Medicare Bulletin
Jurisdiction 15

Reaching Out to the Medicare Community
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Going Green with myCGS: Remittance Advices

myCGS users are able to view and print copies of remittance advices (RAs) at their own convenience. Having this option not only saves time and money for you, but it also saves the program on printing and postage costs.

For information on viewing and printing copies of RAs through myCGS, please refer to the myCGS User Manual at http://www.cgsmedicare.com/pdf/mycgs/chapter3.pdf on the CGS website. There you will find screen shots and step-by-step instructions on viewing and printing RAs.
For Home Health Providers

MM9698: Update to Editing of Therapy Services to Reflect Coding Changes

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: MM9698
Related CR Release Date: December 1, 2016
Related CR Transmittal #: R3670CP

Change Request (CR) #: CR 9698
Effective Date: January 1, 2017
Implementation Date: April 3, 2017

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

Provider Action Needed
Change Request (CR) 9698 instructs the MACs to apply certain coding edits to the new Current Procedural Terminology (CPT) codes that are used to report physical and occupational therapy evaluations and re-evaluations, effective January 1, 2017. Make sure your billing staffs are aware of these coding changes.

Background
Original Medicare claims processing systems contain edits to ensure claims for the evaluative procedures furnished by rehabilitative therapy clinicians – including physical therapists, occupational therapists and speech-language pathologists – are coded correctly. These edits ensure that when the codes for evaluative services are submitted, the therapy modifier (GP, GO or GN) that reports the type of therapy plan of care is consistent with the discipline described by the evaluation or re-evaluation code. The edits also ensure that Functional Reporting occurs, that is, that functional G-codes, along with severity modifiers, always accompany codes for therapy evaluative services.

For calendar year (CY) 2017, eight new CPT codes (97161-97168) were created to replace existing codes (97001-97004) to report physical therapy (PT) and occupational therapy (OT) evaluations and reevaluations. The new CPT code descriptors include specific components.
that are required for reporting as well as the typical face-to-face times. In another recent issuance, CR 9782, the Centers for Medicare & Medicaid Services (CMS) described the new PT and OT code sets, each comprised of three new codes for evaluation – stratified by low, moderate, and high complexity – and one code for re-evaluation. CR 9782 designated all eight new codes as “always therapy” (always require a therapy modifier) and added them to the 2017 therapy code list located at http://www.cms.gov/Medicare/Billing/TherapyServices/index.html. For a complete listing of the new codes, their CPT long descriptors, and related policies, see the article related to CR 9782 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9782.pdf.

CR 9698 applies the coding requirements for certain evaluative procedures that are currently outlined in the “Medicare Claims Processing Manual,” Chapter 5 to the new codes for PT and OT evaluations and re-evaluations. These coding requirements include the payment policies for evaluative procedures that (a) require the application of discipline-specific therapy modifiers and (b) necessitate Functional Reporting using G-codes and severity modifiers. The new codes are also added to the list of evaluation codes that CMS will except from the caps after the therapy caps are reached when an evaluation is necessary, for example, to determine if the current status of the beneficiary requires therapy services.

This notification implements the following payment policies related to claims for therapy services for the new codes for physical therapy (PT) and occupational therapy (OT) evaluative procedures – claims without the required information will be returned as unprocessable:

**Therapy Modifiers.** The new PT and OT codes are added to the current list of evaluative procedures that require a specific therapy modifier to identify the plan of care under which the services are delivered to be on the claim for therapy services. Therapy modifiers GP, GO or GN are required to report the type of therapy plan of care – PT, OT, or speech language pathology (SLP), respectively. This payment policy requires that each new PT evaluative procedure code – 97161, 97162, 97163 or 97164 – to be accompanied by the GP modifier; and, (b) each new code for an OT evaluative procedure – 97165, 97166, 97167 or 97168 – be reported with the GO modifier.

**Functional Reporting.** In addition to other Functional Reporting requirements, current payment policy requires Functional Reporting, using G-codes and severity modifiers, when an evaluative procedure is furnished and billed. CR9698 adds the eight new codes for PT and OT evaluations and reevaluations – 97161, 97162, 97163, 97164, 97165, 97166, 97167, and 97168 – to the procedure code list of evaluative procedures that necessitate Functional Reporting. A severity modifier (CH – CN) is required to accompany each functional G-code (G8978-G8999, G9158-9176, and G9186) on the same line of service. For each evaluative procedure code, Functional Reporting requires either two or three functional G-codes and related severity modifiers be on the same claim. Two G-codes are typically reported on specified claims throughout the therapy episode. However, when an evaluative service is furnished that represents a one-time therapy visit, the therapy clinician reports all three G-codes in the functional limitation set – G-codes for Current Status, Goal Status and Discharge Status.

For the documentation requirements related to Functional Reporting, please refer to the “Medicare Benefits Policy Manual,” Chapter 15, Section 220.4.

CMS coding requirements for Functional Reporting applied through CR9698 ensure that at least two G-codes in a functional set and their corresponding severity modifiers are present on the same claim with any one of the codes on this evaluative procedure code list. The required reporting of G-codes includes: (a) G-codes for Current Status and Goal Status; or, (b) G-codes for Discharge Status and Goal Status. Remember that your MAC will Return to the Provider (RTP):

This newsletter should be shared with all health care practitioners and managerial members of the provider/supplier staff. Newsletters are available at no cost from our website at http://www.cgsmedicare.com. © 2016 Copyright, CGS Administrators, LLC.
1. Claims you submit for the new therapy evaluative procedures, HCPCS codes 97161-97168, without including one of the following pairs of G-codes/Severity modifiers required for Functional Reporting: (a) A current status G-code/Severity modifier paired with a goal status G-code/Severity modifier; or, (b) A goal status G-code/Severity modifier paired with a discharge status G-code/Severity modifier.

2. Institutional outpatient claims reporting HCPCS codes 97161, 97162, 97163, and 97164 that you submit without including modifier GP.

3. Institutional outpatient claims reporting HCPCS codes 97165, 97166, 97167, and 97168, that you submit without including modifier GO.

Additional Information
The official instruction, CR9698, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3670CP.pdf. The updated “Medicare Claims Processing Manual,” Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Sections 10.3.2 (Exceptions Process), 10.6 (Functional Reporting), and 20.2 (Reporting of Service Units with HCPCS) is attached to CR9698.

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

SE1635: Continuation of the Home Health Probe and Educate Medical Review Strategy

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: SE1635
Article Release Date: December 16, 2016
Related CR Transmittal #: N/A
Change Request (CR) #: N/A

Effective Date: Episodes beginning on or after August 1, 2015
Implementation Date: N/A

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

Provider Action Needed
STOP – Impact to You
MACs, in conjunction with the Centers for Medicare & Medicaid Services (CMS), will be conducting Round 2 of medical review and reporting under the Home Health Probe & Educate medical review strategy. These reviews relate to claims submitted by HHAs related to Medicare home health services and patient eligibility (certification/re-certification), as outlined in CMS-1611-F (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1611-F.html).

CAUTION – What You Need to Know
Final rule CMS-1611-F eliminates the face-to-face encounter narrative as part of the certification of patient eligibility for home health services.
GO – What You Need to Do
Make sure that your billing staffs are aware of these revised policies.

