Provider Type: I confirm that a face-to-face encounter occurred with (Beneficiary’s Name) on __/__/___ (date) and the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course.

Hospice physician/NP (Printed Name): Marcus Welby, M.D.
Hospice physician/NP (Signature): Marcus Welby
Date: 06/28/2016
Additional Information

CMS acknowledges that this article is based on a product created by the National Government Services.

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


For Hospice Providers

SE1631: Sample Hospice Notice of Election Statement

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/index.html

MLN Matters® Number: SE1631
Related CR Release Date: November 22, 2016
Related CR Transmittal #: N/A
Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians and hospices submitting claims to Home Health & Hospice Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

What You Need to Know

In a September 2016 report (OEI-02-10-00492) at https://oig.hhs.gov/oei/reports/oei-02-10-00492.pdf, the Office of the Inspector General (OIG) noted that hospice election statements lacked required information or had other vulnerabilities in more than one-third of general inpatient care stays. Notably, the statements did not always mention, as required, that the beneficiary was waiving coverage of certain Medicare services by electing hospice care or that hospice care is palliative rather than curative. The OIG report, entitled “Hospices Should Improve Their Election Statements and Certifications of Terminal Illness,” also noted deficiencies in certifications of terminal illness required of physicians for hospice patients. In MLN Matters Special Edition Article, SE1628 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1628.pdf), the Centers for Medicare & Medicaid Services (CMS) details the requirements for and provides further guidance to hospices on election statements. Model Medicare Hospice Election Statement language is included at the end of this article.

Background

As discussed in the “Medicare Benefit Policy Manual,” Chapter 9, Section 10, (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf), hospice care is a benefit under the hospital insurance program. To be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the medical prognosis is that the individual’s life expectancy is 6 months or less if the illness runs its normal course. Only care provided by (or under arrangements made by) a Medicare certified hospice is covered under the Medicare hospice benefit.
An individual (or the individual’s authorized representative) must elect hospice care to receive it. The first election is for a 90-day period. An individual may elect to receive Medicare coverage for two 90-day periods, and an unlimited number of 60-day periods. If the individual (or authorized representative) elects to receive hospice care, he or she must file an election statement with a particular hospice. Hospices obtain election statements from the individual and file a Notice of Election with their MAC. Once the initial election is processed, Medicare systems maintain the beneficiary in hospice status until a final claim indicates a discharge (alive or due to death) or until an election termination is received.

For the duration of the election of hospice care, an individual must waive all rights to Medicare payments for the following services:

- Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice), and
- Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition, or services that are equivalent to hospice care, except for services provided by:
  1. The designated hospice (either directly or under arrangement)
  2. Another hospice under arrangements made by the designated hospice, or
  3. The individual’s attending physician, who may be a Nurse Practitioner (NP), if that physician or nurse practitioner is not an employee of the designated hospice or receiving compensation from the hospice for those services.

Medicare services for a condition completely unrelated to the terminal condition for which hospice was elected remain available to the patient if he or she is eligible for such care.

In their study, the OIG determined that in 35 percent of general inpatient care stays, hospices used election statements that were missing required information or had other vulnerabilities. The key shortcomings included statements that:

- Did not mention Medicare
- Did not include required waiver information or the information was stated inaccurately
- Did not mention required information about palliative care

The Notice of Election Statement is very important in making sure that beneficiaries and their caregivers make informed choices. To assist hospices in completing acceptable election statements, CMS is providing a sample Notice of Election Statement at the end of this article. This sample includes the necessary elements that assure the beneficiary understands the nature of hospice care and makes an informed decision. Note that hospices are not required to use this specific sample, but they must use a statement that contains all the elements in this sample.

**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.


The sample statement is on the next page.
Medicare Hospice Notice of Election Statement

Draft Sample

I, ___________________________________, choose to elect the Medicare hospice benefit and receive
(Beneficiary Name)

Hospice services from ________________________________
(Hospice Agency)

Hospice Philosophy

I acknowledge that I have been given a full explanation and have an understanding of the purpose of hospice care. Hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.

Effects of a Medicare Hospice Election

I understand that by electing hospice care under the Medicare Hospice Benefit, I am waiving (give up) all rights to Medicare payments for services related to my terminal illness and related conditions and I understand that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected. I understand that services not related to my terminal illness or related conditions will continue to be eligible for coverage by Medicare.

Right to choose an attending physician

I understand that I have a right to choose my attending physician to oversee my care. My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

☐ I do not wish to choose an attending physician

I acknowledge that my choice for an attending physician is:

Physician Full name: ___________________________ NPI (if known) ___________________________

Office Address: ________________________________

I acknowledge and understand the above, and authorize Medicare hospice coverage to be provided by ________________________________ to begin on ________________________________.

(Hospice Agency) (Effective Date of Election)

Note: The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.

__________________________________________ (Signature of Beneficiary/Representative) (Date)

☐ Beneficiary is unable to sign

Reason: ______________________________________

__________________________________________ (Witness signature) (Date)

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 Home Health Change of Care Notice (HHCCN) web page at http://devinternet/hhh/coverage/hh_coverage_guidelines/hhccn.html was updated to remove outdated information, and to add CMS resources.
For Home Health and Hospice Providers

Medicare Credit Balance Quarterly Reminder

This article is a reminder to submit the Quarterly Medicare Credit Balance Report. The next report is due in our office postmarked by **January 30, 2017**, for the quarter ending **December 31, 2016**. A Medicare credit balance is an amount determined to be refundable to the Medicare program for an improper or excess payment made to a provider because of patient billing or claims processing errors.

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

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

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

|--------------------------|-------------------------------------------------------------------------------------------------------------|
| Reports may be faxed to: | 1.615.664.5987  
MCBR Receipts  
Attn: Credit Balance Reporting |
| Regular and Certified Mail: | CGS  
Attn: HHH Credit Balance Reporting  
PO Box 20014  
Nashville, TN 37202 |
| Fed Ex/UPS/Overnight Courier: | CGS  
J15 Credit Balance Reporting  
2 Vantage Way  
Nashville, TN 37228 |

Please note that if you have or will be submitting an adjustment, please send the UB-04 along with the CMS-838 form.

If you are issuing a refund check for a credit balance:

Send the CMS-838 and a copy of the refund check using one of the options listed above.

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

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

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

For Home Health and Hospice Providers

Medicare Secondary Payer (MSP) Prepayment Process

Saving Medicare program dollars has become more important than ever. The following is an important reminder for Part A providers as it relates to MSP claims.

Background

Please be aware that there is a CMS mandate that requires Medicare contractors to report MSP cost savings. According to the MSP Internet-Only Manual (Pub. 100-05), chapter 5, section 60.1.3.2.1 – To prevent duplicate counting, CGS suspends all MSP claims returned unpaid. This process sets up a control on the claim when it is returned for development. It maintains this control for 75 days, unless further information is received before that time.
which allows processing the claim. If no further information on the claim is received, the claim may be denied after 75 days.

In the past, if the claim was holding in an MSP pre-payment location (e.g., R B7516) the provider was able to request that the claim finalize prior to the 75 day holding period by adding remarks stating “the services are not related to an open MSP record.” This process is no longer available.

What Can Providers Do?

There are options/actions providers can take. CGS can only request to have the pre-pay location closed if:

- The MSP record has been updated in CWF
- The provider is adjusting to make Medicare secondary, or
- If the claim has been in the pre-pay location for 75 days

As a reminder, it is the provider’s responsibility to double check Medicare beneficiaries’ MSP records thoroughly, take special care in noting diagnosis codes reported on claims that may impact payment determinations, and detect other factors that determine whether or not the claim is submitted in a proper and accurate manner.

NOTE: Please keep in mind that even something as simple as a fall in the home (i.e., possible homeowners’ insurance plan’s responsibility) could affect the outcome of the claim adjudication.

Resources


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

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

The Centers for Medicare & Medicaid Services (CMS) has revised 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/index.html

MLN Matters® Number: MM9533 Revised Change Request (CR) #: CR 9533
Related CR Release Date: February 19, 2016 Effective Date: April 1, 2016
Related CR Transmittal #: R140DEMO Implementation Date: April 4, 2016

Note: This article was revised on November 9, 2016, to correct a typo in the list of G-codes in the lower half of page 6. The original article mentioned code G9499 and it should have stated G9489. All other information remains the same.

Provider Types Affected
This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare 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 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.