Background
On November 6, 2014, CMS issued CMS-1611-F, Calendar Year (CY) 2015 Home Health Prospective Payment System (HH PPS) Final Rule. The changes, discussed below, were effective beginning January 1, 2015.

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

CMS is continuing the Probe and Educate medical review strategy to assess and promote provider understanding and compliance with the Medicare home health eligibility requirements.

Claims Subject to Review as Part of the Probe and Educate Process
For round 2 of the Probe and Educate program, CMS anticipates MACs will begin sending Additional Documentation Requests (ADRs) on or after December 15, 2016 and that this round of claim reviews and provider education will conclude in approximately one year. This document contains a summary of the technical direction that CMS will issue to the MACs.

CMS is directing Home Heath MACs to select a sample of 5 claims for pre-payment review for from each HHA within their jurisdiction, excluding those providers who had 5 claims reviewed in Round 1, with zero or one claim in error. As they are completing the second round of Probe and Educate reviews, MACs will continue to focus on the Home Health Agency’s (HHA) compliance with the policy outlined in CMS-1611-F, as well as to make sure all other coverage and payment requirements are met.

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

In addition to these educational outreach efforts, for those providers that are identified as having moderate or major concerns, the MACs may repeat the Probe and Educate process for dates of services occurring after education has been provided. The following table outlines MAC actions following HHA probe reviews.
<table>
<thead>
<tr>
<th>No or Minor Concerns</th>
<th>Moderate/Major Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 claim sample 0-1*</td>
<td>2-5*</td>
</tr>
<tr>
<td>Action</td>
<td>For each provider with no or minor concerns, CMS will direct the MAC to:  1. Deny non-compliant claims; and  2. Send detailed review results letters explaining each denial.  3. Send summary letter that:  - Offers the provider a 1:1 phone call to discuss claim denials if any; and  - Indicates that no more reviews will be conducted under the Probe &amp; Educate process.  4. Await further instruction from CMS</td>
</tr>
</tbody>
</table>

* Note: If the HH claim submissions do not fulfill the requested sample, the provider will be considered of moderate concern unless it is mathematically impossible based on the claims reviewed (for example, the provider had four claims reviewed by the MAC and all were paid).

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

Hospice Cap Changes

The Centers for Medicare & Medicaid Services (CMS) published the fiscal year (FY) 2016 Hospice Wage Index and Payment Rate Update final rule on August 6, 2015. The final rule included a change to align the Inpatient and Aggregate Cap Accounting Year with the Federal Fiscal Year (9/30).

CMS is aligning the cap accounting year for both the inpatient cap and the hospice aggregate cap with the federal fiscal year for FYs 2017 and later. In addition to aligning the cap accounting year with the federal fiscal year, they will also align the timeframe for counting the number of beneficiaries with the federal fiscal year.

FY 2017 will be the transition year and the cap period will be 11/01/16 to 9/30/17. Then for FY’s 2018 and forward the cap period will be 10/01/yy to 9/30/yy. This will move the Self-Determined Hospice Caps due dates for, FY 2017 and forward, to between 12/31/yy to the end of February/1st week of March.

The table below summarizes FY 2016 to 2018 cap years, Beneficiary Id Periods and payments. Those hospices that use the streamlined method for counting beneficiaries please note that beginning with FY 2018 and forward the Beneficiary ID Period matches the cap year.

<table>
<thead>
<tr>
<th>Cap Year</th>
<th>Streamlined</th>
<th>Patient-by-Patient</th>
<th>Streamlined</th>
<th>Patient-by-Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 (Transition Year)</td>
<td>9/28/16 – 9/30/17</td>
<td>11/1/16 – 9/30/17</td>
<td>11/1/16 – 9/30/17</td>
<td>11/1/16 – 9/30/17</td>
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<tr>
<td>2018</td>
<td>10/1/17 – 9/30/18</td>
<td>10/1/17 – 9/30/18</td>
<td>10/1/17 – 9/30/18</td>
<td>10/1/17 – 9/30/18</td>
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</tbody>
</table>
Please contact Tom Bisbee at 1.615.660.5560 if you have any questions regarding above changes or Hospice Cap questions in general.

For Hospice Providers

SE1631 (Revised): Sample Hospice Election Statement

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

MLN Matters® Number: SE1631 Revised  
Article Release Date: December 13, 2016  
Change Request (CR) #: 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 at 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 certification/recertification of terminal illness. 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. An individual may 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

Note: This article was revised on December 13, 2016, to clarify that the subject is the Hospice Election Statement and not the notice of election.
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 hospice 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 Hospice 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 OIG report is available at https://oig.hhs.gov/oei/reports/oei-02-10-00492.pdf.


The sample statement is on the next page.

Document History

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<thead>
<tr>
<th>Date of Change</th>
<th>Description</th>
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<tr>
<td>December 13, 2016</td>
<td>The article was revised to clarify that the subject is the hospice election statement and not the notice of election.</td>
</tr>
<tr>
<td>November 22, 2016</td>
<td>Initial issuance.</td>
</tr>
</tbody>
</table>
Medicare Hospice Election Statement

Draft Sample

I, _______________________________ (Beneficiary Name), choose to elect the Medicare hospice benefit and receive 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 _______________________________ (Hospice Agency) to begin on _______________________________ (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 Hospice Providers

SE1633: Exceptions For Late Hospice Notices of Election Delayed by Medicare Systems

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: SE1633
Related CR Release Date: December 1, 2016
Change Request (CR) #: N/A
Related CR Transmittal #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Article is intended for hospices submitting Notices of Election to Medicare Administrative Contractors (MACs) for Medicare beneficiaries.

What You Need to Know

Hospices must file a Notice of Election (NOE) for each patient within 5 calendar days after the effective date of the election. When a hospice’s NOE is not submitted and accepted within 5 calendar days after the effective date of election, Medicare will not cover and pay for days of hospice care from the effective date of election to the date of filing of the accepted NOE.

MACs will grant an exception for the late NOE if the hospice is able to provide the MAC with documentation showing:

1. When the original NOE was submitted
2. When the NOE was returned to the hospice for correction or was accepted and available for correction, and
3. When the hospice resubmitted the NOE.

Background

When an NOE is submitted within the 5 day timely filing period, but the NOE contains inadvertent errors (such as transposed numbers in a beneficiary identifier), the error does not trigger the NOE to be immediately returned to the hospice for correction. In these instances, the hospice must wait until the incorrect information is fully processed by Medicare systems before the NOE is returned to the hospice for correction. There are other NOE errors, such as incorrect admission dates, that will not be returned for correction and instead must be finalized and posted by the Medicare systems before the hospice can correct the NOE. These delays occur because the submitted data appears valid to Medicare systems; only the hospice is aware of the error. Such delays in Medicare systems could cause the NOE to be late and thus the days between the effective dates of the election and when the NOE is corrected, resubmitted, and accepted to be non-covered.