<table>
<thead>
<tr>
<th>CJR Model: 5 Performance Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Year</td>
</tr>
<tr>
<td>Performance Year 1 (calendar year 2016)</td>
</tr>
<tr>
<td>Performance Year 2 (calendar year 2017)</td>
</tr>
<tr>
<td>Performance Year 3 (calendar year 2018)</td>
</tr>
<tr>
<td>Performance Year 4 (calendar year 2019)</td>
</tr>
<tr>
<td>Performance Year 5 (calendar year 2020)</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
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 Fee Schedule (MPFS). Medicare policy also allows such physicians and practitioners to bill Medicare for services furnished incident to their services by licensed clinical staff. Additional information regarding the “incident to” requirements is available in 42 CFR 410.26 (https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec410-26.pdf).

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](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**


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 G9489. 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 1.866.590.6703 and choose Option 1.

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 9, 2016</td>
<td>Article revised to correct typo and to show correct code of G9489 on page 6</td>
</tr>
<tr>
<td>February 22, 2016</td>
<td>Initial issuance</td>
</tr>
</tbody>
</table>
For Home Health and Hospice Providers

MM9681: Modifications to the National Coordination of Benefits Agreement Crossover Process

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/index.html

<table>
<thead>
<tr>
<th>MLN Matters® Number: MM9681</th>
<th>Change Request (CR) #: CR 9681</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related CR Release Date: October 27, 2016</td>
<td>Effective Date: April 1, 2017</td>
</tr>
<tr>
<td>Related CR Transmittal #: R1733OTN</td>
<td>Implementation Date: April 3, 2017</td>
</tr>
</tbody>
</table>

Provider Types Affected

This MLN Matters® Article is intended for providers, including hospices, submitting institutional claims to Medicare Administrative Contractors (MACs) requiring Coordination of Benefits (COB) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9681 modifies Medicare's Part A claims processing system to, among other things:

- Always ensure that a Remittance Advice Remark Code (RARC) accompanies claim denials tied to Claims Adjustment Reason Code (CARC) 16, as required.
- Prevent duplicate entry of hospital day counts expressed as value codes (for example, value code 80, 81, 82).
- Prevent reporting of Present on Admission (POA) indicators on outpatient Coordination of Benefits (COB) facility claims.

Make sure your billing staff is aware of these changes.

Background

The Council for Affordable Quality Healthcare Committee for Operating Rules for Information Exchange (CAQH CORE) dictates which CARC and RARC combinations must be used by all covered entities in the healthcare industry. Medicare routinely reports CARCs and RARCs on Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Institute (ASI) 835 Electronic Remittance Advice (ERA) transactions in accordance with HIPAA requirements. Medicare also includes CARCs and RARCs within HIPAA ASC 837-N claims transactions, including 837 Coordination of Benefits (COB) claims transactions. However, within 837 claims transactions, RARCs are referred to as “Claim Payment Reason Codes” and appear within the 2320 Medicare Inpatient Adjudication Information (MIA) and Medicare Outpatient Adjudication Information (MOA) segments.

As a result of systems issues, MACs are not always including a valid and relevant RARC in the 2320 MIA field when they deny Medicare claims. Medicare crossover claims are often being rejected by supplemental payers as a consequence. Though not the only example, this scenario seems to occur frequently when a claim service line is editing to deny with CARC code 16—“Claim lacks information or has submission/billing error(s) which is needed for adjudication......” CR9681 will ensure that at least one informational RARC is provided to comply with HIPAA and CAHQ/CORE requirements.

The Part A system is producing instances of duplicated hospital day counts on outbound 837 institutional COB/crossover claims. CR9681 remedies this situation. Important: Hospital billing staffs should avoid entering hospital day counts via Direct Data Entry (DDE) screens.
Lastly, at present there is no editing with the Part A system to prevent the entry of a POA indicator on incoming outpatient facility claims. CR9681 remedies this issue by returning to the provider (RTP) any outpatient claim (type of bill other than 11x, 18x, 21x, 41x, and 82x) that contains a POA indicator. Important: Billing vendors for hospitals should make it a practice to only include POA indicators on 11x, 18x, 21x, 41x, and 82x type of bill (TOB) claims submitted to Medicare.

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

MM9708: Internet-Only Manual, Pub. 100-06, Chapter 3, Section 90 (Provider Liability) Revision

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/index.html

MLN Matters® Number: MM9708
Related CR Release Date: November 18, 2017
Related CR Transmittal #: R275FM
Change Request (CR) #: CR 9708
Effective Date: February 21, 2017
Implementation Date: February 21, 2017

Provider Types Affected
This MLN Matters® Article is intended for physicians, providers, or suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice MACs (HH&H MACs) and Durable Medical Equipment MACs (DME MACs), for services provided to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 9708 provides additional criteria for determining when a contractor shall assume a physician, provider, or supplier should have known about a policy or rule. CR9708 updates Chapter 3, Section 90 of the “Medical Financial Management Manual.” Make sure your billing staff is aware of these updates.