Medicare has determined that timely-filed NOEs with inadvertent errors that cannot be immediately corrected due to Medicare system constraints (and thus returned to the provider for correction, causing late system acceptance of NOEs and non-covered days) are outside the control of the hospice and so qualify for an exception to the timely filing requirement in the circumstances described below. All current provider education about errors that can be fixed immediately remain in effect. MACs will grant an exception only for instances where timely-filed NOEs contained errors that could not be immediately corrected due to system constraints.
MACs will grant an exception for the late NOE if the hospice is able to provide the MAC with documentation showing:

1. When the original NOE was submitted
2. When the NOE was returned to the hospice for correction or was accepted and available for correction, and
3. When the hospice resubmitted the NOE.

MACs will grant the exception if all documentation is provided and the hospice took appropriate actions within 2 business days to make corrections. Once the NOE is returned for correction the hospice will have 2 business days to resubmit. When the NOE was posted to the Common Working File (CWF) and must be cancelled and resubmitted, they will have 2 business days to cancel the NOE and then 2 business days to submit the new NOE after the date that the cancellation NOE finalizes.

If the hospice provides sufficient information in the Remarks section of its claim to allow the MAC to research the case, then MACs will make a determination without requesting the additional supporting documentation described above. The provider’s remarks must clearly indicate the circumstances and time frames in order to substitute for documentation providing the same information. If it does not, MACs will request documentation. Documentation should consist of printouts or screen images of any Medicare systems screens that contain the information shown above. In instances where the MAC suspects a hospice has such a volume of exceptions requests for inadvertent errors that suggests abuse, the MAC may request documentation for every exception request rather than allowing those hospices to utilize the Remarks section of their claim.

MACs have previously educated that hospices need not wait until an NOE is returned to correct many errors. In these instances, an exception will not be granted. It is not appropriate for hospices to submit a partial NOE to fulfill the timely-filing requirement. MACs will not grant exceptions in cases where it appears that the hospice is engaging in such practices.

MACs will also not grant exceptions in cases where hospices with multiple provider identifiers submit the identifier of a location that did not actually provide the service.

Additionally, hospices have reported cases of system delays beyond their control occurring when Medicare systems are not available (“dark days”). In the great majority of cases, the 5 day timely filing period allows enough time to submit NOEs on a day when Medicare systems are available. Additionally, the receipt date is typically applied to the NOE immediately upon submission to Medicare systems, so subsequent dark days would not affect the determination of timeliness. However, hospices report cases in which an NOE is submitted on the day before a dark day period and the NOE does not receive a receipt date until the day following the dark days. If the hospice can provide documentation showing this situation occurred, MACs will grant an exception to the timely filing requirement. The Centers for Medicare & Medicaid Services (CMS) expects these cases to be very rare.

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
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 **Hospice Payment Rates** Web page at [http://www.cgsmedicare.com/hhh/claims/fees/hospice_rates.html](http://www.cgsmedicare.com/hhh/claims/fees/hospice_rates.html) was updated to include a link to the MM9729 article which provides the hospice rates from October 2016 through September 2017.

- The **Resources for the Most Common Home Health and Hospice Medicare Questions** Web page at [http://www.cgsmedicare.com/hhh/education/materials/resources_most_common_hhh_questions.html](http://www.cgsmedicare.com/hhh/education/materials/resources_most_common_hhh_questions.html) was updated to correct the link to the National Plan & Provider Enumeration System (NPPES) and to add a link to the new Medicare Secondary Payer Claim Entry via Direct Data Entry (DDE) Online Education Course.

- The **Helpful Links** Web page at [http://www.cgsmedicare.com/hhh/cs/links.html](http://www.cgsmedicare.com/hhh/cs/links.html) was updated to correct links to CMS information as well as deleting links that are no longer available.

- The **ICD-10-CM/PCS** Web page at [http://www.cgsmedicare.com/hhh/claims/5010.html](http://www.cgsmedicare.com/hhh/claims/5010.html) was updated to correct links to CMS resources as well as deleting links to information that is no longer available.

- The following Web pages have been updated to reflect changes to non-MR ADRs regarding hospice exception requests, per SE1633 ([https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1633.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1633.pdf)):

- The **Home Health Advisory Group Members** list at [http://www.cgsmedicare.com/hhh/education/pdf/ag_members.pdf](http://www.cgsmedicare.com/hhh/education/pdf/ag_members.pdf) was updated.

- The **Hospice Cap** Web page at [http://www.cgsmedicare.com/hhh/financial/hospice_caps.html](http://www.cgsmedicare.com/hhh/financial/hospice_caps.html) was revised to update the “Provider Self-Determined Aggregate Cap Limitation” form, as well as the file used to calculate a prorated Hospice cap amount, and instructions to assist in obtaining your PS&R report.

- The **Medical Review Widespread Edits** Web page at [http://www.cgsmedicare.com/hhh/medreview/med_review_edits.html](http://www.cgsmedicare.com/hhh/medreview/med_review_edits.html) was updated to show the current home health and hospice edits.


- The home health **Claim Page 02 – Entering a RAP or Claim** Web page at [http://www.cgsmedicare.com/hhh/education/materials/hhe_claim_page_2.html](http://www.cgsmedicare.com/hhh/education/materials/hhe_claim_page_2.html) was updated to include the new G codes associated with registered nurse and licensed practical nurse visits for services provided on or after January 1, 2017.
• All of the home health and hospice Frequently Asked Questions, available at http://www.cgsmedicare.com/hhh/education/faqs/index.html were reviewed and updated as necessary as part of the quarterly review.

• The Pre-Claim Review Demonstration for Home Health Services Web page at http://www.cgsmedicare.com/hhh/medreview/pre_claim_review_demo.html was updated to include the start date for the state of Florida, and the new G codes associated with registered nurse and licensed practical nurse visits for services provided on or after January 1, 2017.

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

MM9612: July 2016 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: MM9612
Related CR Release Date: April 22, 2016
Related CR Transmittal #: R3494CP
Change Request (CR) #: CR 9612
Effective Date: July 1, 2016
Implementation Date: July 5, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9612 informs MACs to download and implement the July 2016 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the April 2016, January 2016, October 2016 and July 2015, 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 July 5, 2016, with dates of service July 1, 2016, through September 30, 2016. Make sure that 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 OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the “Medicare Claims Processing Manual” (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER)) (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>
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<tbody>
<tr>
<td>July 2016 ASP and ASP NOC</td>
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Additional Information

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

For Home Health and Hospice Providers

MM9716 (Revised): New Physician Specialty Code for Hospitalist

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: MM9716 Revised
Related CR Release Date: November 25, 2016
Related CR Transmittal #: R3637CP and R276FM
Change Request (CR) #: CR 9716
Effective Date: April 1, 2017
Implementation Date: April 3, 2017

Note: This article was updated on November 28, 2016, to reflect a revised CR9716, issued on November 25. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. 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 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.

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For Home Health and Hospice Providers

**MM9724: October 2016 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:** MM9724  
**Change Request (CR) #:** CR 9724  
**Related CR Release Date:** July 29, 2016  
**Effective Date:** October 1, 2016  
**Related CR Transmittal #:** R3573CP  
**Implementation Date:** October 3, 2016
Provider Types Affected
This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know
Change Request (CR) 9724 provides the October 2016 quarterly update and instructs MACs to download and implement the October 2016 ASP drug pricing files and, if released by CMS, the July 2016, April 2016, January 2016, and October 2015, 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 October 3, 2016, with dates of service October 1, 2016, through December 31, 2016. MACs will not search and adjust claims that have already been 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 the Centers for Medicare & Medicaid Services (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.