Background
Contractors shall assume the provider, physician, or supplier should have known about a policy or rule, if:

• The policy or rule is in the provider, physician, or supplier manual or in Federal regulations;
• The Centers for Medicare & Medicaid Services (CMS) or a CMS contractor provided general notice to the medical community concerning the policy or rule;
• CMS, a CMS contractor, or the Office of Inspector General (OIG) gave written notice of the policy or rule to the particular provider/physician/supplier;
• The provider, physician, or supplier was previously investigated or audited as a result of not following the policy or rule;
The provider, physician, or supplier previously agreed to a Corporate Integrity Agreement as a result of not following the policy or rule;

- The provider, physician, or supplier was previously informed that its claims had been reviewed/denied as a result of the claims not meeting certain Medicare requirements which are related to the policy or rule; or
- The provider, physician, or supplier previously received documented training/outreach from CMS or one of its contractors related to the same policy or rule.

Additional Information
The official instruction, CR9708, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R275FM. pdf. The revised Chapter 3, Section 90, of the manual is attached to CR9708.

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

MM9716: New Physician Specialty Code for Hospitalist

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/index.html

MLN Matters® Number: MM9716 Change Request (CR) #: CR 9716
Related CR Release Date: October 28, 2016 Effective Date: April 1, 2017
Related CR Transmittal #: R3637CP and R274FM Implementation Date: April 3, 2017

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

Provider Action Needed
Change Request (CR) 9716 announces that the Centers for Medicare & Medicaid Services (CMS) has established a new physician specialty code for Hospitalist. The new code for Hospitalist is C6. Make sure your billing staffs are aware of this physician specialty code.

Background
When they enroll in the Medicare program, physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O), or in the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). CMS uses these Medicare physician specialty codes, which describe the specific/unique types of medicine that physicians (and certain other suppliers) practice, for programmatic and claims processing purposes.

Medicare will also recognize the new code of C6 as a valid specialty for the following edits:

- Ordering/certifying Part B clinical laboratory and imaging, durable medical equipment (DME), and Part A home health agency (HHA) claims
- Critical Access Hospital (CAH) Method II Attending and Rendering claims
- Attending, operating, or other physician or non-physician practitioner listed on CAH claims
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

MM9767: Implement Operating Rules - Phase III
Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE)

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/index.html

MLN Matters® Number: MM9767
Related CR Release Date: November 23, 2016
Related CR Transmittal #: R3665CP
Change Request (CR) #: CR 9767
Effective Date: April 1, 2017
Implementation Date: April 3, 2017

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9767 informs MACs of the regular update in the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE EFT & ERA Operating Rule Set that was implemented on January 1, 2014, under the Patient Protection and Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be
exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CR9767 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2017. This update is based on the Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC) updates as posted at the WPC website on or about November 1, 2016. This will also include updates based on Market Based Review (MBR) that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them.


Note: Per Affordable Care Act mandate all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/Group Code for a minimum set of 4 Business Scenarios. Medicare can use any code combination if the business scenario is not one of the 4 CORE defined business scenarios. With the 4 CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

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
MM9769: Claim Status Category and Claim Status Codes 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/index.html

MLN Matters® Number: MM9769 Change Request (CR) #: CR 9769
Related CR Release Date: November 18, 2016 Effective Date: April 1, 2017
Related CR Transmittal #: R3661CP Implementation Date: April 3, 2017

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.
Provider Action Needed
Change Request (CR) 9769 informs MACs about system changes to update, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure that your billing staffs are aware of these changes.

Background
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes. The codes sets are available on the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the January 2017 committee meeting shall be posted on these sites on or about February 1, 2017. Your MAC will complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes, by the implementation date of CR 9769.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR 9769.

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.
MM9774: Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print 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/index.html

MLN Matters® Number: MM9774
Related CR Release Date: November 18, 2016
Related CR Transmittal #: R3660CP
Change Request (CR) #: CR 9774
Effective Date: April 1, 2017
Implementation Date: April 3, 2017

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.

Provider Action Needed
Change Request (CR) 9774 updates the Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) lists and instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

Background
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs contractors to conduct updates based on the code update schedule that results in publication three times a year – around March 1, July 1, and November 1.

CMS provides this CR as a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in this CR, contractors must implement on the date specified on the WPC website, which is at http://wpc-edi.com/Reference/.

A discrepancy between the dates may arise as the WPC website is only updated three times a year and may not match the CMS release schedule. For this recurring CR, the MACs and the SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update CR (CR 9695).
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

MM9793 (Revised): Implementation of New Influenza Virus Vaccine Code

The Centers for Medicare & Medicaid Services (CMS) has revised 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/index.html

MLN Matters® Number: MM9793 Revised Change Request (CR) #: CR 9793
Related CR Release Date: September 30, 2016 Effective Date: August 1, 2016
Related CR Transmittal #: R3617CP Implementation Date: January 3, 2017

Note: This article was revised on October 21, 2016, to correct a date on page 2 in bold. The dates should have read, “.... from August 1, 2016, through December 31, 2016. All other information is unchanged.

Provider Types Affected
This MLN Matters® Article is intended for physicians and providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 9793 which informs MACs about the changes to instructions for payment and edits for the Common Working File (CWF) to include influenza virus vaccine code 90674 (Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use) as payable for claims with dates of service on or after August 1, 2016, processed on or after January 3, 2017. Make sure that your billing staffs are aware of these changes.

Background
CR9793 provides instructions for payment and edits to include influenza virus vaccine code 90674. Medicare waives coinsurance and deductibles for code 90674. Medicare will pay for code 90674 based on reasonable cost when submitted by:

- Hospitals on Type of Bill (TOB) 12X and 13X
- Skilled Nursing Facilities on TOB 22X and 23X
- Home Health Agencies on TOB 34X
- Hospital-Based Renal Dialysis facilities on 72X, and
- Critical Access Hospitals (CAHs) on TOB 85X

MACs will pay for influenza virus vaccine code 90674 based on the lower of the actual charge or 95 percent of the Average Wholesale Price (AWP) to:

- Indian Health Services (IHS) hospitals submitting claims on TOB 12X and 13X
- IHS CAHs submitting claims on TOB 85X
It is important to note that MACs will hold institutional claims with code 90674 with dates of service on or after January 1, 2017, through February 20, 2017, until the Fiscal Intermediary Shared System (FISS) changes are implemented on February 20, 2017. Medicare will issue further instructions on how to handle claims for code 90674 with dates of service from August 1, 2016, through December 31, 2016.

Medicare will use the Centers for Medicare & Medicaid Services (CMS) Seasonal Influenza Vaccines Pricing webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html to determine the payment rate for influenza virus vaccine code 90674. This applies to professional claims with dates of service on or after August 1, 2016.

Coinsurance and deductible do not apply.

Additional Information


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

Document History

<table>
<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
</tr>
</thead>
</table>
| October 21, 2016 | The article was revised to correct a date on page 2 in bold. The dates should have read, "... from August 1, 2016, through December 31, 2016."
| September 30, 2016 | Initial issuance |

For Home Health and Hospice Providers

**MM9843: January 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files**

The Centers for Medicare & Medicaid Services (CMS) has 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/index.html

**MLN Matters® Number:** MM9843  
**Change Request (CR) #:** CR 9843  
**Effective Date:** January 1, 2017  
**Implementation Date:** January 3, 2017

**Related CR Release Date:** October 28, 2016  
**Related CR Transmittal #:** R3640CP

**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) 9843 provides the January 2017 quarterly update and instructs MACs to download and implement the January 2017 ASP drug pricing files and, if released by the
Centers for Medicare & Medicaid Services (CMS), the revised October 2016, July 2016, April 2016, and the January 2016 Average Sales Price (ASP) drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 3, 2017 with dates of service January 1, 2017, through March 31, 2017. MACs will not search and adjust claims previously processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

**Background**

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in Chapter 4, Section 50 of the “Medicare Claims Processing Manual” at [https://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/clm104c04.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance-Manuals/Downloads/clm104c04.pdf).