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

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Additional Information

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

For Home Health and Hospice Providers

MM9776 (Revised): Clarification of Certification Statement Signature and Contact Person Requirements

The Centers for Medicare & Medicaid Services (CMS) has revised the following Medicare Learning Network® (MLN) Matters article on December 14, 2016. CMS then issued a revised article on December 22, 2016. The following reflects the revised 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
Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9776 clarifies the certification statement signature requirements for the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) and paper Medicare enrollment applications, and addresses contact person requirements.

CR9776 does not involve any legislative or regulatory policies. Make sure that you are familiar with these requirements.

Background

CR9776 informs the MACs that the Centers for Medicare & Medicaid Services (CMS) is updating Chapter 15 of the "Medicare Program Integrity Manual" in order to clarify the certification statement signature requirements for online and paper Medicare enrollment submissions, and to address contact person requirements. The main points of the updates are summarized below; and you can find the details in the manual’s updated Chapter 15 (Medicare Enrollment), which is an attachment to CR9776.

Certification Signature Requirements

A. Paper Submissions

A signed certification statement shall accompany all paper CMS-855 applications, which your MAC will only accept if the signature date is within 120 days of the receipt date of the application. If the provider submits an invalid certification statement or fails to submit a certification statement, your MAC will still proceed with processing the application, however, a valid certification statement will be solicited as part of the development process. This includes certification statements that are: (a) unsigned; (b) undated; (c) contains a copied or stamped signature; (d) was signed (as reflected by the date of signature) more than 120 days prior to the date on which the MAC received the application; (e) for paper Form CMS-855I and Form CMS-855O submissions, someone other than the physician or non-physician practitioner signed the form, except as noted in Section 15.5.14.1; or (f) missing certification statements. The MAC will send one development request to include a list of all of the missing required data/documentation, including the certification statement. The MAC may reject the provider’s application if the provider fails to furnish the missing information on the enrollment application - including all necessary documentation - within 30 calendar days from the date the MAC requested the missing information or documentation. The certification statement may be returned via scanned email, fax or mail to the MAC (as long as an original certification statement signature exist on file).

B. Internet-based PECOS Submissions

A signed certification statement shall accompany all web submitted CMS-855 applications. You may choose to electronically sign the application or submit the paper certification statement to your MAC. Paper certification statements may be submitted by email, fax, or mail (as long as an original certification statement signature exists on file).
You should note that your MAC will not compare the signature on the application with the same provider, authorized or delegated official’s signature on file to ensure that it is the same person; nor will they request the submission of a driver’s license or passport to verify a signature.

Specific form signature requirements follow:

- The enrolling or enrolled physician or non-physician practitioner is the only person who can sign the Form CMS-855I or the Form CMS-855O. (This applies to initial enrollments, changes of information, reactivations, revalidations, voluntary withdrawals, etc.) This includes solely-owned entities listed in section 4A of the Form CMS-855I. A physician or non-physician practitioner may not delegate the authority to sign the Form CMS-855I or Form CMS-855O on his/her behalf to any other person. Note: Exceptions to the above policy may apply in the following scenarios: (1) in the case of death (an executor of the estate), may sign on behalf of the deceased provider, or (2) if an employer is terminating an employment arrangement with a physician assistant, the Authorized or Delegated Official of the organization may sign the application. These situations would only apply to change of information applications.

- Form CMS-855R (Medicare Enrollment Application - Reassignment of Medicare Benefit), submitted for initial applications, must be signed and dated by the physician or non-physician practitioner and the authorized or delegated official of the provider or supplier; while those submitted to change and/or update the provider or supplier’s Medicare enrollment data (to include updates to the primary practice location) may be signed by either the physician or non-physician practitioner or the authorized or delegated official of the provider or supplier.

- Form CMS-855A (Medicare Enrollment Application - Institutional Providers), CMS-855B (Medicare Enrollment Application - Clinics/Group Practices and Certain Other Suppliers), and CMS-855S (Medicare Enrollment Application - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers), submitted for initial applications, must be signed and dated by an authorized official of the provider or supplier; while those submitted to change, update and/or revalidate the provider or supplier’s Medicare enrollment data may be signed and dated by the authorized or delegated official of the provider or supplier.

The certification statement for the CMS-855A, CMS-855B and CMS-855S Medicare enrollment applications must be signed by an individual who has the authority to bind the provider or supplier, both legally and financially, to the requirements set forth in 42 CFR 424.510 (http://www.ecfr.gov/cgi-bin/text-idx?SID=7abb0c441a8cabe6594ca609f6194c5&mc=true&node=se42.3.424_1510&rgn=div8&wb48617274=9DC191AA). This person must also have an ownership or control interest in the provider or supplier, such as, the general partner, chairman of the board, chief financial officer, chief executive officer, president, or hold a position of similar status and authority within the provider or supplier organization. The signature attests that the information submitted is accurate; and that the provider or supplier is aware of, and abides by, all applicable statutes, regulations, and program instructions.

Your MAC will verify and validate all information collected on the enrollment application, provided that a data source is available. You should remember that:

1. For paper CMS-855 submissions, if you submit an invalid certification statement or do not submit a certification statement, your MAC will treat this as missing information and will request that you submit a correct certification statement, preferably via e-mail or fax. The certification statement may be returned via scanned email, fax or mail to the contractor (as long as an original certification statement signature exist on file).
2. For Internet-based PECOS submissions, if you choose to submit your certification statement via paper rather than through e-signature, you may do so by email, fax or mail (as long as an original certification statement signature exist on file). You must submit the paper certification statement within 20 calendar days of the date on which you submitted your Internet-based PECOS application, otherwise the MAC may reject your application.

3. When submitting the certification statement, only the signature page is required, you do not have to include the additional page containing the certification terms.

4. MACs will not request a driver’s license or passport to verify the signature.

5. Your MAC will send approval letters to the contact person listed on the application via email (if there is no contact person on file, they will send the approval letter to the provider or supplier at their correspondence address).

Contact Person Requirement Clarifications

MACs will accept end dates to contact persons via phone, scanned email, fax or mail from the individual provider, the Authorized or Delegated Official or a current contact person. This is an interim process until the Form CMS-855s can be updated to delete contact persons.

If any contact person listed on a provider or supplier’s enrollment record requests a copy of their Medicare approval letter or revalidation notice, MACs will send it to the contact person via email, fax, or mail.

Additional Information

While the above provides the key points of CR9776, providers may wish to review the entire revision to Chapter 15, which is attached to CR9776. CR9776 is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R689PI.pdf.

42 CFR 424.5120 is available at http://www.ecfr.gov/cgi-bin/text-idx?SID=7abb0c441a8cabde6594ca609fd194c5&mc=true&node=se42.3.424_1510&rgn=div8.