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

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2017 ASP and ASP NOC</td>
<td>January 1, 2017, through March 31, 2017</td>
</tr>
<tr>
<td>October 2016 ASP and ASP NOC</td>
<td>October 1, 2016, through December 31, 2016</td>
</tr>
<tr>
<td>July 2016 ASP and ASP NOC</td>
<td>July 1, 2016, through September 30, 2016</td>
</tr>
<tr>
<td>April 2016 ASP and ASP NOC</td>
<td>April 1, 2016, through June 30, 2016</td>
</tr>
<tr>
<td>January 2016 ASP and ASP NOC</td>
<td>January 1, 2016, through March 31, 2016</td>
</tr>
</tbody>
</table>

**Additional Information**


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

**For Home Health and Hospice Providers**

**New Online Education Course for Medicare Secondary Payer Claims!**

CGS is pleased to offer providers a new resource for submitting home health and hospice Medicare secondary payer (MSP) claims. The “Medicare Secondary Payer Claim Entry via Direct Data Entry (DDE)” online course includes screen prints and examples guiding providers through the process of entering MSP claims directly into the Fiscal Intermediary Standard System (FISS) using DDE.

This online course can be accessed from the “Education & Resources” left side menu at [http://www.cgsmedicare.com/hhh/education/index.html](http://www.cgsmedicare.com/hhh/education/index.html). Simply click the “Online Education Center” link at [http://www.cgsmedicare.com/medicare_dynamic/education/001.asp](http://www.cgsmedicare.com/medicare_dynamic/education/001.asp) and enter your email address. If you are a new user, select “Create your profile here”. Once you have access to the online courses, select “Home Health & Hospice” under the “J15 Courses:” heading. Scroll through the available list of courses and click on the course name to begin.
In addition to the online courses, CGS encourages providers to use the many resources available on the Educational Materials & Resources web page [http://www.cgsmedicare.com/hhh/education/materials/index.html](http://www.cgsmedicare.com/hhh/education/materials/index.html).

**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>New Years Holiday - Monday, January 2, 2017</td>
<td>Office Closed</td>
</tr>
<tr>
<td>Thursday, January 12, 2017</td>
<td>8:00 a.m. – 10:00 a.m. Central Time</td>
</tr>
<tr>
<td>Martin Luther King, Jr.’s Birthday - Monday, January 16, 2017</td>
<td>Office Closed</td>
</tr>
<tr>
<td>Thursday, January 26</td>
<td>8:00 a.m. – 10:00 a.m. Central Time</td>
</tr>
</tbody>
</table>

The Interactive Voice Response (IVR) (**1.877.220.6289**) is available for assistance in obtaining patient eligibility information, claim and deductible information, and general information. For information about the IVR, access the IVR User Guide at [http://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf](http://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf) on the CGS website. In addition, CGS’ Internet portal, myCGS, is available to access eligibility information through the Internet. For Additional Information, go to [http://www.cgsmedicare.com/hhh/index.html](http://www.cgsmedicare.com/hhh/index.html) and click the “myCGS” button on the left side of the webpage.


**For Home Health and Hospice Providers**

**Quarterly Provider Update**

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

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

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

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

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

For Home Health and Hospice Providers

Redetermination Requests Reminders

In order to process your appeal request timely, please place your Redetermination form, or appeal request letter as the first page of your submitted documentation. This will ensure your appeal request reaches the correct department without delay. Also, please remember that stamped signatures on your Redetermination requests cannot be accepted.

Duplicate Redetermination Requests

CGS has recently seen an increase in the submission of duplicate Redetermination requests. CGS encourages providers to have a process in place to track submitted redeterminations in order to avoid duplicate submissions. Using the Interactive Voice Response (IVR) is one tool that allows you to check the status of your redetermination.

The HH&H Interactive Voice Response (IVR) System User Guide at http://www.cgsmedicare.com/hhh/help/pdf/IVR_User_Guide.pdf includes information about checking the status of your redetermination. Please note that after the beneficiary information is validated, the IVR will prompt you to enter the date of service for the claim. The “from” date and “through” date of service must be entered in the MMDDYY format (e.g., December 1, 2016, is entered at 120116). If the dates of service are entered incorrectly, the IVR will be unable to provide a status and will inform you that CGS has not received a redetermination request.

In addition, when redeterminations are submitted through the CGS web portal, a message is provided that verifies receipt of your request and also allows you to check the status of your redetermination request. Refer to the myCGS User Manual, “Chapter 7: Forms Tab” at http://www.cgsmedicare.com/pdf/mycgs/chapter7_hhh.pdf for Additional Information.
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 email 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.

Unsolicited/Voluntary Refunds

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

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

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


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

Expanding possibilities with myCGS

Are you missing out on a fast and secure system that provides Medicare information with a click of a mouse? Visit the myCGS website at http://www.cgsmedicare.com/hhh/mycgs/index.htm to check out the many portal features and learn how to register if you are a new user. Save time and resources - take advantage of this web-based resource today!