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

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<tr>
<td>December 22, 2016</td>
<td>The article was revised on December 22, 2016, to clarify certain information in the bullet points on pages 3 and 4.</td>
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<td>December 14, 2016</td>
<td>Initial issuance</td>
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For Home Health and Hospice Providers

**MM9844: Summary of Policies in the Calendar Year (CY) 2017 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, and CT Modifier Reduction 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
MLN Matters® Number: MM9844
Related CR Release Date: December 16, 2016
Related CR Transmittal #: R3676CP
Change Request (CR) #: CR 9844
Effective Date: January 1, 2017
Implementation Date: January 3, 2017

Provider Types Affected

This MLN Matters® Article is intended for physicians and other providers who submit claims to Medicare Administrative Contractors (MACs) for services paid under the MPFS and provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9844 provides a summary of policies in the Calendar Year (CY) 2017 MPFS Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. Make sure that your billing staffs are aware of these updates.

Background

Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary of Health and Human Services to establish by regulation a fee schedule of payment amounts for physicians’ services for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) issued a final rule on November 2, 2016, that updates payment policies and Medicare payment rates for services furnished by physicians and Non-Physician Practitioners (NPPs) that are paid under the MPFS in CY 2017.

The final rule (CMS-1654-F) also addresses public comments on Medicare payment policies proposed earlier in 2016. The proposed rule, “Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017,” was published in the Federal Register on July 15, 2016.

The key changes are as follows:

CT Modifier Reduction Changes from 5 percent to 15 percent

As required by Medicare law, effective January 1, 2016, a payment reduction of 5 percent applies to Computed Tomography (CT) services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the MPFS. The payment reduction increases to 15 percent in 2017 and subsequent years. See MLN Matters Article MM9250 for more details.

Multiple Procedure Payment Reduction (MPPR) on the Professional Component (PC) of Certain Diagnostic Imaging Procedures

As required by Medicare law, CMS revised the MPPR of the PC of the second and subsequent procedures from 25 percent to 5 percent of the physician fee schedule amount. The MPPR on the Technical Component (TC) of imaging remains at 50 percent.

Currently, CMS makes full payment for the PC of the highest-priced procedure and payment at 75 percent for the PC of each additional procedure, when furnished by the same physician (or physician in the same group practice) to the same patient, in the same session on the same day. See MLN Matters Article MM9647 for more details.

Telehealth Origination Site Facility Fee Payment Amount Update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each...
subsequent CY, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act. The MEI increase for 2017 is 1.2 percent. Therefore, for CY 2017, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $25.40. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

Access to Telehealth Services
CMS is adding the following services to the list of those that can be furnished to Medicare beneficiaries under the telehealth benefit:

- ESRD-related services CPT codes 90967 through 90970
- Advance care planning CPT codes 99497 through 99498
- Telehealth consultation HCPCS codes G0508 through G0509

Note: For the ESRD-related services, the required clinical examination of the catheter access site must be furnished face-to-face “hands on” (without the use of an interactive telecommunications system) by a physician, Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), or Physician Assistant (PA). For the complete list of telehealth services, visit [http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html](http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html).

New Place of Service (POS) Code for Telehealth
The new POPS is 02 with a description of the location where health services and health related services are provided or received, through telecommunication technology.

X-ray Reduction for Film
As required by Medicare law, Medicare reduces payment amounts under the MPFS by 20 percent for the TC (and the TC of the global fee) of imaging services that are X-rays taken using film, effective January 1, 2017, and after.

To implement this provision, CMS has created Modifier FX (X-ray taken using film). Beginning in 2017, claims for X-rays using film must include Modifier FX, which will result in the applicable payment reduction. See MLN Matters Article MM9727 at [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9727.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9727.pdf) for more details.

Primary Care, Care Management, and Cognitive Services
CMS is finalizing the following coding and payment changes for CY 2017 to improve payment for various primary care, care management, and cognitive services. Each of these codes is included in the 2017 HCPCS update and payment information is included in the routine annual update files:

- Separate payment for existing codes describing prolonged Evaluation and Management (E/M) services without direct patient contact by the physician (or other billing practitioner) (CPT codes 99358, 99359), and increased payment for prolonged E/M services with direct patient contact by the physician (or other billing practitioner) (CPT code 99354) adopting the RUC-recommended values. CPT codes 99358 and 99359 are listed in the “Medicare Claims Processing Manual” as non-payable (Chapter 12, Section 30.6.15.2). As of January 1, 2017, these codes are separately payable under the MPFS and changes to the manual are forthcoming.

- The MPFS includes new coding and payment for Behavioral Health Integration (BHI) services including substance use disorder treatment, specifically three new codes to describe services furnished using the psychiatric Collaborative Care Model (CoCM) (HCPCS codes G0502, G0503, G0504) and one new code to describe services furnished using other BHI care models (HCPCS code G0507).
• Separate payment for complex Chronic Care Management (CCM) services (CPT codes 99487, 99489), reduced administrative burden for CCM (CPT codes 99487, 99489, 99490), and a new add-on code to the CCM initiating visit to account for the work of the billing practitioner in assessing the beneficiary and establishing the CCM care plan (HCPCS code G0506).

• A new code for cognition and functional assessment and care planning for treatment of cognitive impairment (HCPCS code G0505).

Implementation of Alternative Medicare Physician Fee Schedule (PFS) Locality Configuration for California

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA 2014) was signed into law and Section 220(h) of the legislation adds Section 1848(e) (6) of the Act, which now requires, for services furnished on or after January 1, 2017, that the locality definitions for California be based on the Metropolitan Statistical Area (MSA) delineations as defined by the Office of Management and Budget (OMB). The resulting modifications to California’s locality structure increases its number of localities from 9 under the current locality structure to 27 under the MSA based locality structure. However, both the current localities and the MSA based localities are comprised of various component counties, and in some localities only some of the component counties are subject to the blended phase-in and hold harmless provisions required by Section 1848(e)(6)(B) and (C) of the Act. Although the modifications to California’s locality structure increase the number of localities from 9 under the current locality structure, to 27 under the MSA-based locality structure, for purposes of payment, the actual number of localities under the MSA based locality structure would be 32 to account for instances where unique locality numbers are needed.

Additionally, for some of these new localities, PAMA requires that the geographic practice cost index GPCI values that would be realized under the new MSA based locality structure are gradually phased in (in one-sixth increments) over a period of 6 years.

Update to the Methodology for Calculating GPICs in the U.S. Territories

CMS is revising the methodology used to calculate GPICs in the U.S. territories, whereby Puerto Rico will be assigned the national average of 1.0 to each GPCI, as is currently done in the Virgin Islands in an effort to provide greater consistency in the calculation of the territories’ GPICs. This change is included in the routine PFS update files.

Data Collection Required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to Accurately Value Global Packages

CMS finalized a data collection strategy to gather information needed to value global surgical services. Practitioners in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon and Rhode Island are required, beginning July 1, 2017, to report claims showing that a visit occurred during the post-operative period for select global services. Practitioners who only practice in settings of fewer than 10 practitioners are not required to report, but may do so voluntarily. Such visits will be reported using CPT code 99024. The requirement to report will only apply to specified high-volume/high-cost services. The list of services for which reporting is required will be available on the CMS website. Practitioners who are not required to report are able to report voluntarily and encouraged to do so. If reporting voluntarily, reporting should be done for all visits relating to all codes on the list of applicable codes.

In addition a survey of practitioners will be conducted to gather data on service furnished in the post-operative period.

To the extent that these data result in proposals to revalue any global packages, that revaluation will be done through notice and comment rulemaking at a future time.
Valuing Services That Include Moderate Sedation as an Inherent Part of Furnishing the Procedure

The CPT Editorial Panel created CPT codes for separately reporting moderate sedation services, which corresponded to elimination of Appendix G from the CPT Manual, effective January 1, 2017. Appendix G of the CPT Manual identified services where moderate sedation was considered an inherent part of the procedural service. The MPFS Final Rule established valuations for the new moderate sedation CPT codes and revaluation of certain procedural services previously identified in Appendix G. These coding and payment changes provide for payment for moderate sedation services only in cases where moderate sedation services are furnished.

Additional Information


The final 2017 MPFS rule is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-f.html.

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

MM9854: CY 2017 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

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

MLN Matters® Number: MM9854  Change Request (CR) #: CR 9854
Related CR Release Date: December 5, 2016  Effective Date: January 1, 2017
Related CR Transmittal #: R3671CP  Implementation Date: January 3, 2017

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9854 provides the calendar year (CY) 2017 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedule on an annual basis in accordance with statute and regulations. The update process for

Payment on a fee schedule basis is required for certain durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for parenteral and enteral nutrition (PEN), splints, casts and intraocular lenses (IOLs) inserted in a physician’s office.

The Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME. The Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. The methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs are established in regulations at 42 CFR Section 414.210(g). Also, program instructions on these changes are available in Transmittal 3551, CR 9642 (MLN Matters article MM9642 - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9642.pdf), dated June 23, 2016, and Transmittal 3416, CR 9431 (MM9431 - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9431.pdf), dated November 23, 2015.

The DMEPOS and PEN fee schedule files contain Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the adjusted fee schedule amounts as well as codes that are not subject to the fee schedule CBP adjustments. Fee schedule amounts that are adjusted using information from CBPs will not be subject to the annual DMEPOS covered item update, but will be updated pursuant to 42 CFR 414.210(g)(8) when information from the CBPs is updated. This update to the adjusted fees includes information from the CBPs that takes effect on January 1, 2017 (Round 1 2017). Pursuant to 42 CFR Section 414.210(g)(4), for items where the single payment amounts (SPAs) from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment would go into effect (for example, 2017 for this update) and for each subsequent year such as 2018 and 2019.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. ZIP codes for non-continental Metropolitan Statistical Areas (MSA) are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis as necessary. Regulations at Section 414.202 define rural areas to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any MSA. A rural area also includes any ZIP Code within an MSA that is excluded from a competitive bidding area established for that MSA.

Policy: Fee Schedule and Rural Zip Code Files
The DMEPOS fee schedule file contains fee schedule amounts for non-rural and rural areas. Also, the PEN fee schedule file includes state fee schedule amounts for both enteral nutrition items and national non-rural fee schedule amounts for parenteral nutrition items.

The DMEPOS and PEN fee schedules and the rural ZIP code public use files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties on the CMS DMEPOS fee schedule website (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html) after November 18, 2016.
New Codes Added
The new codes are not to be used for billing purposes until they are effective on January 1, 2017. For gap-filling pricing purposes, deflation factors are applied before updating to the current year. The deflation factors for 2016 by payment category are in the table below.

<table>
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<tr>
<th>Code Description</th>
<th>Deflation Factor</th>
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<td>Splints and Casts</td>
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<td>Intraocular Lenses</td>
<td>0.952</td>
</tr>
</tbody>
</table>

Codes Deleted
Codes deleted from the DMEPOS fee schedule files effective January 1, 2017, are:

- B9000 - Enteral nutrition infusion pump - without alarm (Enter infusion pump w/o alrm)
- B9000MS - Enteral nutrition infusion pump - without alarm
- E0628 - Separate seat lift mechanism for use with patient owned furniture-electric (Seat lift for pt furn-electr)
- K0901 - Knee orthosis (ko), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf ( Ko single upright pre ots)
- K0902 - Knee orthosis (ko), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf ( Ko double upright pre ots)

Effective January 1, 2017, codes B9000 and E0628 will crosswalk to codes B9002 and E0627 respectively. Payment for necessary maintenance and servicing of B9000 pumps will also crosswalk to B9002MS.

Effective January 1, 2017, the fees for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier ‘KU’ are deleted from the DMEPOS fee schedule file.


Specific Coding and Pricing Issues
Effective January 1, 2017, existing off-the-shelf orthotic (OTS) codes K0901 and K0902 are re-designated as codes L1851 and L1852 respectively. The fee schedule amounts for codes K0901 and K0902 will be applied to the corresponding new codes L1851 and L1852 as part of this update. Attachment B in CR 9854 updates the list of orthotic codes that are designated as OTS on the CMS orthotics website ([https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html)) to reflect the addition of the two renumbered codes (L1851 and L1852).

As part of this update, the adjusted fee schedule amounts for the following groups of similar items are adjusted in accordance with 42 CFR Section 414.210 (g)(6) to limit the single payment amounts (SPAs) for items without certain features to the weighted average of the SPAs for the items both with and without the features prior to using the SPAs in adjusting the fee schedule amounts:

2. Mattress and overlays (HCPCS codes E0277, E0371, E0372, and E0373)
3. Power wheelchairs (HCPCS codes K0813, K0814, K0815, K0816, K0820, K0821, K0822, and K0823)
4. Seat lift mechanisms (HCPCS codes E0627 and E0629)
5. TENS devices (HCPCS codes E0720 and E0730)
6. Walkers (HCPCS codes E0130, E0135, E0141 and E0143)

CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513).

To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004.

For 2017, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2015. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2017.

**Diabetic Testing Supplies**

The fee schedule amounts for non-mail order diabetic testing supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the single payment amounts for mail order DTS established in implementing the national mail order CBP under Section 1847 of the Act.

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated. This can happen no less often than every time the mail order CBP contracts are re-competed. The CBP for mail order diabetic supplies is effective July 1, 2016, to December 31, 2018. The program instructions reviewing these changes are Transmittal 2709, CR 8325 (MM8325 - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8325.pdf), dated May 17, 2013, and Transmittal 2661, CR 8204 (MM8204 - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm8204.pdf), dated February 22, 2013. Note that the mail order DTS (KL) fee schedule amounts for all states and territories were removed from the DMEPOS fee schedule file as part of the July 1, 2016, update.

**2017 Fee Schedule Update Factor of 0.7 Percent**

For CY 2017, an update factor of 0.7 percent is applied to certain DMEPOS fee schedule amounts.

In accordance with the statutory Sections 1834(a)(14) of the Act, certain DMEPOS fee schedule amounts are updated for 2017 by the percentage increase in the consumer price index for all urban consumers (United States city average) or urban consumers (CPI-U) for the 12-month period ending with June of 2016, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP). The MFP adjustment is 0.3 percent and
the CPI-U percentage increase is 1 percent. Therefore, the 1 percentage increase in the CPI-U is reduced by the 0.3 percentage increase in the MFP resulting in a net increase of 0.7 percent for the update factor.

### 2017 Update to the Labor Payment Rates

Included below and in Attachment A in CR9854 are the CY 2017 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI-U for the twelve month period ending with June 30, 2016, is 1 percent, this change is applied to the 2016 labor payment amounts to update the rates for CY 2017. The 2017 labor payment amounts in Attachment A are effective for claims submitted using HCPCS codes K0739, L4205 and L7520 with dates of service from January 1, 2017, through December 31, 2017.

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### 2017 National Monthly Fee Schedule Amounts for Stationary Oxygen Equipment

As part of this update, CMS is implementing the 2017 monthly fee schedule payment amounts for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service from January 1, 2017, through December 31, 2017. As required by statute, the addition of the separate payment classes for oxygen generating portable equipment (OGPE) and stationary and portable oxygen contents must be annually budget neutral. Medicare expenditures must account for these separate oxygen payment classes. Therefore, the fee schedule amounts for stationary oxygen equipment are reduced by a certain percentage each year to balance the increase in payments made for the additional separate oxygen payment classes. For dates of service January 1, 2017, through December 31, 2017, the 2017 monthly fee schedule payment amounts for stationary oxygen equipment range from approximately $67 to $77, incorporating the budget neutrality adjustment factor.

When updating the stationary oxygen equipment amounts, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the payment amounts for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.
2017 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

Also updated for 2017 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, CR 6972 (MM6972 - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6792.pdf), dated February 5, 2010 and Transmittal 717, CR6990 (MM6990 - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6990.pdf), dated June 8, 2010. To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months, beginning 6 months after the end of the 36th month of continuous use or end of the supplier’s or manufacturer’s warranty, whichever is later for HCPCS codes E1390, E1391, E0433 or K0738, billed with the MS modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary for any 6-month period.

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Therefore, the 2016 maintenance and servicing fee is adjusted by the 0.7 percent MFP-adjusted covered item update factor to yield CY 2017 maintenance and servicing fee of $69.97 for oxygen concentrators and transfilling equipment.

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 more information regarding the Competitive Bidding Implementation Contractor website refer to the CBIC website (http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home).

For Home Health and Hospice Providers

MM9892: January 2017 Integrated Outpatient Code Editor (I/OCE) Specifications Version 18.0

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: MM9892
Related CR Release Date: December 9, 2016
Related CR Transmittal #: R3674CP
Change Request (CR) #: CR 9892
Effective Date: January 1, 2017
Implementation Date: January 3, 2017

Provider Types Affected

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

Change Request (CR) 9892 provides instructions and specifications for the Integrated Outpatient Code Editor (I/OCE) used for Outpatient Prospective Payment System (OPPS) and non-OPPS claims. This is for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System (PPS) or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes. The I/OCE specifications will be posted at [http://www.cms.gov/OutpatientCodeEdit/](http://www.cms.gov/OutpatientCodeEdit/). These specifications contain the appendices mentioned in the table below.

Key I/OCE Changes for January 2017

The following table summarizes the modifications of the IOCE for the January 2017 v18.0 release. Note that some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the ‘Effective Date’ column.

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<tr>
<td>1/1/2017</td>
<td>Implement new program logic for the Community Mental Health Center (CMHC) outlier limitation (see OPPS processing logic and Appendix E). Apply new Payment Method Flag 6 to all OPPS payable lines if condition code 66 is present for claims with bill type 76x.</td>
<td></td>
</tr>
<tr>
<td>1/1/2017</td>
<td>Implement new program logic to include Negative Pressure Wound Therapy (NPWT) procedure codes 97607 and 97608 to the list of codes reportable for Home Health claims with bill type 34x that are payable under OPPS (see OPPS special processing logic and Appendix F-(a)).</td>
<td></td>
</tr>
<tr>
<td>8/1/2016</td>
<td>67</td>
<td>Implement mid-quarter Food and Drug Administration (FDA) approval edit for 90674.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td>100</td>
<td>Implement new edit: Claim for Hematopoietic Stem Cell Transplantation (HSCT) allogeneic transplantation lacks required revenue code line for donor acquisition services (claim is Returned to Provider (RTP)). Edit criteria: A claim reporting HSCT allogeneic transplantation (procedure code 38240) is reported and there is no additional line on the claim reporting revenue code 815 for donor acquisition services (see Table 4).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td>41</td>
<td>Add new revenue code 815 (Allogeneic stem cell acquisition services) to the valid revenue code list.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td>Implement updated program logic to process conditional Ambulatory Payment Classification (APC)/packaging, critical care ancillary packaging and advance care planning across the claim rather than by day (see OPPS processing logic).</td>
<td></td>
</tr>
<tr>
<td>1/1/2017</td>
<td>Implement new SI value E1, to replace former SI E for non-covered services (see Table 7). Note: Edits 9, 28 and 50 applied formerly for HCPCS with SI = E are now applied to HCPCS with SI = E1.</td>
<td></td>
</tr>
<tr>
<td>1/1/2017</td>
<td>Reactivate edit 13: Separate payment for services is not provided by Medicare (LIR). Edit criteria: there is a line item HCPCS present with SI = E2 (see OPPS processing logic, Table 4, Table 7).</td>
<td></td>
</tr>
<tr>
<td>1/1/2014</td>
<td>Correction of program logic for Extended Assessment and Management (EAM) composite APC 8009 to not consider conditional APC processing of sometimes therapy codes with SI = Q1 resulting in final SI = A as criteria for preventing assignment of the EAM composite APC. Also, units of service are not reduced to one under conditional APC processing for sometimes therapy codes resulting in final SI = A (see OPPS processing logic and Appendix K).</td>
<td></td>
</tr>
<tr>
<td>9/28/2016</td>
<td>68</td>
<td>Implement mid-quarter NCD coverage for G0499.</td>
</tr>
<tr>
<td>Effective Date</td>
<td>Edits</td>
<td>Modification</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
<td>--------------</td>
</tr>
<tr>
<td>1/1/2016</td>
<td>99</td>
<td>Update the edit logic to include exceptions for certain blood clotting factor HCPCS codes that may be self-administered and do not require that an OPPS payable procedure is present. Also, program logic only is updated to apply edit 99 only to those OPPS bill types where APC information is returned (see Appendix F(a) for reference).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the inpatient procedure processing when the patient expires to also include claims with discharge status codes indicating transfer to another hospital facility (see OPPS processing logic and Appendix L).</td>
</tr>
<tr>
<td>1/1/2016</td>
<td>70</td>
<td>Update the edit logic and description to include transfer discharge status: Edit description: CA modifier requires patient discharge status indicating expired or transferred</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Implement new program logic for identifying non-excepted items or services under Section 603 requirements that are provided in off-campus provider-based hospital outpatient departments that are reported with modifier PN may be subject to alternative payment method or reduction (see OPPS processing logic and new Appendix Q).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td>101</td>
<td>Implement new edit 101: Item or service with modifier PN not allowed under PFS (RTP). Edit criteria: Modifier PN is reported for an item or service that is considered to be non-excepted for an off-campus provider-based hospital outpatient department under Section 603.</td>
</tr>
<tr>
<td>1/1/2016</td>
<td></td>
<td>Update the advance care planning logic to include add-on code 99498; change the SI to A if reported with 99497 and the annual wellness visit, otherwise package with SI = N.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Update the program logic and flowcharts for partial hospitalization and daily mental health to refer to a single level per diem APC (level I/II APCs no longer applicable) (see OPPS processing logic and Appendix C(‘a’ and ‘b’). Appendices are attached to CR9892.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td>87</td>
<td>Update the skin substitute product lists (Appendix O, List E: Lists A and B)</td>
</tr>
<tr>
<td>1/1/2017</td>
<td>22</td>
<td>Modifier L1, associated with the reporting of conditionally packaged laboratory procedures is deactivated (see OPPS processing logic).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Update program logic for LDR brachytherapy composite APC primary code 55875 is assigned under comprehensive APCs if conditions are not met for composite APC 8001 assignment (see Appendix K).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Add the following new payment method flags (see Table 7 and Appendix E): • 6 (CMHC Outlier limitation reached) • 7 (Section 603 service with no reduction in OPPS Pricer) • 8 (Section 603 service with PFS reduction applied in OPPS Pricer)</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Update the description for Payment Indicator value of 2: “Services not paid by OPPS Pricer; paid under fee schedule or other payment system (Sis A, G, K)” (see Table 7).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Add new payment adjustment flag 21 (CAA Section 502b reduction on film x-ray) (see Table 7 and Appendix G).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Add new SI values E1 and E2 (Items and services for which pricing information and claims data are not available) (see Table 7).</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Update Appendix F(‘a’) to include new edits 100 and 101.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Add new Appendix Q: processing steps and criteria for non-excepted items and services under Section 603.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Update Appendix L to include new SI values E1 and E2 in the list of SI’s that are edited as usual under comprehensive APC processing.</td>
</tr>
<tr>
<td>1/1/2017</td>
<td></td>
<td>Update table 4 to add new columns noting versions and dates for edits. effective</td>
</tr>
</tbody>
</table>
Update the following lists for the release (see quarterly data files):
- Bilateral flag lists
- Procedure and gender conflict lists (edit 8)
- Comprehensive APC list
- Complexity-adjusted Comprehensive APC code pairs
- Device and Device-Procedure lists (edit 92)
- Terminated Device offset (offset by HCPCS)
- Pass-through device offset amounts
- Film x-ray HCPCS (new logic)
- Negative pressure wound therapy (new logic)
- Section 603 override HCPCS (new logic)
- Blood clotting factor HCPCS (edit 99 exclusion)
- Skin substitutes (edit 87)
- Pass-through Radiopharmaceuticals
- Pass-through Radiopharmaceutical APC offset amounts
- Pass-through Contrast APC offset amounts
- Pass-through Skin substitutes
- Pass-through Skin substitute APC offset amounts
- Deductible-Coinsurance N/A list (Appendix O, List C)
- Service not paid Medicare list (new SI = E2)
- Not recognized Medicare list (edit 28)
- Non-covered service list (edit 9)
- Statutory exclusion list (edit 50)
- Not recognized OPPS list (edit 62)
- FQHC vaccines
- FQHC code pairs

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

Implement version 23.0 of the NCCI (as modified for applicable outpatient institutional providers).

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

MM9902: Update to Medicare Deductible, Coinsurance and Premium Rates for 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: MM9902  Change Request (CR) #: CR 9902
Related CR Release Date: December 2, 2016  Effective Date: January 1, 2017
Related CR Transmittal #: R103GI  Implementation Date: January 3, 2017

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

Provider Action Needed
Change Request (CR) provides instruction for MACs to update the claims processing system with the new Calendar Year (CY) 2017 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.
Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person’s initial enrollment period, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person’s initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

2017 Part A - Hospital Insurance (HI)
- **Deductible:** $1,316.00
- **Coinsurance**
  - $329.00 a day for 61st-90th day
  - $658.00 a day for 91st-150th day (lifetime reserve days)
  - $164.50 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
- **Base Premium (BP):** $413.00 a month
- **BP with 10 percent surcharge:** $454.30 a month
- **BP with 45 percent reduction:** $227.00 a month (for those who have 30-39 quarters of coverage)
- **BP with 45 percent reduction and 10 percent surcharge:** $249.70 a month

2017 Part B - Supplementary Medical Insurance (SMI)
- **Standard Premium:** $134.00 a month
- **Deductible:** $183.00 a year Pro Rata Data Amount
  - $125.73 1st month
  - $57.27 2nd month
- **Coinsurance:** 20 percent
Additional Information

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

For Home Health and Hospice Providers

Provider Contact Center (PCC) Training

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our customer service representatives (CSRs). The list below indicates when the home health and hospice PCC at 1.877.299.4500 (option 1) will be closed for training.

<table>
<thead>
<tr>
<th>Date</th>
<th>PCC Training/Closures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday, February 20, 2017, President’s Day</td>
<td>8:00 a.m. – 4:30 p.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 on the CGS website. In addition, CGS’ Internet portal, myCGS, is available to access eligibility information through the Internet. For additional information, go to http://www.cgsmedicare.com/hhh/index.html and click the “myCGS” button on the left side of the web page.


For Home Health and Hospice Providers

Qualified Independent Contractor (QIC) Transition (Part A East)

CMS recently awarded the QIC Part A East contract to C2C Innovative Solutions, Inc. (C2C), effective February 14, 2017. Maximus Federal Services, Inc., the current contractor for the QIC Part A East region, will continue to process reconsiderations requested on or before February 13, 2017.

The QIC Part A East region includes the following jurisdictions: Colorado, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, Tennessee, South Carolina, North Carolina, Virginia, West Virginia, Puerto Rico, Virgin Islands, Main, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New Jersey, New York, Delaware, Maryland, Pennsylvania, and Washington DC.

Qualified Independent Contractors (QICs) are responsible for processing:

- Reconsideration requests (second level of appeal)
- Expedited reconsiderations on service termination and hospital discharge reviews performed by the Beneficiary and Family Centered Care (BFCC) Quality Improvement Organizations (QIOs).
For Home Health and Hospice Providers

Upcoming Educational Events

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

For Home Health and Hospice Providers

Update to the Interest Paid on Clean Non-PIP Claims Not Paid Timely

According to the Medicare Claims Processing Manual, (Pub 100-04, Ch. 1., §80.2.2), interest is paid on clean claims, not paid under the periodic interim payment (PIP) method, if payment is not made within 30 days after the date of receipt. The interest rate is determined by the Treasury Department on a 6-month basis, effective every January and July 1. Effective, January 1, 2017, the interest amount is 2.500%.

Note: Interest is not paid on home health prospective payment system (HH PPS) request for anticipated payment (RAP) billing transactions.

For additional information about when interest is paid on a claim, and how to calculate the interest, refer to the Medicare Claims Processing Manual, (Pub 100-04, Ch. 1., §80.2.2) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf on the Centers for Medicare & Medicaid Services (CMS) website. Current and past interest rate amounts can be viewed at http://fms.treas.gov/prompt/rates.html on the Treasury Department website.